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

TRANSCRIPT
Part 1

23rd ANNUAL WALL STREET COMES TO WASHINGTON HEALTH POLICY ROUNDTABLE

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Paul Ginsburg: Good morning. I want to welcome you to the 23rd 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 informed federal policymakers were on what was happening on the ground in health care markets. I also perceived that Wall Street analysts were conducting their own research on these issues to inform their investor clients, and that policymakers could benefit from the analysts' broader market perspectives.

After convening with analysts in New York in a very private setting, I invited them to come to Washington the next year to have these discussions in front of a policy audience, initiating what's been an annual event for many people inside the beltway who value the 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 sixth year. Through research and projects like this conference, the JKTG Foundation hopes to foster discussion about cost reduction, expanding access to care, and improving quality.

The conference's main purpose is to give the Washington health policy community insights into market developments that are relevant to policy through equity analysts. This year we also have a DC-based policy analyst who advises institutional and other investors about the potential impact of government policies on health care companies. Along with a thorough understanding of health care markets, and the companies they follow, all of our analysts today closely follow public policy, because of its implications for publicly traded companies.

The format this morning, as it's always been, is a roundtable discussion, based on questions that have been shared with the panelists in advance. And, we'll have two opportunities for audience Q&As. And, note that the analysts are not permitted by their employers to answer questions about outlooks for specific companies.

We have a great panel this morning. We have two veterans of previous Wall Street Comes Washington Conferences, Matt Borsch of BMO Capital Markets and Ana Gupte of Leerink Partners. And, our third panelist is Paul Heldman, who while new to the panel, knows the event well, dating back to his days as a reporter covering health policy for Bloomberg News. Paul now has his own firm, Heldman Simpson Partners, which advises investors about government policies that may impact their health care holdings.

So, what I'm going to do today is spend a lot of time at the beginning about what I think is the most interesting development over the past year, which is all of the initiatives toward vertical integration and health care financing and policy. And, the first question is that; in the past year or two, we've seen many proposed transactions, some of which have been approved, seeking to achieve vertical integration among health care companies. In many cases, the strategies behind these combinations are not clear, at least to those outside the organizations involved. When they can be discerned, they often provide insight, into long-term potential trends in health care financing and delivery. And, public policies, either implemented or anticipated, are potential motivators of some of these transactions. I'll ask about the strategy behind a number of different types of vertical consolidation, generically. And, if you want, you can bring up specific examples. So, the first type of vertical combination, I'd like to discuss is the integration of large pharmacy benefit managers, or PBMs, into insurers, and the possible strategies include more

seamless access to drug claims, which provide more insight into patient issues than medical claims do, or avoiding the challenging contracting arrangements between insurers and PBMs. So, I'd like the analysts to discuss what they see as the strategies behind, and the potential of, and barriers to, insurer-owned pharmacy benefit managers. Actually, I'll get into my details later. And, who would like to start?

Ana Gupte: So, I think the PBM industry, as it stands today, standalone PBMs, which really, we only have two large ones: Express Scripts and Caremark. And, the deals are poised to close before Thanksgiving. To me, they feel like they've just gotten bigger, and separate from managed care never really ever made sense. And, I think, from the point of view of either the member, or the patient, the point of view of the provider, and even most importantly, the point view of their existing employer and government clientele.

And, there's always been an imperative to vertically integrate pharmacy benefits into medical, because the pharmacy benefit is just going to influence medical cost and utilization, further down the care continuum. Why would you have a different entity managing that member through one benefit, while hospital outpatient and other benefits are managed by managed care. In fact, I used to work at Aetna, a long time ago now, been on the street for over 10 years. But, in 2005, I remember Ron Williams, the CEO of Aetna, had a very, very strong vision at the time of vertically integrating all benefits; pharmacy particularly, but behavioral as well. And then, also disability, life, and so on into the medical benefit.

The problem was, at the time, we only had mostly the commercial employer market. So, there wasn't enough scale for any of these plays. It was far more fragmented, and they were not enjoying the benefits they have right now of growth in Medicare Advantage, and growth in Medicaid, through managed Medicaid and privatization. So, when Aetna tried to do that, and they did have an in-house PBM for quite a while, they did have issues around scale—getting the best drug rebates and discounts from the drug manufacturers. They even had issues, at the time, around mail order fulfillment that met the necessary quality standards. And, at some point, it was impacting their reputation in business in the employer markets as well. So, they chose, after a long period of resistance, to outsource to CVS. Anthem outsourced to Express Scripts. But, Anthem was under a very difficult phase in their history around their execution, and they were in a state of turn around. And, they just wanted to farm out at least one piece of the business so they could focus on turnaround on the medical. And then, Cigna kind of took a middle ground.

Over time now, we've seen growth as I said, in multiple payer mix areas. United realized, and, I think United and Humana had that benefit, more than anybody, because Medicare Advantage and Part D, were the benefits that they really got outsized share gains in. And so, Humana had kept their PBM in house, and now have close to half a billion scripts, which is quite remarkable for their own business. And, United brought the Medco business in house, in addition to their Medicare business, and have really "shown the way" that this is what is possible, with an integrated PBM, with OptumRx under the same umbrella as managed care. They're growing share outsize. They're expanding their margins.

And, here you are, Cigna and Aetna, and you are finally kind of saying, "Well, this is not the best place for us to be to have an outsourced PBM." Simultaneously, Express and CVS have been under a lot of scrutiny because of their revenue line, because they get their revenue on a spread on what the benefits they manage. It's completely misaligned with their end customer. And, the

government is now pointing fingers, of course as you all know, with the way rebates are going, the difference between gross and net pricing. So, here you have an imperative from both sides to come together and sort of become a fast follower, if you will, to United and Optum. So, it makes a lot of sense. I'm very bullish on the deals, as far as the PBM goes. So, particularly Cigna and Express which is largely about integrating the PBM and managed care, and then at least the Caremark portion of CVS and Aetna.

And then, on the physician side—specialty drug spend is going be close to 45, 50% of total drug spend. So, you need control of the physicians, that's the other reason. Beyond the employer alignment and the member alignment, it's the docs. And, all of the managed care companies have contracts with oncologists and rheumatologists and other specialists that are driving injectables. So, they can influence utilization. They can hopefully piggyback on what the government is doing around Medicare Part B, where they're trying to eliminate the whole buy and build distribution model in the doc's office, move to flat fee. Would Express Scripts and Caremark have been able to do that? They have no control over the docs. They have a few infusion centers, that's something that they can do, I think, going forward. So, they'll be bigger. They'll be integrated, and I think it's a new big five. It's ushering a different era.

Paul Ginsburg: Yes. Ana, let's get into the docs a little later on. Paul?

Paul Heldman: I think I'll build on what Ana said. I think and you may disagree, but, really, what we have is a rise of drugs as a percentage of the premium dollar, driven by specialty drugs. So, it makes these vertical integrations even more imperative, from a company's perspective.

Paul Ginsburg: Yes. I still like to dig in a little bit more about-

Matt Borsch: Paul, can I just make one point, because I agree with the comprehensive presentation you made, Ana. I would just add a couple of points, which is, you have this -- it's been something the managed care industry has wrestled with. And, the PBM has emerged as a scale entity, representing multiple plans in a function that is very scale sensitive.

Now, the very largest managed care companies have become big enough, where with their own business alone, they can pretty much get there in terms of scale, and then of course they can do business for other health plans that don't have the scale. And, I don't need to tell you, but there is a large percentage of the industry that is not going to be in those, inside, those big three arrangements that are now owned by the big three managed care companies. And, structurally, they don't have the scale to support their own PBM. So, they now face the dilemma of contracting with the PBM -- 80% of the market share is now held or will be held by PBMs owned by their largest competitors. So, this is something that they may be perfectly comfortable with that, some of them. I know, not all of them are. That they perceive that function while they may be willing to buy services, that actuarial service and things like that from Optum, that the PBM function is closer to the heart of the business. So, it's going to be interesting to see whether the regional and smaller plans get comfortable with that, or whether they feel so strongly about it that they end up supporting ... There are other alternatives, and some of the market share might shift as a result of that.

Paul Ginsburg: Yes, actually, you were getting into what I was going do. So, we had a situation, say 15 years ago, and as Ana mentioned, a lot of the insurers didn't feel they had the

scale to do PBMs. So, they outsourced that function. And so, of the things that happen, I wonder how much of it is, say, innovation. The innovation that United started innovating through Optum with being able to convince other insurers that they could contract with it for PBM services. Maybe another innovation is seeing the value of the flow of the prescription claims data to, and it's value for medical management. I don't know, what are your thoughts? More about what changed during this 15 year period.

Matt Borsch: And, actually though, I will point out the irony here is that if anything that the physical or the organizational integration of the PBM in managed care company, in theory, should be perhaps less important, just given how much better the IT interfaces have gotten, in terms of data sharing, and so forth there. All be it, I recognize there still some significant advantages, I'm sure, to the organizational integration. But, that's the other side of it. And, I'm not sure I have the answer to the question.

Paul Ginsburg: So, in a sense, now is actually somewhat more seamless with a separate PBM, if you're a smaller insurer, as far as that PBM is feeding you data on a real-time basis.

Ana Gupte: Yes, back to your point, I guess the Chinese wall is something. You talked about that in terms of Optum. And, Optum ran a very ... I think this was Steve Hensley's vision, to run an organization that not only served its internal needs, but was able to proceed as an independent neutral confidential vendor for third party benefits management. And, they did a good job of that, building IT systems and firewalls across UHC, the managed care organization.

And, Optum -- rebranded Optum as OptumRx and have had some pretty remarkable success in achieving satisfaction from third-party health plans. So, that's one element of innovation. I think the other element of innovation is that the pharmacy benefits managers, they manage the formulary, they do step therapy, prior authorization, and all of that on the pharmacy side. But, on the managed care side, I think, disease management, which was kind of ... There was a ... They didn't have the best kind of brand around that concept. Today, chronic care management is like part and parcel of managed care. And, a lot of that does involve compliance with pharmaco therapy and so on. So, there's been kind of a convergence of what the PBMs are doing and the managed care companies are doing, and it makes it more seamless to have it under one organization to manage members' health to reduce admissions and readmissions and is heavily about compliance with the pharmaco therapy and managing their health around medications that they take, especially for multiple co-morbid conditions.

Paul Ginsburg: Yes, and, this is for Paul. What about the recent hostility towards PBMs in federal policy world? Is that a factor that these companies are looking at, and trying to protect themselves from?
Paul Heldman: I think they're certainly responding to it. And, sort of anticipating changes, and potential changes in the rebate structure, and the sharing of rebates with the patients, maybe under Medicare Part D, if Trump administration goes ahead and proposes that. So, some of that is already ... They're already starting to do that with customers in the commercial marketplace. And so, they're definitely anticipating changes in Washington and being proactive on the commercial market side.

Paul Ginsburg: So, was this a factor in some of the vertical integration, or they just come up at the last minute?

Matt Borsch: Hard to say. I mean, it might have played some role in, for example, prompting Express's willingness to sell to Cigna, would be my speculation.

Ana Gupte: Partly, I think CVS in today and deal they were in discussions in October of 17. That was when the whole Amazon thread had started to really hit the whole drug supply chain, and the retail pharmacy business as well. So, Aetna and CVS inked the deal in December. And, I think, it's beyond the imperatives we talked about from the point of view of just managing health care better and patient quality and outcomes better, these threats from outside prompted CVS to do something. And then, Cigna was sitting there. They weren't ... Their deal with Anthem had broken. So, they're looking for something to do. And, simultaneously, you started hearing noise from Washington around the PBM role, and the margins, and the middleman, and the role of the middleman. I think it all kind of a came together.

Paul Heldman: That's sort of interesting. I guess, we talk about the risk to PBM, but there are some opportunity to PBMs too, as Ana just talking about playing the middleman in Medicare part B, essentially maybe through their specialty pharma.

Paul Ginsburg: Good points. I would like to move on to the second type of vertical combination, which is the acquisition of medical practices, and freestanding outpatient facilities by insurers. And, some of the examples would be what Optum has been doing, what Florida Blue Cross to a lesser extent has been doing, as far as acquiring practices. And, initially, I perceived these acquisitions as motivated by insurers' desire to keep the practices from being acquired by hospitals. But, now perceive it as a much broader thing and having additional strategic goals. So, explain why we've ... So, yes, please comment on that, and may also want to explain why we've seen very little on the way of insurers acquiring hospitals, in contrast to their very extensive acquisitions of physician practices. Yes.

Matt Borsch: Maybe I can take a stab at that. I mean, recognize of course that the managed care companies are not pursuing a uniform strategy here, and that some of them you'll hear, maybe not so much publicly, but they will say, "Look, we did that 20, 30 years ago, and the results weren't very good. We're not going down that road today." I know that's not the consensus necessarily, but there's certainly more than one opinion that's out there in the industry. On the other hand, clearly the other end of the spectrum, you have United Health that has been very acquisitive, and done many acquisitions of providers. I would comment that bear in mind, and I'm sure by the way that a defensive objective is part of this is to not have hospitals acquire every practice in a given market.

But, bear in mind the difference between the Kaiser Permanente model of having the doctors under the roof of the plan, and captive to that plan, if you will, serving only Kaiser members. What United and Optum have done is acquire practices that are multipayer, and that remain multipayer. And, United's intention is very much to keep the multipayer. And, in fact, that's true generally across the spectrum of the Optum providers. MedExpresss, for example, their urgent care centers operate under the same model.

And, that probably makes sense if United is going to continue to be a broad based network contracted health plan that appeals to a wide potential customer base. But also raises some of the

same possible conflict of interest, I guess you might say, with United owning the practice, and the practice serving -- perhaps 25% of their volume is United, and 75% of it is other payers.

Ana Gupte: I guess I could just build on what Matt is saying. I think it's more, as I think you may be alluding to Paul, it's more offensive than defensive. From, I think, United's angle, two things -- one is you want to reduce hospital spend in your own managed care business. And, hopefully, as they have a vision that they service other third party plans for others as well, to improve your medical loss ratio, which is a percentage of cost spent on claims.

And, where is the spend? The spend is in hospitals. And, they have had this vision of not just moving health care cost out of the inpatient setting into the outpatient setting. But, just creating very robust ambulatory access. And, their vision is in 75 target markets., They will build out, home health. They'll buy up the primary care docs, and that's a huge piece of it, because primary care is the linchpin of managing a member's health.

Then, you have freestanding urgent care centers, which is under the MedExpress brand. And then, the ambulatory surgery centers. They bought a company called Surgery Care Affiliates. And then, they have some hospice wrapped in, and they're trying to integrate data, clinical and claims, across all of those sites of service, and develop out those markets. And, they're having remarkable success. They claim they're seeing a remarkable mix shifting of emergency room visits, which high are high spend, into urgent care.

And then, a lot of elective surgeries and procedures are being able to be done in the ambulatory setting. And, they're keeping people healthy, and all that. So, it's that. So, it's medical loss ratio and reducing cost. But, I think they also looked at it and said, "Hey! The economy, with the health care economy, it's three and a half, whatever, trillion. $3.3 trillion." And, you're capped in how much you can grow, if you just trying to grow your insured membership. In this way, they're able to really get a growth rate that's backed to the growth of the overall economy, and where it's growing, which is in the ambulatory setting, and it's aligned on cost, quality and outcomes , from the point of view of the government, employers and the member, and they can make nice growth revenue, growth and profit on that.

I don't think it succeeded in the old days because there was no ... I mean, the way this works is payer mix. Payer mix is important. It's working the best, I think, in Medicare, to a large degree. A lesser degree, I think, they're able to optimize payer mix across commercial, Medicare, and Medicaid by site of service. So, that's a big one.
And then, you need local market share. I think, the old, I guess, view of some health plans, where they're like, "We won't do this." They don't have enough Medicare patients, and they don't have enough local market share to be able to monetize it. And then finally, they don't have enough cash flow. I think a big part of why Cigna and Express have merged, and CVS and Aetna merged, I mean, eventually CVS and Aetna will pay down their debt. But, particularly Cigna, Express should do it more quickly. They'll have more cash flow. United has $15.5 billion in cash flow from operations this year. You might have all the vision to buy docs, but can you afford the valuations, when United Healthcare, and then in on a defense basis HCA as a hospital are competing with you. It's been hard for Humana. They want to buy more physicians, but they now are just building it out, organically. They say valuations are too stretched.

Paul Ginsburg: So, it says ... Oh, go ahead.

Paul Heldman: I was just going to say; certainly government policy and on the commercial payer side, more and more procedures are shifting into lower cost ambulatory surgical centers. Medicare has been moving in that direction. And, on the commercial side, they've actually started, I guess they've been doing for a while, total knee replacements. So, Medicare isn't allowing payment in a surgical center for that yet, or they are allowing it in the hospital outpatient setting. But, they're moving in that direction.

Paul Ginsburg: So, you'd have-

Matt Borsch: Paul, could I just make one ... I just want to build on what Ana said about the cash flow. And, recognize that a lot of this really is about UnitedHealth Group, rather than the industry overall. There is certainly activity with integration, but the lion's share of the acquisitions have been driven by the largest company in the industry, which of course is very important, and enabled by the huge cash flow that they have, which is not to say that there's isn't financial strength in the others—but, it is an order of magnitude larger.

I think the question here, where I think we can say the jury is out, even though it's clearly United continues to be successful, but are you better off owning that MedExpress urgent care centers as a means of reducing emergency room utilization, or can you do just as well, or maybe better by contracting with urgent care centers, and doing it virtually. And of course, just to add this point too, which is despite the scale and volume of the acquisitions that United has done, it's still the case, it's only around the providers who've been acquired by United cover about 15% of United's insured medical expense. So, enough to absolutely move the needle. It's significant. But, we're not talking 50% yet.

Paul Ginsburg: I would think, strategically, some of the potential upside might be in actually changing the behavior of the physicians that they control, particularly primary care physicians. Have they actually had any success in doing that, or are they at very early stages, and just kind of acquiring the assets, and not figuring out how to influence them?

Matt Borsch: Well, remember, I mean, this is where we, as analysts, cover these companies and try to get visibility on those things that are two levels down at an operational level. But, it's limited. So, certainly, it would be a lot more likely that they've had success with those that two or three, or four years under their ownership, than the ones recently acquired. I guess, from our perspective, I have to say, it makes sense. The jury is still out. The one other point though that's important is that compared to, let's say, 15 years ago, there's a lot more bang for the buck in terms of medical cost reduction in the IT investment. So, if you own the practice, as an insurer, you're able to capture some of the return on that ... that actually wouldn't go to the practice because it's ... It might if they're under a comprehensive risk contract. But, if they're reducing medical expenses because of their IT investments, that's something they can, and their insurer parent can, benefit from, if they're under the same roof. Whereas, if they are an independent, thinly capitalized practice, they may not be able to make that investment. It may not make sense.

Paul Ginsburg: Yes, that's a good point. And, I guess another thing is that to the degree that they're investing in IT to change physicians' behavior, they're still sharing a lot of the gains with their competitors who are also using those physicians.

Matt Borsch: In theory, right. Well, I don't mean to be cynical. I think that's another point where I guess I would say the jury's out.

Ana Gupte: So, I think, as Matt says, we're outside.... So, I don't have visibility into what United's doing in their Optum care practices. But, you may be coming to this later, but other companies, they don't have United's strength of physicians, are not able to do it all themselves. Do you outsource or have vendor relationships with the startup privates now, called ChenMed and Iora Health, and so on.

So, for sure, when you think about Medicare Advantage again, that's where this is really kind of the incentive, and the behavior's changing. If it's $1000 a month on per month per member premiums, the Humanas and WellCares of the world, but I think what I hear from these private companies' CEOs is that, they skim 5% profit, 10% they take on G&A, which they use for their administrative expenses, distribution sales, and marketing.

Then you kind of have that 85% medical loss ratio pot. And, they give that to the outsourced vendor relationship. Now, if they come at 65%, because they ended doing such a great job of managing all these seniors who showed up at their door, they get to pocket most of it, so that will change behavior pretty quickly. I don't know whether United is that generous with their internal physician, but ...

Paul Ginsburg: Good. Guess that gets us to our next question which is; although not vertical integration, I'm struck by the degree to which physician practices are being acquired by private equity partnerships, or funded by venture capital. And, some of these have become publicly traded companies. So, you started talking about this, Ana, but what is the attraction for private equity in this area? Meaning, what opportunities does private equity perceive to make more money from the practices than the practices are making today? Because isn't that the essence of the strategy, that if you can't make more money, with those practices, it won't work.

Matt Borsch: Yeah. But, maybe you don't have to make a lot more, because maybe what you're objective is to have it make a little bit more and to have the value of the practice increase, because of that, but also because the value of practices is increasing generally. And, sell the practice five years down the road, and reap some considerable profit. I mean, we don't know exactly what the perceived end game is for some of these acquirers.

Ana Gupte: I guess from the practice perspective though, what is the life of a onsie, twosie primary care practice today? You don't make that much doing fee-for-service based treatment right now. The whole back end of billing managed care in all this is very challenging. If you're trying to move to value-based care, there are scale and scope economies of being able to do that. And, world for primary care is, the model I described. That's very attractive. If you can make 10 to 15% loss ratio differential, because of how you manage that senior, there's a lot of money to be made there. Can you do that as a solo practice, no.

So, private equity is trying to bring that scale together, at least in primary care. You have other specialties, which have different objectives, where you can roll up all these primary care practices and have a methodology to how you're doing the chronic care management. And, each one of them has a different recipe. Iora has their recipe, ChenMed does their thing, Agilant does their thing, Bright Health is doing a completely different thing. But, they don’t do it with primary

care practice, they do it with a health system. But, they're all doing their own thing. And, there's scale and scope economies. And then, there's a lot of appetite among the public investing community, again, to really see IPOs. And, they want to invest in this. So, it's a great idea for private equity, or they can sell it to United, or Humana, or somebody else, or even HCA, for all you know.

Matt Borsch: Can I just say one point on that, Paul?

Paul Ginsburg: Sure.

Matt Borsch: Which is just to say; I agree with all of that. The one overarching thing is just a reminder, which is close to my heart, because I spent most of the late 1990s in what was the physician practice management industry, which many of you may recall had a very fast rise and then very calamitous fall. All three of the public companies exited the business. A lot of private companies, including the one I worked for, essentially became insolvent. So, it was an incredibly comprehensive boom and bust. Now, we can go back in looking, I'm not going to try to do that here, all of the factors that were running against the environment of what the companies, what these new companies, were trying to do, back in the 1997-1998 era. And, it was a little bit of everything that could go wrong was going wrong. And now, a lot of those factors are running in favor of this model but, still that made sense in the mid '90s, on paper. And, Wall Street absolutely loved the idea. And, it was a complete disaster in its implementation. So, that's just one thing not to forget from our industry history.

Paul Heldman: I would just add that, for the doctors, because of the 2015 Medicare payment reforms, there's more risks, and more administrative burden.

Ana Gupte: With MACRA and ...

Paul Heldman: Yes. So, more risk and more administrative burden, and opportunity based on for pay performance may also for private equity translate into an opportunity for them to help with the administrative burden, and spread the cost, and reduce cost per doctor. And, also find a way to maximize their reimbursement under the pay-for-performance metrics.

Paul Ginsburg: So, this may be of an inevitable recognition that small practices don't have a future, and one way or the other being acquired by insurers, working for a hospital, or being acquired by private equity or other organizations. That may be the opportunity set for small practices. Nobody is going into them, anymore. I think newly trained physicians want to work for a large organization. And so, I guess that's just part of the landscape.

Ana Gupte: Yes, Universal American, which was purchased by WellCare, with public companies, started to help out the onsie, twosie primary care practices with the Medicare shared savings plan. So, that was their model. It was mixed in success because this whole upside downside risk in the payout was challenging for UAM. And, I'm not sure it's played itself out, particularly well for WellCare either, because I hardly hear them talk about it. So, that was something that, Rick Barish, the CEO of UAM put a lot of energy into trying to keep these onsie, twosie practices independent but still able to partake of some of the shared savings models, beyond Medicare advantage.

Paul Ginsburg: Good points. Let's move on to hospitals creating insurance plans focused on Medicare Advantage and the ACA exchange markets, and partnerships between hospital systems and insurers to offer such plans. And, as you mentioned Ana, one of the examples is Bright Health—I believe Aetna has done a lot in this area. And, you'd comment on how significant those developments are.

Ana Gupte: So, Bright Health does an interesting model, I think. Bright Health doesn't have a primary care practice model, but they're doing this neighborhood care model, which is as I understand, practically a single health system in the neighborhoods. It's a narrow, narrow, narrow network, where you're creating a joint venture branded relationship in every local market with one health system. And, you are underwriting risk on that Medicare Advantage, but you're managing the cost and outcomes, in partnership with that health system.

How the economics work for the health system is interesting. I think not for profit health systems clearly are more willing to go down that path, because you do end up emptying beds, even though you might drive more volume through your physician workforce and all of that. But, it feels like they're in a good place. I do talk to their management on a regular basis, and I think they sound like they're doing well.

Actually, Centene is an interesting one because more than Aetna, and Aetna has tried to do this with all of these large flagship Pioneer ACOs, I guess, Banner and others in Virginia, North Carolina, and so on. But, I don't know how much success they really had. I think they started to do it with the employees of the health system, as opposed with MA. I hate to keep coming back to MA, but I think the big difference between now and in the '90s was we didn't have Medicare Advantage, and today we do. And, it's a value-based care model that's actually succeeding. But, Centene has inked a deal with Ascension. And, 26 states ... This is the catholic health system. And, they're going to do, by 2020, a co-branded Medicare Advantage product across all of these 26 states. And, it's nontriviall, as I said, from an economic stand point. It's been tried and done successfully. But, if they manage to come with a successful approach and grow, I think it will be a blueprint for others to do as well.

Matt Borsch: Not to be the curmudgeon party pooper on some of these things. But, just another historical precedent here of failed models that we call ... Again, I'll go back to the late '90s or really the '90s, that there were many provider-sponsored, particularly hospital-sponsored, health plans that failed -- ultimately failed. And, there were many factors that went into that failure. But, one of the questions was can hospital systems that have in their DNA, if you will, the objective of filling beds, can they actually do a good job running health plans, and incenting doctors to efficiently work toward managing medical cost. And, not to be too wishy washy on this, but I think the jury's out. A lot has changed, and of course there probably isn't one answer anyway. There are some of these models that will work, and some of them won't. But, we're in the middle of an experiment of something that has been tried before. And, when it was tried before, it was overall more of a failure than a success.

Paul Ginsburg: I'm glad you brought that up. I want to go into a fifth type of integration, which is insurance and retail pharmacies. And, examples of course, they see via CVS and Anthem and a rumored relationship between Walmart and Humana. So, if you could comment on; what is the potential strategy, what do they hope to accomplish, with this type of vertical combination?

Matt Borsch: I mean, I just offered, and initially it was Aetna's CEO Mark Bertolini who expressed the vision around this. The idea is to take some subset of the 10,000 CVS stores and repurpose them towards being, to some degree, neighborhood health centers, and certainly depending on the socio-economic surrounding that may be the primary care delivery for Medicaid populations, in some cases. But, something that would out from the relatively limited low-acuity level of the services provided by the Minute Clinics. So, you'd have more than that.

But, on the other hand, Aetna and CVS, thus far, have been pretty clear that they do not anticipate having physicians as part of this model. So, I'm a little surprised given that, that we haven't heard a little pushback from the physician community. But, of course, it's still early days for this. They're talking about doing pilots of it, after they complete the merger, and then if all goes well, and informed by that, to roll it out more broadly. And, clearly if it works, it has the potential to be a lower cost site of care delivery, particularly with the nonphysician personnel. I will make a sort of a snide comment that it seems a little backwards for them to be merging first, and then piloting the concept, but, that's what they talked about doing.

Ana Gupte: Yeah ... I agree with everything Matt said. It's "supposedly transformative" but the existing care delivery model is primary care, and they would have to disrupt that. My pushback would be, I think, a couple fold. It feels like it's coming at it to Matt's point -- backward, because the surplus commercial real estate. And, CVS has more stores than they know what to do with, and obviously front of the store sales are going down. And, hey, Amazon is always sitting there, trying to do retail online fulfillment, online, and they just bought Pill Pack. And, obviously they're not stopping at Pill Pack.

And so, here you have CVS worried about what do they do with these 10,000 stores, and here you have Aetna, who's been a little of a laggard, I would say, among the large insurance companies, in terms of creating any medical cost-structure advantage. Their growth has been heavily about just pricing above trends and managing the underwriting cycle. And, that's the game that they played 10 years ago. You can't play that game anymore, with medical lost ratios, and floors and all of that.

The other pushback I would have is; if you build it, I guess as I said, will they come. I mean, here you have a health coach, Minute Clinic nurse ... I've been used to managing sore throats and headaches, and all. Can they do chronic care longitudinal population health management, which is the vision that CVS has around this? And then, they're talking about engaging the pharmacist. I mean, you've seen the CVS pharmacists. They're so busy -- . The lines just to fill up the scripts is kind of crazy. Where is the capacity to so something like that?

So, they've put a Teladoc – telemedicine terminal is their vision. So, they mean to deal with Teladoc to try to bring the primary care doc in there, through a telemedicine visit. And, they have a relationship with Epic on the back end, on the electronic health record. But, here you have a few doing this for seniors, and, that's what they want to do. Very early stage seniors, may want to look at telemedicine and health on their phone; they don't need to travel to a store. By the time you're 75 and above, do you want drive to a store. I think the virtual home concept is the biggest concept right now.

And, Humana is investing a ton in home health. They just bought a portion of Kindred at Home, with a private equity consortium. And, United is investing a ton in home health. Home health has

exploded as far as MediSYS, and LHC, and the others are also circling around -- private equity wants to get into home health.

So, the jury is very much out around what CVS will be able to do. Besides which, Aetna has like 10% market share, on average, maybe less, in many markets. And, a little bit more in others. Can you monetize this by selling a visit for $100... How many visits can you do in a store. You make your money by reducing your medical loss ratio. And, you'll be selling that visit to the Blue Cross, who's your arch enemy competitor. And so, there's a lot of if's around that model. We'll see.

Paul Heldman: And, on home health side, I think it's important to note that the Trump administration changed the Medicare Advantage supplemental benefit structure for next year. And basically, they're allowing sort of "non-medical" care, including in home help to keep ... to help people with activities of daily living to help keep them out of the hospital.

Paul Ginsburg: Good. Actually, one thought I had, inspired by what Ana said is that I can see CVS wanting to pursue this model, whether it's a good model or not, but I was always baffled by why do it with Aetna? Why do it with an insurer? And, the only cynical reason I can think of is that that, "Well, Aetna had the capital." And, maybe no one else was willing to come forward.

Ana Gupte: Yeah. The cash flow. It's also the cash flows. I mean, Optum and United work because United Healthcare generates all of this cash, because the insurance model is amazing. There's more free cash than you would ever see in any other business because they get their premiums before they pay the claims, there's no capital expenditure and their debt load is low. So, I mean, Aetna can fuel a lot of the maintenance and [capital expenditure] growth for CVS. That's I think why those two things work together. We didn't talk as reason for these deals but Wall Street view of it-

Matt Borsch: It's a great business, while the margins hold up. And, we've been through long period where margins have been very healthy. But, of course, in the past we've been through cycles where it's not-

Ana Gupte: He's the underrating cycle bear.

Matt Borsch: [crosstalk 00:49:37] Right. Well, no. Actually-

Ana Gupte: You just called the 2008. You did.

Matt Borsch: I just don't want us to forget our history. About 2006.

Ana Gupte: He was right.

Matt Borsch: That was a long time ago.

Ana Gupte: I worked at Aetna, and then Ron Williams is like, "This guy, this Goldman guy is so bearish." And, I think he was reaching out to you, or whatever. It felt like you were getting ...

Matt Borsch: Well, thank you, Ana.

Ana Gupte: Kudos.

Matt Borsch: And, my point relative to CVS is we'll see how Aetna is a market participant in terms of its pricing, and how that changes under CVS ownership. I have a gut feelg that they're going to be more aggressive and not so cautious as they have been under-

Ana Gupte: I worry about that too, I know. I hope they don't bust that bubble.

Paul Ginsburg: Good. This leads up to our closing question in this is that putting aside the partnership between Amazon and Berkshire Hathaway and JP Morgan, we'll get to that later— But, what do you see as the greatest potential for Amazon in health care, if anything?

Ana Gupte: Well, what do they have? I mean, they have the best order fulfillment. That's the first thing. And then, they have technology and an online platform with the relationship with the consumer. Those are the two big assets. So, the move with Pill Pack and the speculation around them entering the drug supply chain, it's very rational. Why wouldn't they? They do everything else. They can get into food and grocery, they can get into drugs. They may start with OTC, then maybe you do generics. They compete with Walmart who does $4 and $9 generics, a list of 500 drugs or something. Why wouldn't they do that? And, get into it with the generic profit, but you're now drawing people onto your platform, and they shop on your "marketplace." In your front store online.

So, all of that makes sense. Maybe they backward integrate that into wholesaling. That's why the McKeesons, Amerisources, Bergens and Cardinals have under pressure as well, because the expectation would be then they have a hub and spoke wholesaling distribution model that's a little more state of the art than some of these legacy drug distributors. I'm just speculating. And, none of us know. But, Pill Pack we know, their entry move was about co-morbid conditions and delivering packaged order fulfillment to people with co-morbid conditions, but they're not stopping there.

Other than that, I guess, and you said you'll talk about the coalition later. But, they've started work site wellness for their own members. And, it feels like that might be consistent with Bezos ... triumvirate and the noise they made around the health care tapeworm and all that.

But, they're going after, I think, angst that employers are feeling right now, particularly large employers, self-insured employers. Where maybe health insurers have been so taken up trying to grow in Medicare and Medicaid where there's a lot more lucrative financials, that there's been disappointment and lack of satisfaction among working Americans and employers. So, maybe Amazon makes a play there. Across telemedicine, work site wellness; that would be another thing.

And then, I guess you didn't talk about Apple and Google, but they're doing a lot right now. Google just hired David Feinberg from Geisinger. And so, they're looking at doing integrated ... And, it's a business-to-business model, with artificial intelligence and some machine learning and data analytics. But, they're looking at integrated data and decision support to help other businesses like health systems and other businesses. How can they enable more value-based care? I think, and other relationships as well.

I mean, Amazon can try to do a bit of that as well. Apple right now, you can go to your Apple Health Phone today. I didn't even realize, I can look at my Yale medical records. I didn't realize I could do that. But, I can.

Matt Borsch: Can I look at your Yale medical records?

Ana Gupte: So, all three of those, very big deck is coming in. I still feel very bullish. I'm very, very bullish about managed care, because I think they're very adaptable creatures of anything. But also secondly, I would be very surprised if Amazon, Apple or Google got into clinical network contracts with docs and hospitals. I mean, that is a slog. It needs years of work and IT systems. And, all of that -- there's a lot of downside risks associated with getting so involved in running policy to manage health and treatment decisions. That's not conducive to the consumer clean image, brand image of the big tech companies.

Matt Borsch: Well, that's the question, really. I mean, it's a world Both of us are ... At the core of our industry focus is managed care. And, there's a little bit of a tendency, but with good reason in this case, because I agree with what Ana said that, it makes the most sense that Amazon is going to go to the areas that play to its strengths.

Yet, Amazon, and maybe Google and Apple too, have some potential to be unpredictable. And, we had a person from Amazon on a panel, a year ago. And, somewhat reminiscent of United Health, and maybe even US Healthcare way back when, there are some ... a little arrogance. But, they said, "Look, we can get into any area that we want."

And, clearly in terms of having heft and investment scale to that, they can. And, I agree with Ana about the slog, the difficulty. I mean, the things that make it tough to enter the managed care industry are considerable, effectively barriers to entry. Whether it comes to Medicare Advantage, the length of time to establish strong star scores, the economies of experience and of scale, associated with the risk coding.

And, in fact, when you think about it, The Affordable Care Act has erected barriers to entry in a certain sense, by making it more complicated. Therefore it takes more time to do these things. And yet, those things aren’t insurmountable. So, that's going to be the most interesting area to watch.

Ana Gupte: One of the things that we have been watching is this whole notion right now, in the health care tech community about the digital door. And, there's a battle for the digital front door to health care. What consumer ... Which portal will they use? What will be their entry point? When they try to seek access to their records, like I talked about... but, not just that. A telemedicine portal and provider -- It's like the first step, and then you funnel out and go elsewhere. Maybe also linked to your benefit design and so it tells you what your network options are, what your out-of-pocket costs are. "Hey! I'm in DC. I want to get my knee done. What are my options? And, with my benefit design and I have an HSA, what is my deductible, and out of pocket cost, and all of that."

And so, you have tech companies coming in, trying to do that. And, Apple is obviously trying to do it. Google hasn't made a B to C play, but Amazon could. I haven't yet seen quite what they might do in that area.

We have employers and brokers trying to that, on their own. There a little private companies like Accolade and Heal that are helping Comcast and other companies to do that. And then, you have the incumbents. I mean, United is making a huge push with something that they have, that they bought called Rally. And, they're determined to make Rally the digital door. And, they have their investor day, in a couple of weeks, and we'll, I'm sure, hear more. But, they are building out individual health records, they're staying accessible to very large portion, not of just of their members, but anyone sort of by Optum. They'll have access.

I've seen Rally. And, I got a demo from their CEO, one day in Boston and he did exactly that. We were going around meeting investors. And, he was showing people this thing that said, "Well, I want to get my knee done." There were like 10 providers that popped up, the distance to travel. And then, he had his benefit design. What it would cost him personally and what the payout will be. So, we'll see how that battle plays out. It's very much where the tech companies want to come in.

Paul Ginsburg: Yes -- it's very interesting given the hysteria about Amazon eating all the healthcare system. Your discussion about, where does Amazon actually have a strategic advantage, as opposed to areas where it clearly doesn't. But, it's striking about the Amazon panelist not going along with that.

Okay. Next topic is physician consolidation. And, it appears that some hospital-based physician specialties, such as emergency physicians, have become highly consolidated into a small number of national staffing firms. How extensive are these consolidations, and what impact is it having on what insurers and patients are paying for these services, including the balanced bills to patients, and are similar trends proceeding for specialties such as anesthesiology, pathology or radiology?

Matt Borsch: Paul, do you mean the just consolidation of them, or the ownership by hospitals, for example?

Paul Ginsburg: I should have said owner-- I think it's the ownership. Ownership, but in a sense, it's also consolidation, because if Envision owns so many of the emergency department docs, that's part of the story.

Matt Borsch: And, this is another area where there's a lot in motion. And, it's tough to draw conclusions on a broad scale yet. Particularly, if you start with the hospital ownership of physicians, is that part of these hospitals building accountable care organizations and being able to integrate and offer the spectrum of care, that's broad and to take on population- based reimbursement?

Paul Ginsburg: Actually Matt, at this point we're just focusing on the hospital-based physicians, and the sense the ED, as opposed to the employment of the primary care others.

Matt Borsch: Right. Okay.

Ana Gupte: I can talk a little bit about this. These are physician staffing. And, there are different hospital-based physicians for different service lines. So, I mean, Envision has largely has been an emergency department vertical. But, we have ... And, Envision had largely an ED organization. Is largely an ED organization. It's been taken out now that KKR so I'm calling it a was. But, it's gone private. Team Health has had emergence department and anesthesia. That got taken out by Blackstone. And, I cover Mednax which is still public, but we shall see. They have neonatal and pediatric services. And, they have some anesthesia, and some radiology.

So, the reason that there's been some roll up of these hospital-based specialties is there's economies of roll up on the back end, in terms of the billing, continuing medical education. And, it makes it easier, again, to a point around onsie, twosie being hard on the primary care side, there is some efficiencies that these state hospitals, their specialists also realized being part of a larger organization ...

It is still heavily unconsolidated though. So, it's not as though you're talking about like 75 to 80% is still fragmented. And, you're seeing that also in the orthopedic and the surgical specialties as well, where Surgery Partners, and Surgical Care Affiliates now under United, and USPI, United Surgical Partners under Tenet healthcare. They've also seen roll ups, and they've either exited through a plan like United, or a provider like Tenet, or you have like a Switzerland organization as Surgery Partners tries to call themselves.

And, there are some efficiencies of being able to build out surgery centers in an ambulatory setting under a corporate umbrella. A lot of them have equity relationships with these surgeons. So, they kind of still get part entrepreneurship and some upside and all of that. But, that's what they're doing, I think, in terms of the physician staffing story.

They've had a huge amount of issues, which is why a lot of them are exiting right now to private equity and getting turned around. They're getting a lot of lever up debt added to them to turn them around, away from the scrutiny of public analysts like myself. Because then you're like subject to quarterly earning scrutiny, which makes it very, very hard for these players to operate.

But, the private equity firms want to buy them. They see the potential to wait it out, turn them around, invest, lever up, continue to roll up. And then, eventually, they'll probably go public again, or whatever.

United and Envision have had ... There are two types of battles going on the ED side. ED different than hospital-based anesthesia or surgery or whatever. The relationship there is between the hospital, and that physician staffing company. ED on the other, part of it is B to B, where United is having gigantic public battle on the in-network rate they get with Envision and claim that Anthem and others are paying less. And, Envision disputes that mightily. But, we'll see where that battle ends up.

But, you have heard Anthem, most recently, and some of the Blues. But, they are saying, "Well, if have just gone off to an emergency room. And, even though that poor hospital has delivered that emergency care, they're saying, "We won't pay if we believe it deemed unnecessary." And, that's a utilization thing, where they're going after poor consumers. So, I don't know how that ... That's not going to last. I don't think it'll stay. But, that's just my opinion. That piece of it.

Paul Ginsburg: So, what you were saying is that, in a sense, the acquisition by private equity of these publicly traded staffing companies is a sign of distress?

Ana Gupte: It is, completely. I mean, Envision got taken out for nine, nine and a half times. That's an incredibly low multiple. Team got taken out for 11, and we thought 11 was kind of low. That was like two to three years ago. But, the ED, public valuation continues to get depressed. I think investors are now looking at Mednax as a value investment. And, I did upgrade them on that. It's oversold at this point. And, there isn't enough cash flow generation. They don't put money into building beds and improving their facilities. They have a better cash flow profile. So, from that angle, they're more attractive than Community Health, which is weak.

Paul Ginsburg: And so, you'd mentioned United's dispute with Envision, and they're arguing that they're being charged more than others. I thought-

Ana Gupte: That's what they claim. That's what they claim.

Paul Ginsburg: That doesn't sound like a leverage.

Ana Gupte: Yeah. So, I guess ...

Paul Ginsburg: You can't charge us more than you charge Anthem.

Ana Gupte: I think what they're saying is, if you don't give us the same rate, we believe and we have heard you're getting a better rate, others are getting a better rate, then as of December 31st, we're going take you from in-network and make you out of network. The question is is Envision caring United is big enough? I suppose if they shout loud enough, maybe they get their way.

Paul Heldman: Of course the public policy angle is this is a partisan town, right now. But, one area of bipartisanship on health care is legislation that would address patient's concerns about being billed out of network.

Ana Gupte: Balance billing you.

Paul Heldman: For surprise emergency care, anesthesiology, in network hospital.

Ana Gupte: That's more of the Anthem and Blues story than United, which is just fighting on rates. But, they're just fighting publicly on rates.

Paul Ginsburg: And actually, even though its finally federal legislation might come about, states have been pretty far along in this. Large states; New York, California, New Jersey. So, that might be a factor in influencing the industry. Good. Hospital employment of physicians -- how much further, if at all, will the trend go?

Matt Borsch: Well, maybe it gets back to the question of how well the hospitals can do it. And, I think that's ... we're ... In one sense, this has been going for a long time. It's been a huge transformative trend if you look at the statistics of the number of doctors that operate under

hospital employment. I don't have them top of mind, but it's a major change from the beginning of this decade, to where we are, now.

But, as I said about a number of things here, the jury's out on how well Hospitals are really getting to running those positions, and again as things sort of go through historical patterns, there was a precedence of hospitals doing this, insignificant scale, back in the 1990s, in particular, and divesting many of the practice, as it turned out that they didn't do it very well.

Now, that was in fee-for-service service environments where doctors who were in an entrepreneurial driven independent practice style and went to hospital employment, and surprise surprise, they weren't as productive. That was certainly one of the issues. And so, the doctors, the new doctors coming of medical school, like the offer of stable employment. That's more appealing nowadays, given the entrepreneurial independent practice model isn't nearly as attractive as it used to be. But, the hospitals are going to have to be successful with it. And, thus far, the results, I think are mostly more good than bad. But, we'll see.

Paul Heldman: I don't know how much whether this is enough of policy changes or have enough of an impact to make a difference in whether this is appealing. But, the Trump administration's becoming pretty aggressive in sort of cutting off one potential source of revenue, for hospitals acquiring doctors, where they basically moving to this policy of site-neutral payment and saying that they're going to dock practices that are off campus of the main hospital were getting reimbursed at the Medicare hospital outpatient reimbursement rate, which is 60% higher than the physician fee schedule rate. And, the administration is making policy changes to reduce that in certain areas. And, I would think they would continue to be aggressive in that area.

Matt Borsch: That arbitrage certainly has been something that the hospitals have benefited from in many of these practice acquisitions and employment of physicians. So, it's going to take a while for that policy change to ripple through since there are so many ... Since the sites were grandfathered, the ones that they're already operating. But, it will be a change.

Paul Heldman: And, I think the administration is interested in going after the grandfathered ones, and there's a question, certainly, the American Hospital Association has a different opinion about whether the administration has authority to do that.

Ana Gupte: .... I feel we're hearing from the hospitals, the publicly traded guys. I feel like they're talking a little less about physician recruitment. It used to be physician recruitment, recruitment, recruitment. There was no return from this recruitment. But, they were recruiting them, and their salary, wage and benefits were looking bad. And, even Community, I feel, has stopped talking about it. The latest buzz word is service line investments. They're all investing in service lines. High acuity because everything that can be possibly moved to the ambulatory setting is slowly getting moved to the ambulatory setting. So, what you want to do is whatever beds you've got left, that are filled, you want to fill them up with the highest acuity, and the best payer mix.

So, that's what they're trying to do. Optimize for the orthopedic service lines, the neuro, and that's kind of the whole name of the game, it feels. Even the little rural guys are saying, "Service lines." And, we've seen pricing growth to revenue per admission, this year, has been remarkably high. Even beyond anything you might see in the Medicare-like rates. It's been more than you

would project out just based on rate environment in Medicare. So, the question and the controversy right now is did we see a lot of whatever could likely move to ambulatory in a big way, is kind of getting squeezed out. And, if you're a high capacity utilization hospital, like HCA is like 75% utilized, you can really play some nice economics with you left ... With your capacity -- put the low priced ones elsewhere.

Matt Borsch: Yes. Although there's a little bit of an open question here in terms of how much of that, the revenue per unit, moving up as much as it has this year, how much of that reflects things like hospital charge master inflation, and relatively successful contract negotiations with the payers, at least relative to recent years, versus really to Ana's point, the mix, so that as the low acuity things go out to the outpatient setting, that you've had an order of magnitude change there, and that's now reflected in higher revenue per unit, but it doesn't reflect anything about same store pricing.

Ana Gupte: It's hard say. I mean what about bad debt accounting. Is that even considered? Because they changed the bad debt accounting this year.

Matt Borsch: I didn't think about that one.

Ana Gupte: There's many reasons. But, I mean, there's at least a portion of it sounds like it may be service lines and acuity.

Paul Ginsburg: Well, this would be a good time to transition to questions. And, we're getting more high tech this year. Not only can people raise their hands and ask questions, but people watching online have been sending in questions. And, Alwyn Cassil can read some of them. But, let's start with someone here. I don't think we're going to use the cards, if you don't mind just reading your questions. Yes. There's someone there.

Bruce Steinwald: I'm Bruce Steinwald. I have a consulting practice here in Washington, and I'm working with the Brookings Schaeffer Initiative as well. With regard to the last topic you just talked about, service lines, I'm very interested in imaging and other advanced testing technologies. As you know, the site of service has changed over the past two decades, going first toward physician's offices, and then back to the hospital. I wonder how you see that trend developing further. Is it firmly entrenched now in the hospital, is it a byproduct of Medicare payment policy, are there other factors such as technological change at work? Generally, where do you see that portion of the industry going?

Matt Borsch: I don't have a strong view on that question. It's a little specialized. I don't think anything is that firmly rooted today. So, certainly there's a potential for change. But, I'm not sure. Do you have anything?

Ana Gupte: I guess I agree with Matt. I guess whatever I can tell you from the few lenses I see it, the managed care plans, they each have ... They started with radiology benefits management, and they've been building out these kind of divisions, like Anthem has this thing called AIM Specialty. And, they have muscularskeletal, and radiology. And, they're doing as much as they possibly can outside the hospital setting.

And, I can't tell you they're in ... I don't think they're in early innings of this, if that's what you question. I think, it's actually mid innings. It may be late innings but I don't know. But, it does feel like they're still pushing to do as much as they can. Just maybe later innings than surgery centers, and ED. I feel like ED and surgery centers are slight ... Have a little more opportunity, particularly surgery centers because radiology has been going on for a long time.

The other thing is I cover MEDNAX, and they have ... They're a physician staffing company. They roll up radiologists and radiology practices. And, they're trying to move also into teleradiology. They partnered with company called vRad to do that. But, they're a hospital-based physician staffing player. And, even they are investing heavily in teleradiology. So, site of service, whether it's virtual, or outside the hospital, it seems like it's moved and continues to move.

Matt Borsch: Although the policy on radiology, as you probably know better than I do, is somewhat of a barrier to international, outside US outsourcing, of radiology services, which in theory might actually make sense from form an economic stand point. Is there any reason that a very highly trained radiologist in Bengaluru, India, at one fourth the cost of a U.S.-based radiologist might be able to do the service just as well, or most of that service. But, today, state laws, I believe it's at the state level, prohibit a lot of that.

Paul Ginsburg: Good. Next question over there.

Mark Brodsky: I'm Mark Brodsky, retired CEO who used to pay a lot of medical bills for employees. What's the difference between the U.S. and other developed countries, with respect to the trends that you've been talking about today?

Paul Heldman: Their prices are a lot lower, and they spend a lot less.

Ana Gupte: This is where their single-payer systems will not allow the kind of utilization that we do. I mean, how many MRIs do people get in the UK or Canada. Then, I guess ...

Matt Borsch: I mean, I think that's true on a ... I would also just add that if you do a comparison of the U.S. system versus, say Britain or Canada, certainly one of the things that comes out of that comparison is the capacity per capita is so much higher in United States. And, you can ... To take this example, that you can run an MRI machine, and I don't actually do it, so, I'll be a little careful with what I say here, but you can run an MRI machine at a profit at 25% capacity. Maybe it's 50% capacity. You don't have that kind of capacity in Canada or in Britain because a lot of the cost control comes from supply side global budget constraints. So, instead you have 100% occupancy, if you will. I should say, not capacity. And, you are going to have waiting times in all likelihood as well.

Paul Ginsburg: Yeah. There's been a lot of literature over the years, and consistent conclusion is it's the prices. They actually don't find much difference in the utilization. And, part of it may be the cues. The country's versus our price barriers to consumers in this country, the two ways, and they wind up with similar utilization.

Paul Ginsburg: There was a McKinsey Global Institute study about five years ago, which really found what Matt was talking about. The dramatically different rates of capacity utilization

because when the prices are really high, you can make money running at a low capacity. When the prices are squeezed, you have to run at a high capacity, or you just don't do it.
And, I think that's pretty consistent, and something that our policy makers are going to have to grapple with, one of these days the fact that the difference comes from the prices.

Deb Williams: I want to refer to two past policy changes that resulted in rapid change. One is what happened in cardiology after the Deficit Reduction Act with the change in radiology payments, where they all fled to the hospitals. That exists in literature. The second is what happened to physical therapy after the changes in the Balanced Budget Act of 1997. So, if the proposed proposal on drug pricing, which breaks the link between buy and bill goes through and is finalized. How rapid will the change be? Because history is informative, but not predictive?

Ana Gupte: And, can you remind me of what history say. How quickly did it happen then? I'm not follow that-

Deb Williams: Overnight.

Ana Gupte: Really?

Deb Williams: Overnight, the for profit physical therapy chains were broken ... A month. I remember ... well, anyway, we'll have to talk about that some other time. And, for cardiology, I believe according to literature, by the former MedPAC commissioner, that was also fairly rapid.

Ana Gupte: Interesting. Yes, no. They can actually get this rate through. I thought when the rate came out, everyone's so focused, onnected to the earlier question that was being discussed by Matt and Paul, around the international pricing index. I mean that to me feels like ... I don't know. You guys know way better than me. But, everyone on Wall Street has shrugged it off. It feels like it's going to get kind of diluted down at the very least, if not, and also delayed. But, the two other pieces of it, which I thought were the most impactful got the least amount of attention. This whole notion of switching from buy and bill ild to flat fee, I think will make a huge difference.

If I'm an oncologist, and the way I get paid is 6% of the drug I'm administering, what is my downside in a terminally ill patient to have multiple combo therapies, and I'm making more. I mean, the more I do, in fact I'll say I tried everything. So, it's going be very different if that happens. I think the private sector started doing a lot of that. Maybe not all the way, but Anthem, United and Aetna, two, three, four years ago, have started to give their oncology networks a fixed fee for each patient that they see in the practice. It was quite remarkable. If I remember, it was something in the couple of hundred dollars per patient per month. And, then another pay for performance bonus on top of that, if they follow certain treatment pathways. And then, I think under Andy Slavitt, the oncology care model adopted some of those private sector approaches. And, they have I think 3,000 oncologists were in that pilot, which translates to quite a number of patients, it's under CMMI. We haven't seen whatever came out of that. But, I did think I saw the current CMS or some communication that they're going to try to change and kickstart that ...make it more powerful and all that. But, between that and buy and bill, I think going away will a big thing. And, maybe that has knock on implications and we haven't talked about this, rolling up oncology practices, not under McKesson, it became a distribution model, of getting paid.

And, McKesson bought US Oncology. And, will it make more sense for United and BriovaRx to maybe even buy oncologists? And, might hospitals try to take a defensive tack and do something there and employ them as well. I mean, it's going to change a lot of what happens around how drugs are utilized and what manufacturers will need to do to manage this huge big stable of oncology drugs coming in the pipeline. I think it's untenable. Something's got to give, right now. We haven't even scratched the surface of all these drugs hitting the market. If many of them are successful, something's gotta give. Buy and build will be huge, I think, going away.

Alwyn Cassil: So, this is from John Cutler who's watching online. And, he would like to know, could the panel talk more about Medicare Advantage changes to add nonmedical services. Medicare itself has been increasingly covering what one could call long-term care through its current SNF and home health benefit, and this change in policy could impact who delivers long term care providers, and insurers deliver and finance long term care need.

And, I would just add, this is a question about how we medicalize growing old in this country, as opposed to providing the social supports that a large proportion of the elderly population needs. What's the impact of that, I think for health care markets going forward? Are we going to get smart anytime soon?

Matt Borsch: Probably not. And, correct me if I'm wrong, my understanding is that these benefits that now can be made available through Medicare Advantage generally not on the traditional Medicare side, or through Medicare Supplemental Policy. So, that's the relevant thing for the healthcare markets. You have an environment going into next year where it's sort of a perfect storm of positive factors for Medicare Advantage growth.

You has a strong reimbursement rate, you have a suspension of the health insurer fee, which is an added expense that the insurers don't need to worry about in their benefit designs for ... Or did not need to worry about because it's all set at this point. And then, you have this flexibility, and of course you have another somewhat larger cohort of seniors turning 65 who are yet more likely to be familiar with managed care and less likely to have employer-provided retiree coverage. So, CMS has come out with this huge growth forecast of 11.5% growth in the Medicare Advantage population.

The companies thus far have said, "Well, that would be nice but we're going to stick with our 78% forecast. And, it's going to be interesting to see if CMS for 2.4 million joining Medicare Advantage, actually is what we see. That's going to be a step function higher in the Medicare Advantage penetration, and probably if that's right, we'll be setting the pace for where we go over the next few years. And, maybe getting to 50% penetration, a lot sooner than we thought.

Paul Heldman: It seems to me that the administration is using Medicare Advantage, trying to encourage its growth, but using it to experiment, in this case, with in-home services for sort of loosely described nonmedical needs to avert what reduces medical needs in the future. But, they're also doing that on the Part B drug side, before they announced the international pricing model, they announced sort of more flexibility for the plans on Part B drugs.

Paul Ginsburg: On step therapy.

Paul Heldman: On the step therapy. So, I would expect them to continue to do that. And, it seems to me that they're bias, the Republican bias, and even to some degree, less so. I mean, the Democrats have sort said, "Medicare Advantage is here to stay." But the Republican bias is to grow it.

Ana Gupte: I guess, I mean, I'm also hearing on that question something around social determinants of health. Is that sort of also the focus?

Alwyn Cassil: Yes. I think so. I think that because the rigid benefit structures don't ... Other than the home based and community supports for Medicaid dual eligibles. There's a significant cohort of elderly people who could do just fine in their homes. But, they need help with the activities of daily living. And, we don't pay for them, and we don't think-

Ana Gupte: Right. I think what I've heard rom WellCare which has probably the most dual special needs plans portfolio, but also from Humana and others. Maybe you're not that focused on the lowest income. Is that CMS did a little bit in the 2019 ... The design to help. Initially, they proposed more. I think in the conversations were more about transportation and food, and housing. But then, the final rule that came out in April, or whatever, didn't go as far as they would've like it to. All that being said, I think most of the plans are excited that they can include some of that and at least get paid part way, because they were doing it, but not getting paid. So, this is on pure MA. And then, of course also the MMP integrated duels maybe didn't go all the way. But, to the degree that they're also ensuring the same provider, or plan is ensuring long term care. And, even if they're not, they're outfitting low income projects with wheelchairs and so. I mean, United spent in many towns, in many cities, where they have a focus on low-income assisted living, and so on. They're actually investing in that physically. And then, they're all putting together a wrap around care management that the home, with social workers, and their own home health aides and so on. But, I think that's moving, but maybe not fast enough.

Paul Ginsburg: This would be a really good time for a break. So, let's take one. And, we'll be back at 10:45 to resume.

TRANSCRIPT
Part 2

23rd ANNUAL WALL STREET COMES TO WASHINGTON
HEALTH POLICY ROUNDTABLE

Washington, D.C.

Wednesday, November 14, 2018

Moderator:

PAUL GINSBURG, Director, USC-Brookings Initiative for Health Policy

Panelists:

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PAUL HELDMAN, Managing Partner, Heldman Simpson Partners, LLC

Paul Ginsburg: Okay I'd like to move to hospital consolidation and the increasing pace of announcements of mergers of large systems with each other, often across distinct geographic areas. So the question is, what's motivating these systems to combine? Particularly the cross market mergers, that's what seems to be new and what do they see as the up side, and is there a rush to do this at a time when the federal trade commission has yet to challenge a cross market merger?

Matt Borsch: If I could just start, couple of observations. For the obvious, the cross market merger obviously does not involve the other issue that policy makers have with hospitals, consolidations within a local market, the potential for higher prices. But needless to say, the hospitals are operating where many of them are economically challenged by the continuing reduction in utilization of inpatient days and, so any organizations that are operating under duress become more likely to be willing to look at something that would offer at least some cost efficiencies and maybe a better chance at organizational survival, because on the flip side of this,

when you think about these institutions operating in a rural market, this is true on a different level some of the maybe single region health plans, while it works as a not-for-profit institution, if you're on the board your incentives are probably to continue to let it go.

It's a good, I mean have it operate independently, and maybe a lot of justification for that but also taking the mindset of someone on the board of one of these institutions, there's nothing that they gain by selling the institution, except losing their community influential board seat that they've been on maybe for some number of years. And my point is, obviously though when the going gets tough enough, the door opens to consolidation, that hasn't happened on the health plan side and I'm not going to pick on them but that's why Blue Cross of Wyoming doesn't seem to be interested, you know the smallest of the Blue plans by the way, still continues to operate as an independent entity.

Ana Gupte: Then you look at the for-profit hospital universe, it's pretty small.

Paul Ginsburg: Yes.

Ana Gupte: So there's a huge not for profit thing that we don't analyze that deeply, I kind of look at their financials at a broader level, but to Matt Borsch's point, there's been a lot of headwinds on patient volumes -- they were masked to some degree by the exchanges and a little bit with Medicaid, so the first couple of years of the Affordable Care Act they saw a nice bad debt pop and it improved because self-pay patients at least got Medicaid not exchanges. Then around 2016 you started to see the ACA membership tapering off, and some of the underlying things that were happening around the mix shifting to outpatient and ambulatory and all started to play into their P&L's, and I think what we started to see was kind of a bifurcation and a divergence of some hospital systems where the managements are just top notch and I'd say HCA is one of them who had been investing and doing the right level of capital deployment all along.

They weren't lulled into a sense of security by the exchanges, underlying they were investing in their ambulatory platform in a big way, And while their stock was pretty depressed, they did buy backs and they introduced a dividend, most recently. But they kept investing in service lines and their inpatient settings and I mean, so that's why they have a portfolio of hospitals where now they're getting outsized share gains, they're in the market, after tax reform especially because that kind of leveled the playing field in part between the not for profits and for profits to be able to invest more in other health systems, coming back to Paul's question. So they bought hospital system in Savannah, they just bought the top hospital system called Mission in Asheville, which gives them a number one position in this town in North Caroline, they haven't been in that state before.

So that's kind of a cross market story that's happening. Simultaneously there were some of them who had done these deals like, Tenet bought Vanguard, and Community that bought HMA and they just took on a huge amount of debt to do these deals and the promise of the ACA did not materialize for them. After the Supreme Court allowed states to walk away from Medicaid expansion, a lot of the earlier promise just never got realized, and that was so painful and the low of volumes, the weaker pricing, it all just crushed them and their leverage ratios went so high that their bond holders, they had to do a lot of portfolio rationalization.

Community has been selling hospitals because they've had to sell these hospitals, and there are not for profit health systems who buy them because, and so do HCA, why do they buy them? They buy them because they can get better pricing leverage and contract leverage with managed care in certain markets, so it's much more synergistic for someone else than for Community to hold it, that's one. You might go into the same or new market because you're trying to enter markets where there's population migration -- so in the south, southeast and southwest, there's been better markets because the labor markets are better, so you might enter because of that.

And then maybe large systems even do it just for supply efficiencies, procurement efficiencies, so you have acquirers and those that who have actually generated enough cash flow to do this and then those that have to be acquired, and the pipeline is getting richer now again with some of these outpatient pressures on 340b and the like, and it's going to continue to put pressure on the P&L's and all of these things that we're doing with the drug pricing. There are underlying negative threats for hospitals in that as well, on site of service and clinical visit reimbursement inside a hospital even in an outpatient setting versus outside. ASC rates are getting better per CMS from Medicare. All of this stuff is diving continued consolidation.

Paul Heldman: And I would just add, and you guys can certainly weigh in on this. When I talk to investors and I give them a Medicare forecast on the reimbursement side for inpatient hospital care, which hasn't looked that bad and doesn't look that bad going forward, they always remind me that people retiring into Medicare, baby boomers retiring into Medicare, is a huge pay cut to the hospitals so, they don't care as much because-

Ana Gupte: Yep, the negative margin mix shift-

Paul Heldman: They're taking a big hit from 10,000 baby boomers a day retiring into Medicare, which pays 50 percent less than commercial payers.

Paul Ginsburg: Yeah that is enormous, in comparison to with just the tweaks of the Medicare reimbursement rate from year to year. So sounds like it's a story of distress, to some extent.

Ana Gupte: Winner and losers, I guess the distressed and the ones who are rescuing them from distress.

Paul Ginsburg: Yes that's right, but you didn't bring up the gaining market power, other than getting to more of a critical mass in some communities that you may not-

Ana Gupte: Market power for sure I mean, that's why Community has been able to get very good multiples, and that's what I've heard too from a separate independent channel checks, in many markets from hospitals that want that extra share that catapults you into the number one or number two position and now suddenly you get a much better pricing story from the managed care company. HCA bought Houston hospitals from both Tenet and Community because it's really strengthening that -

Paul Ginsburg: So in a sense this is where it's a cross market, it's really focused on particular markets, leverage in particular markets as opposed to some of these gigantic mergers say among Catholic hospitals-

Ana Gupte: Like Advocate or Providence or Ascension

Paul Ginsburg: That's right, where in a sense presumably these aren't driven by the dynamics in individual markets it's just acquiring a huge-

Ana Gupte: Scale and scope, geographic scope.

Paul Ginsburg: Other than the distress thing that Matt brought up and you did also, any other sense of ... do you think that's valuable as far as leverage, being in a lot of markets?

Matt Borsch: Not necessarily to a large degree because the negotiation process is between the managed care companies and the hospitals, still tends to be locally focused. There certainly are some national or regional templates that can potentially get outlined, that cross markets for a company that is a parent of hospitals in many different markets. But to my understanding, and certainly from back when I was in the industry, I didn't see that translate into real negotiating leverage. Obviously in-market consolidation's a totally different story.

Paul Ginsburg: Sure, that's right. Is there a trend in whether plans or providers are gaining leverage? This is a difficult big question, but you know I know that as far as the plan, clearly consolidation is increasing that's giving providers more leverage but are the plans feeling more pressure from their clients to be tougher? Or in the sense of this time of booming economy, you wouldn't expect that kind of pressure?

Matt Borsch: Well you know, the pressure, for example, for the large employer customers is, and I think Ana, you alluded to this earlier, that there is this trend and companies that enable this trend of the large companies seeking alternatives to the large managed care status quo, normal pattern, "Okay we'll choose between Aetna, United, Cigna and maybe the Blues if that makes sense.", and that they're going out to niche companies and maybe a bunch of them and getting a solution that way. And my point, I'm sorry I should come back to this, so because you have this in essence sort of new source of competition that is putting more pressure on the managed care companies to develop as cost efficient a network as they can put in front of their customers and keep them from going to these alternatives.

Paul Ginsburg: Yeah so some of these alternatives are direct contracting with systems.

Matt Borsch: Yes.

Paul Ginsburg: Do you think that's going to become a significant factor in health care delivery or is it going to be just more of a special situations that work because an employer happens to have a lot of people in a market which has the right degree of concentration for it?

Matt Borsch: Well I think that there are probably configurations where that can happen and it hasn't happened yet and so we probably will see more of it. But it's going to be limited by the number of circumstances, where I think you do have to have a concentration of an employer in a certain market, and utilizing a provider to a significant degree in that same market otherwise, direct contracting is a very much scale inefficient process for a purchaser to engage in. Now when you start talking about private exchanges and that sort of thing, I won't get into that but, that's another ball game potentially.

Paul Ginsburg: Okay.

Ana Gupte: I guess the question is also around, is there, and I may be misinterpreting it, the hospitals that consolidating, is that creating pressure on managed care? Or that's not part of the question?

Paul Ginsburg: Oh yeah, go ahead.

Ana Gupte: If that's part of the question then, managed care has been fortunate to have a whole bunch of secular, organic growth right, also. They're growing huge as Medicare's privatizing to Medicare Advantage, and Medicaid is privatizing. Even though there's no growth in the commercial, self-insured and fully insured membership really on that basis, they're growing in those. So they are, I mean you now have power concentrated in the hands of what? Five large plans and three Medicaid plans in essence, and then the Blues, right? And then they've also regionally seen some consolidation, Centene bought Health Net, and you know, bought Fidelis, and WellCare bought Meridian, I mean these are large regional Medicaid and other plans that are getting absorbed into these large companies so I think while hospitals are consolidating there's a combination of organic and inorganic scale being built.

Matt Borsch: And I think Paul, I just want to make one point on it because Ana alluded to it, you know, the Centene acquisition of Fidelis is just as a separate point, is significant, is the largest to my knowledge, the largest not for profit conversion. Effectively it was handled as bypassing the conversion process, but that's what it was, since the IPO of Well Choice Empire Blue Cross in 2002.

Paul Ginsburg: Good, let me go into spending trend, so the spending trends have moderate for many years, certainly a relief in contrast with earlier trends but still exceeding wage trends so that health insurance is becoming less affordable. What's you expectation for the next five years as far as aggregate spending trends?

Matt Borsch: Let me just start with a stab on that, just as a backdrop I followd a model that was originally developed by Millerman, John Cookson in the ‘90s that showed the pattern and statistical significance of a relationship between healthcare spending trends and the economic cycle. And basically the pattern there has been that health care spending trend is a lag, cyclical in other words, demand for health care services picks up in an improving economy but it does so generally three to five years into a given business cycle, into an economic expansion.

And using that model for the current economic expansion, we should have seen that in 2014, the trend bottoming in 2013 and then rising up from there. Now it fact, the United, just to go back to the, United health's figures suggests that the pattern actually was there, it just was so muted in the current environment, where that's been a really strong pressure point on managed care companies in the past. There wasn't even a ripple really this time around and then of course you also had the obscuring issue of the ACA coming in at the very same time.

But let me just offer this one more thing which is, when you think about trend having gone from basically zero to the double digits from the mid-1990s to around 2000, 2001 -- as a generalization, one of the things that was happening there was you had a whole range of new procedures that had not fully penetrated the population -- hip replacements, knee replacements,

stents. And so going back again to United Health, if you go to their conference calls from 2000, 2001, that's what they kept coming back to, which is those services penetrating a greater and greater segment of the U.S. population.

Fast forward to today and arguably, I'm putting specialty and biotech drugs aside and that's a big thing but when you look at the medical side in terms of new, expensive, inpatient procedures that are not fully penetrated, the environment' a lot less ripe for an upward turn in healthcare spending trend or at least that one perspective on it. And maybe why we didn't see a bigger turn, not withstanding the historic pattern.

Paul Ginsburg: Yes, that's very interesting and my sense is that you probably have good visibility in this because it takes quite a while for important. New technology to become wide spread enough so that people, at least in theory, should be able to identify the knee replacements early on before they actually became high volume. And so my sense is, you're not seeing anything in the early phase like knee or hip replacements, or some of the other major procedures.

Matt Borsch: It doesn't seem like we are.

Paul Ginsburg: Yeah.

Ana Gupte: I just feel like, I think there was definitely as Matt says in the '90s and even 2000s, a pretty tight linkage between healthcare utilization and the macro economic cycle, but that over time as we've adopted high deductible plans and this may seem like, "is this true?", but I do think there's a structural depression of medical costs trend because of the adoption of very high deductible health plans on the one side which is a leverage point with the consumers so they're not just third party pay, "Now we've been employed, we have insurance and we're just piling into the health care system", no matter whether it's necessary or not, we're actually seeing some consequence from it.

And then also, mix shifting to ambulatory surgeries, site of service and all that more recently which is also reducing the price of services utilized, I think. And then value based care, so those things are actually all working I think and we are in a late macro cycle right now, that trend had to tick up, it would have ticked up and I don't see it as downside risk for the managed care group anymore. And there was, -- touch wood yeah -- and you know there was this long/short thesis always about this macro call about providers should be bought at the late cycle and plans in the early cycle.

I think we've gone past that, my call is you buy managed care because the fundamentals remain good from an external standpoint. Macro economically, policy wise, they're very adaptable. As long as they don't underprice their business because they're their own worst enemy, they're good and they can all work. On the provider side it's the winner and losers, survival of the fittest, if you're an HCA, you're good. And even Tenet and Community, they've come back from the dead practically kind of thing, Community is coming back from the dead. They're not getting any help from the macro economic cycle.

Paul Heldman: Those are very compelling points, particularly on the technology, I guess just the other side of it is, in the employee marketplace or in the Medicare program is the 20 to 25

percent of the sickest people, they count for 80 percent of costs. And so, that sort of pressure especially as we get older remains.

Matt Borsch: The demographic trend.

Paul Heldman: Yes.

Matt Borsch: That is ongoing and accelerating even, that may be something that we haven't seen all the fruit bear out. That of course, what we tend to be talking about when the companies, for example, will focus on commercial trend per member that's not to say what you're talking about isn't a very real dynamic to watch.

Paul Ginsburg: One thing I was thinking you might comment on, Paul, see if you think I'm right. Is that when it comes to the policy environment, I would say, and this is a big statement, you may say I'm wrong. But that I would say that for the last ten years, the policy environment has not been very aggressive in trying to contain costs.

Paul Heldman: I agree.

Paul Ginsburg: And that could change, I can't predict when, but I'm thinking that with the fiscal situation, with the federal government deteriorating so quickly, you could make a prediction that's going to change and that will affect the aggregate spending trends.

Paul Heldman: Right so, if you look at the national healthcare spending statistics, there has been a little bit of an acceleration in sort of a larger sense, in projected spending growth. You're talking five and a half percent a year, and they're saying that's largely being driven by Medicare and Medicaid. And politicians are reluctant to contain costs, and my guess is that they're probably not going to feel sufficient pressure to do so until-

Matt Borsch: it's really bad.

Paul Heldman: Really bad.

Ana Gupte: Until they're like, drug pricing I think.

Paul Ginsburg: Until the bond market tells them to.

Paul Heldman: Right until the next day, and yeah until the bond market tells them to.

Ana Gupte: Or maybe because of drugs, they think that's going to be the next burning platform.

Paul Ginsburg: Yeah actually lets get into the trend we might expect in drugs.

Ana Gupte: You know I was on my soapbox earlier anyway, but just don't think we've even scratched the surface of it. And it could drive double-digit trend for employers if something doesn't give and that to me feels like it's going to end up, if CMS and I doubt this happens legislatively, but between CMS and the private payers, they can coalesce around an approach I

think and it's not the middle man. Because the middle man doesn't make enough profit to make it even possible for them to make a dent in this and I kind of look at is as, "We've seen this movie before." 2009, all the health plans, after the whole Obamacare fear, trading at three and five times, how much profit did they make? Like five to seven billion dollars in total in a two and a half trillion economy?

It was the hospitals that were going to get screwed, and I used to make that call, "It's the hospitals, it's going to move down the value chain." No one believed it and look at where we are ten years later. The hospitals got screwed, so it's got to be the -- biopharma at the end is at the heart of it. But of course we can always say that innovation will stall and Secretary Azar comes out with an international pricing index and you say, "but you know, we as a nation fund innovation for the rest of the world" but can it continue?

And if we have a stable of oncology, life saving therapies, are we going tell someone that, "Oh but the out of pocket cost is so much higher that you are a lower income person, you're a working American, you cannot afford it." No matter how right wing you are, that's a hard argument to make.

Matt Borsch: If I could just, the one thing though I would say is that, today the trend drivers in specialty and related biotech products, it's not big enough to be having a major impact on overall trend.

Ana Gupte: Not yet.

Matt Borsch: Not yet, right. So that's the question, when and to what extent is that going to change as a result of what may be quite good news, of a range of new product innovations that apply to broader segments, not just drugs but broader segments of the population. And that would be an awful lot, it's feasible, but that would be an awful lot to drive overall trend up into something approaching the double digits. And if that did happen it would, I think pretty clearly, be a real cost crisis and so you would see any number of possible responses emerge.

Paul Ginsburg: Yeah, as far as insurers, the tools that they use to control spending on specialty drugs, which are the tools that have been most effective and how effective are they in the light of new drugs coming in at extreme prices?

Ana Gupte: Solvaldi and Harvoni was an example, kind of the first time I think in 2014, it actually hit the P&L's, of even United through one drug, who would have thought? And after, by the end of the year I think, abV came with what was their drug? I forget now, but anyways, there was a competitive, not a once a day therapy and all. But it was something and they negotiated better prices.

Matt Borsch: Harvoni?

Ana Gupte: Harvoni was the next gen of Solvaldi, but there was something else that abV came up with. So competitively they were able to negotiate better rates with Gilead actually, on Solvaldi and Harvoni that was acceptable to everyone, and I think that was actually the time probably where managed care and Anthem and others were just frustrated with their PBM suppliers, I think Express Scripts and CVS hadn't warned Aetna or Anthem about this new drug

coming down the pipe. Like, how hard was that to do, you know? They made more money if that drug was prescribed so that's the whole misaligned incentive situations, for injectable drugs, it's about ... Briova, which is part of United and then Humana has their own specialty pharmacy in captive PBM, they influence the specialist and that's the way to incent them differently but now with the buy bill potentially getting approved at the CMS level, it gives cover to the private payers because if CMS does something I think it just allows them to adopt that in all settings beyond that payer mix.

Matt Borsch: I was just going to add to that, I don't think that there's really that much that the Uniteds and other carriers can do on the specialty drug side because they're not going, in the commercial side in Medicare, they're generally not going to say no, they're not going to say no now. And there isn't necessarily a management technology that any of them have developed that somehow makes the selection of those who get it and those who don't in some way more efficient. So there isn't that much influence, now having said that, when you look at the Medicaid population, that's been a state by state determination, it's been at some states very restrictive. And there has been, because it's the Medicaid low-income population, politically there's been a willingness in some states to allow that and it's even more restrictive amongst the inmate population.

Ana Gupte: Formulary exclusions were done in Medicaid yeah.

Matt Borsch: Right.

Ana Gupte: Much less so in commercial, though you've seen some plans like Harvard Pilgrim and I'll talk about it even in commercial, but its one off and they're very careful.

Paul Ginsburg: I see, I was under the impression commercial, there was a fair amount of restriction of hepatitis C drug use, but you're saying no.

Matt Borsch: Well I mean it has to be documented that it is indeed, that you have Hepatitis C, and I don't know, the doctor prescribes it. Beyond that I'm not aware of any particular restrictions although maybe below the radar there is something that I don't know about.

Ana Gupte: But there is also this thing that I think in that same rule, CMS has now come up with the, is it approval of biosimilars... You know, Eylea and other age-related macular degeneration, I think that's kind of gotten a little ... I was talking to somebody about this. There's a bunch of them I think, that could be not just for part B drugs but also for Medicare Advantage. Eylea, lucentis, biosimilar swap outs, Nulasta, Remicade, that could be huge.

Paul Heldman: So the administration announced guidance in August, it will allow Medicare Advantage plans to use step therapy, and they're allowing the plans to basically combine part B and part D, so you can be in a situation where humera can be substituted for Remicade or the biosimialr version of Remicade, the Pfizer version could be substituted for remicade.

Matt Borsch: I'm curious Paul, what you think, but I think that one area where you might see a successful policy change on drug pricing would be with regard to what happens today with the patenting and re patenting and so you have a drug and it ends up having a twenty-year monopoly

effectively or something like that as a result of all the legal maneuvering in the patent laws. Beyond what anybody would have envisioned.

Paul Heldman: Right, so that's a great point. I think that the house democratic leader has expressed some interest, or I certainly heard this from democrats about going back to the idea of being able to break the patent, through NIH, through a law called the Bayh-Dole act. In cases where somebody would be able to make the argument that a drug price is so high that it's creating an access problem. So far I mean, the NIH has been pretty firm says that that's not within the authority of the Bayh-Dole act. But that issue could come back, and then certainly on the issue of biosimilars, it used to be, it's probably still the case, there's probably a biosimilar seminar a week in Washington and always you sort of come to the same conclusion that no matter how aggressive the FDA and CMS is in trying to promote the uptake of biosimilars in the marketplace, it's the patent issues and the legal issues that are keeping biosimilars, or slowing the market penetration in the U.S.

Matt Borsch: If I could, just one point from the audience I want to catch, relevant to what we were talking about.

Audience Speaker: I just wanted to say the hepatitis C medication [inaudible 00:32:52] is a special case, before that [inaudible 00:33:01] side effect, they didn't work, [inaudible 00:33:06]

Matt Borsch: Are a different story okay, that's good point, that's a good point. It is definitely is a black and white with that particular.

Paul Heldman: The other issue I would just add on is patents - this gets into trade policy. The new NAFTA, and setting exclusivity for biologics at 10 years versus the current 12, in the U.S., if it's finalized for those who want to bring exclusivity below 12, and there were advocates for original crafting of the law to make it 7, that's an obstacle.

Paul Ginsburg: Good, what about labor costs? As the economy is getting very high, are labor costs and shortages becoming a larger issue for providers these days?

Matt Borsch: They are generally and in particular areas, most noticeably for psychiatric hospitals and outpatient facilities where there does seem to be more of a shortage on the mental health side. That's become an issue for some of the, excuse me sorry, that's become an issue for a couple of the public companies at least, in particular UHS that we follow.

Ana Gupte: A little less so from maybe you know, anesthesia a little bit in surgical practices as well. But it's not hitting the P&L in such a meaningful way that they're not able to offset it here and there. Mental health has been huge.

Paul Ginsburg: Yeah, well what about the large general hospitals?

Matt Borsch: Somewhat, but they seem thus far to be able to ... it hasn't been a transformatively higher trend, it's a cost pressure point that they've been able to manage.

Ana Gupte: And they've been offsetting it with some consolidation, when you look at their P&L's, they're generally very simple. It's what's the admissions' growth, what's the pricing

growth, what's the salaries, wages and benefits, supplies costs and other opexs -- they have like five line items. It can offset on ...

Paul Ginsburg: Oh thanks, now I have a couple of questions on the ACA marketplace exchanges and you've pointed out in the past years, that this is not a large part of publicly traded insurers business so, probably not that big a topic here but, what's your interpretation of the large premium increases for 2018, followed by the much smaller increases for 2019?

Matt Borsch: Well I think the interpretation is you see this dramatic cycle of first very heavy losses on the initial implementation of the exchange coverage. In 2015 that sort of bottomed out as one sign of that, the not for profit Blue Cross plans we track in aggregate have the first full year loss since 1988, as a result of the exchanges, that was in 2015. And then with the application of steady rounds of fairly large price increases combined with some changes on the rules, there's been ... you've almost gone to the other end of the extreme.

The margins are one might say, unreasonably high across the universe of health plans participating in exchange coverage. And somewhat to mitigate that, you see those price increases soften very considerably going into 2019 -- in some cases they're actually reductions. I will say this though, the surprise in some ways was, when we have three consecutive years of very high rate increases that we didn't see what we refer to, or they refer to in health insurance or any insurance in general is adverse selection.

In other words, that you didn't see the high price increases driving out all the good risks, if you will. Now one of the reasons for that was that so much of that exchange population is heavily subsidized and so in fact, it's the federal government that's footing the bill much more so than the member, that's probably the biggest reason. But it was still somewhat surprising.

Paul Heldman: Of course, you did see a fall off in the individual market off the exchanges-

Matt Borsch: Yes.

Paul Heldman: By a couple million people.

Matt Borsch: Right.

Paul Heldman: So that surprises me, it did have more impact in terms of their-

Matt Borsch: Their risk mix, not substantial or at least the rate increases kept well ahead of those, otherwise, we wouldn't be at this point in terms of the profitability.

Paul Ginsburg: So it sounds like we've, over the years, talked about the underwriting cycle for commercial insurance in general and now it’s really become more and more muted over time. But the ACA market being a brand new, particularly uncertain market, looks like we just had a huge initial underwriting cycle. Which perhaps if things are stable, will mute over time. But in a sense, a very understandable underwriting cycle because of the great uncertainty about the nature of the customers that would sign up.

Matt Borsch: Well I wouldn't, in my classic definition of the underwriting cycle, I wouldn't count that even though on a graph it looks like an underwriting cycle. The reason I say that is because, historically what we've tracked is more the results in a group, that core, the largest area of coverage, the group commercial insured market. Where we see those margins move, and in fact because of the exchange loses, that has helped to keep the pricing disciplined if you will in the group commercial market.

And now, as it relates to what happens next, the question is with many of the not for profit plans having made dramatic profit recoveries, and the capital ratio on the Blue Cross not for profit plans looking like it will recover to the peak level of five years ago, are we going to see more aggressive price competition and maybe even a cycle or the conditions for a cycle building in 2019?

Paul Ginsburg: Oh that's really interesting.

Ana Gupte: In '18 it was heavily about the defunding of the cost-sharing subsidies, that's another point. But in '19 you have the repeal of the individual mandate, but again because it's the carrot and the stick issue, if you're subsidized, it shouldn't impact the subsidized exchanges. So again my forecast would be, you'll still see 11 to 12, actually I'm going to go out on a limb and say this, I think it's about 11 to 12 million members subsidized. I think that short-term plans and association health plans are providing some affordability or affordable options for those that are off exchange and don't have the subsidies and the deregulation could in fact at least help pull out some of the people from either the uninsured or give affordable options to those that are really getting you know, crushed I would say, upper middle class people, under the very partial subsidies or no subsidies. And their sole proprietors are individuals and they do not have employer insurance. So you might see a million or so people coming in on the short term plans and association health plans, some from uninsured, some from mixed shifting, from off exchange, to Paul's earlier point.

Paul Heldman: Of course, that might all be effected by the administration's latest proposal to allow states to apply for wavers that might allow the use of the ACA subsidies to buy short term-

Ana Gupte: To buy short term, that helps actually you know in some ways, are you worried that the risk under the subsidized plans will-

Paul Heldman: Right I just wonder whether there are healthy people who say, "Wow, I can run with this subsidy and pay nothing."

Matt Borsch: Sure, it will potentially deteriorate the risk pool.

Paul Heldman: But, I mean maybe it might help in some other areas.

Ana Gupte: Well, if you have full subsidy, you wouldn't, but I think if you have partial subsidy that's where it becomes an alternative.

Paul Heldman: Right.

Ana Gupte: And there are people between 250 and 400 percent of federal poverty level where the subsidies are just not enough to-

Paul Heldman: Right they're not.

Ana Gupte: You know? For them to be able to afford it.

Paul Heldman: Right.

Paul Ginsburg: Yeah, let me switch to Medicaid expansions and you know, we saw in the elections some significant movements as far as state referendum, election of democratic governors, so presumably there's going to be a lot, very significant Medicaid expansion. What's the thinking about the insurers that are in the Medicaid business, about their existing and future investments in Medicaid managed care?

Matt Borsch: I mean, I think you're going to see more of it. I think that the precedent from the Medicaid expansion in 2014-15, unlike the exchanges, the Medicaid expansion was quite profitable for the health plans right from the get go. The Medicaid expansion rates were fairly generous, and so you had that going on even at the exchanges from a financial standpoint for the health plans were an absolute disaster. Now this played out a little differently depending on which companies we're talking about, because for the most part, the not for profit plans, regional plans, tended to be more oriented towards the exchanges. And so they took a big bath, whereas the public for profit companies` by business mix, were more oriented towards the Medicaid expansion, the Medicaid business and so that was a source of profitability for them. But in terms of investment interest and focus, it's pretty strong and second only to Medicare Advantage.

Ana Gupte: And there's also a lot of the focus is on Medicaid privatization and not just on Medicaid expansion, which gets a lot of attention in the media, for obvious reasons. But from privatization of state Medicaid to managed Medicaid, the dollars are way higher than the expansion of the market that they see -- , the plans from Medicaid expansion. And in fact the aged, blind, and disabled and long term care populations, it can be $10,000 to $15,000 in premiums a year and then you have dual eligibles with Medicare and Medicaid that are $25,000 to $30,000, so if you're even making a 2 percent profit margin on that, it's very big.

And, earlier to Alwyn's question about social determinants of health, the plans are being either encouraged and now increasingly I think, with the Bipartisan Budget Act, by 2021 there's upside to being integrated across Medicare and Medicaid for the low income, dual eligibles. So they're investing a lot in Medicaid even if they were earlier only in Medicare Advantage because they need to be in Medicaid in states like Florida and Texas -- to be able to partake of that life across Medicare and Medicaid.

So you're seeing interest from companies like Humana that were at one point, pretty clear they didn't want to be in Medicaid. They bid heavily in Florida for the reprocurement contract and won very nicely, and now they're waiting for the Texas star plus and star announcements which are in May in the third quarter of this year. And they're really putting a lot of effort, all of them, into social determinates of health as part of dual special needs plans and then, also separately right now with the Medicaid ABD and long-term care population.

Paul Ginsburg: Good, they're really interesting points. What about, and probably something you've been looking at for many years is, when a state expands its Medicaid program, what's the net impact on hospital bottom lines?

Ana Gupte: It helps on bad debt, it does. It's much better than self-pay, now it's not as good as for sure, you know from a payer mix perspective, the pricing growth is not as strong as Medicare and definitely not as good as commercial. But if you have a bed where you're having to treat someone because they come to your emergency room uninsured, this is better, especially also over time if your capacity is underutilized and outside of ACA and the publicly traded, I don't hear 75 percent capacity utilization. It was your earlier point around, you know, the prices are okay you can run at underutilized capacity.

Paul Ginsburg: Yeah.

Ana Gupte: But I think for those of them that are running at underutilized capacity, a Medicaid life is still a life that they're covering some fixed cost around.

Paul Heldman: I think some of what was driving the Georgia governor race, which is still undecided was the Medicaid issue with the rural hospitals really pushing for the Medicaid expansion, they help the Democratic candidate.

Ana Gupte: From the plan standpoint, Paul you may know this right now, I did a lot of work at one point and it's I on't know for a fact but, if the ACA, if a state did not expand Medicaid and you were only at 135 percent of federal poverty level to 400, you got exchanges. Those that fell through the cracks between 100 and 135, I believe were eligible for exchanges, right?

Paul Heldman: Yes, it could be put on-

Ana Gupte: So if I'm a Centene or anyone who's in exchanges, a Blue Cross of Florida, and I'm managing exchange members who came in from the uninsured in a state like Florida, I mean Centene and Molina are doing like mid- to high-single digit margins. The Molina CEO announced 9 to 10 percent on the call. So I'm not saying anything that's speculative here. If they expanded Medicaid, and those people moved from an high profitable exchange program to Medicaid, you actually stand to lose, so I'm not sure and in any case if Gillam wins, I think it's unclear in any way that the Republican legislature would allow him to expand on Medicaid, but I'm not sure the plans want that. Maybe the hospitals would benefit, but.

Paul Heldman: Yeah it seems like more of a hospital win.

Paul Ginsburg: Well in a sense your conclusion about the hospital show that, sounds like hospitals were treating a fair proportion of the uninsured patients who showed up because if they weren't-

Ana Gupte: They had to.

Paul Ginsburg: Because they have to stabilize them.

Ana Gupte: Yeah, can't turn them away from ER.

Paul Ginsburg: But it sounds like maybe they're doing a lot more than stabilizing them, so that's why the Medicaid expansion is such a positive for them even though the rates are low.

Matt Borsch: You drop straight to the bottom line for the most part.

Ana Gupte: That line item went way down.

Matt Borsch: Either it's incremental volume in some cases it is because there's some new volume that comes out of the expansion. Or its volume that they got paid virtually nothing for and now they get a low rate but again, the costs they they're incurring on those persons who are otherwise coming to the hospital is incremental cost is zero. So it all drops to the bottom line.

Paul Ginsburg: Next, I want to turn to large employer health benefits strategies and maybe place to get started is, what's you assessment of the potential for the partnership between Amazon, Bertrand Hathaway and JP Morgan either for the three companies or beyond the three companies?

Ana Gupte: I think I talked a little bit about it, there's angst and dissatisfaction in the very large employers, you're seeing that with Comcast, G.E., Apple, Amazon, Walmart, you know? They're doing either direct to provider contracting, or work site wellness, they're doing medical concentric networks and centers of excellence, even offering transportation and all to their workers to go lower cost hospitals, even if that means travel and the like.

Amazon and Walmart to me feel like they have an aspiration to carve a position for themselves in employer sponsored benefits, beyond their own worker population. And so, we talked about Amazon doing drug supply chain, possibly the digital front door in healthcare, and they're doing work site wellness. I would think, and no one knows this for a fact but they will use the coalition of which is about 1.2 million members, as a pilot testing ground -- you come up with your ideas and now you have a much larger employee population and if it works out, then you can market those solutions more broadly.

I think Walmart is being underestimated on this as well. They've been looking at their retail stores as a way to, I think they're going to put not just you know, they have the drug distribution partnership with Humana, but they're retail clinics in their parking lots. And they've been doing a lot for their own workforce, which can be heavily hourly paid and blue collar, on negotiating better rates and contracts and networks for their own workers and I think they have aspirations, and you can listen you know, Marcus Osborn is their leader of health transformation and he speaks at many public events, including at ours.

And they definitely seem like they have a broader aspiration to health care in their own workforce and then they are again, if Amazon is trying to do this online, they are also trying to draw people into their stores on a retail basis -- not employers now -- but to their stores for low cost generics, for dollar and nine dollar, will then also have them at the same time that you go fill your drug, you go shopping, do some back to school shopping for your kid, go get to the clinic in the parking lot and all of that. Well they could use that as a network for employers as well, and it goes head to head against CVS-Aetna and it has a more aligned value proposition with the front store.

Because seniors on a fixed income are more likely to shop in Walmart than try to do convenience shopping in CVS for a product that's being sold at three times the margin that they could pick it up online or somewhere else, then they don't have grocery in the mix, and the inventory and product positioning is not aligned either.

Paul Ginsburg: You know one of the things that occurs to me is that when I read about large employers that a very active in innovating in their health benefits, I hear about Walmart, I don't recall hearing about JP Morgan, Chase, or Berkshire Hathaway. So in a sense, I think your notion of being testing field for Amazon is probably what makes the most sense.

Matt Borsch: I will just say in a little bit of defense of JP Morgan, it was five, six years ago, they went to a firm-wide high deductible plan offering, which is certainly further than some of the other big banks have gone. They also with that, they tiered the costsharing according to income level to some degree, I don't have the exact design but that was somewhat innovative in of itself. But since then, it's been a pretty stable configuration.

Ana Gupte: Back to the plans on this, I think the whole announcement from ABC, this Amazon coalition in January was a massive wake up call When JP Morgan had United Health Group and Cigna as their only two carriers so they found, you know I think both those plans were caught flat footed with this media announcement one morning. Aand so I think they're realizing they need to do more on what they call national accounts, which would be very large self-insured Fortune 100, even Fortune 50 employers. And then Anthem, because Gail Bourdreaux with the 14-state Anthem and then you have all these Blue Cross Blue Shields and the Henry Ford GM thing that happened on the direct contacting, Blue Cross of Michigan now only has the TPA role to pay claims, a third party administrative role.

And Anthem has an opportunity ,and I think Gail knows that ,and if anyone can do it, she can, to try to corral the Blue system to develop better value for multi-state employers because they have 50 percent market share, they have the most leverage, the Blues against hospitals and docs, and they do not need to buy anybody because they control half the market in every market.

And so you know, I asked both of the CEO's the same question in the third quarter call, and they clearly are on high alert and United said they're going to pivot to growth in national accounts in 2020, so obviously they're taking steps and Anthem, Gail said she's definitely got ... she gave me a long answer to what she plans to do, kind of the help the Blue system realize it's value, because there's more value than they realize because they're each all an independent little company, 36 of them.

Matt Borsch: One qualification as you know that, 50 percent market share for the Blues wouldn't hold fom Medicare Advantage or the Medicare drug plan business-

Ana Gupte: Commercial.

Matt Borsch: Much more, the Blues particularly I'm really talking the not for profit blue, although to a degree Anthem were much more passive than the public companies when ... not surprisingly the public companies, the for profit companies are a lot more aggressive about chasing profit and that explains in significant degrees, scale's factor too, why the public

companies are now close to two thirds of the market share in Medicare Advantage and taking almost all of the growth.

Ana Gupte: True, very true.

Paul Ginsburg: That's a good point, I guess this will be our last segment before we have questions from the audience. About alternative payment approaches and want you to characterize how hospitals and physician organizations perceive ACL and bundle payment contracting in Medicare and in private insurance, and kind of what's the experience of private insurers when they try to do these things?

Ana Gupte: BPCI I think there's are bundle payments even outside, you know bundle payments initiative, there's a clear aligned incentive for the hospitals because the decision was made to have the money for the bundle to flow through the hospital. So they were able to create narrow network contracts, with post acute and do a lot of post acute diversion. Sometimes even increase length of stay and then move people to the home and reduce post acute, but post acute providers got crushed except for the survival of the fittest stories.

So there is a clear kind of incentive alignment there. ACO, what is an ACO you know? I mean it can be anything, I think it's like, they come up with these announcements about being sold the ACO's, sorry I don't know what that means...

Matt Borsch: It's very good point, I mean you get this both with ACO's where 900 or however many accountable care organizations, some of them are really new, innovative, integrated delivery systems in fact, and some of them have just taken on the organizational title and there's a lot of busy work going on but not much real change or innovation and you can't tell, you have to get down into the details to tell one from the other. And somewhat likewise for value-based reimbursement in that, when you hear plans or policy makers say, "We're X percent value based reimbursement today versus Y percent three years ago," it doesn't necessarily tell us ... really mean as much as what they're saying -- because it may just be fee for service with a few bells and whistles on top to be able to call it value based reimbursement. Or on the other end, going from fee for service all the way to population based reimbursement, that's obviously a profound change. We lack the specificity around these things to come up with good metrics to track them.

Paul Heldman: You know and I get asked by investors about this area, really most of the questions are on the big dialysis provider, because they're very interested in trying to ... Medicare the money loser for them but that's where most of the patients are, so trying within Medicare to find a way to manage the care of the whole patient and they don't going to like the current model very much, and they're looking for legislations to do something different. The large providers are, I think the small providers may disagree. But that seems to be sort of in the institutional investor community where most of the focus is when they're asking the Washington guy about ACOs.

Ana Gupte: Dialysis, I mean I cover small dialysis provider, and so I watched Davita and Fresinius just because I cover a little guy, my god that landscape seems so challenged I mean, are these investors short or long?

Paul Heldman: I think that they either have been long or they'd like to be long but they're constantly worried about what's going on in California with their-

Ana Gupte: The prop 8 thing at least, I know ...

Paul Heldman: Right, and whether that's going to come back, and there is regulation related to third party payments that we're still awaiting publication on the challenge of their model.

Paul Ginsburg: I got some questions now and one is for Matt Borsch, I know Matt Borsch has to leave early so let me just ask you.

Matt Borsch: I have to catch a flight, I apologize. I was hoping to avoid any tough questions.

Paul Ginsburg:I have no idea if this is a tough question, why wouldn't larger self insuring employers naturally follow Berkshire Hathaway, Amazon, Walmart's lead to gain economies of scale, pool risk and reduce cost, is this initiative essentially an AHP? I don't know what AHP means.

Matt Borsch: Association health plan.

Ana Gupte: Association health plan.

Paul Ginsburg: Okay.

Matt Borsch: I think that there's a little bit of confusion behind that question, in my view anyway, the association health plan usually applies to small group employers banding together so, where they can't self-insure on their own, they can as a multi-employer organization and take advantage of the ERISA preemption and so forth. As it relates to the potential scale advantages of Berkshire, Amazon and JP Morgan, you know it's not clear that they're leveraging, not necessarily scale because they have scale already. But rather, to come together to pool their resources to come up with innovative models to disrupt and improve the existent vanilla relationships between health plans and large employers.

Paul Ginsburg: Thanks Matt, don't want you to miss your plane so.

Matt Borsch: Turns out Dallas is further away than I thought.

Paul Ginsburg: I've got a question directed to Ana, and it's also about AHP's, association health plans, but it's really an insurance question. What are some of the obstacles of expanding geographic-based association health plans? How do you expect payers to react to an organization that would both bring in more business but do so by cutting into their margins? Why haven't AHPs taken off and do you see them as presenting a threat to health benefits exchanges by draining healthy lives away from the exchange, effectively leaving them as high-risk pools?

Ana Gupte: I guess I'll take the last piece first, I don't see them as draining at least the subsidized exchanges. So the subsidized exchanges give you full medical coverage, you're getting the subsidy, so I think that pool is pretty stable, don't think the risk pool is at risk. It's the off-exchange pool and there are people that are uninsured that do not have access to employer-

sponsored insurance and they're not old enough for Medicare, or poor enough for Medicaid, that they offer some optionality too.

I think the issues have been, and as we were doing a dive into this, clearly this was of a very stringently regulated, almost onerously regulated market for all of this while and the Obama administration certainly made it even more challenging, even more challenging than it had been in the early 2000s because there's always been this fear that we will suck out the exchange population out of Obama care and move it into association health plans. So regulations been a hurdle. I think state insurance commissioners may be feel little bit of a lack of control when you're talking about insurance across state lines and there's been a lot of work that's been done by this administration to get them comfortable with this.

And I finally saw a piece this week in Modern Healthcare showing a comparison of plans with association health plans versus just individual coverage if you didn't have subsidies, and there's a pretty nice difference, Modern Healthcare did a nice article saying, so it seems like they're surmounting the barriers in certain states at the very least, from the bureaucracy potentially at the top. As far as what the plans would do, I think multi state plans that already have networks and distribution, across the multi state mode or have distributions at least in more than one state would embrace this.

UnitedHealthcare has been doing this with the National Restaurant Association, and other types of association health plans. They're looking at all of this as an opportunity, I think for regional plans, it becomes hard. If Harvard Pilgrim is in Massachusetts, and now you say, "Oh you can market across all of New England," it's not happening easily, they don't have a network to do that.

Paul Ginsburg: Interesting question about artificial intelligence. To what extent is artificial intelligence a serious market factor in any health care sector, biomed, pharma, provider services. IBM's Watson seems to have been greatly oversold as a disruptive innovation for clinical services.

Ana Gupte: You know, I think I'd say A.I. and machine learning are the buzzword right now and the applicability, I am not an expert in it, but certainly, venture capital as well as the various private providers and tech-enabled services which I've also started covering now do make a lot of investments in this. And United Health group with Optum ventures is putting money into it.

But I have one real-life case example of where it's working, it's a company that I cover, there's this notion of payment integrity, I don't know if you guys know what that is, it's basically there's the plans are always looking to see where the providers are overcharging, and they do audits and they do claims checks to see whether there's overpayment and then conversely happens on the provider side where they feel getting underpaid. So I covered a name called HMS, health medical management systems holdings, and they are a payment integrity provider.

They do coordination of benefits in [Medicare], they do payment integrity and now are increasingly leveraging their data because they have access to all this gigantic claims data, because of coordination of benefits and the population health management and care management. And they've been investing heavily in AI and machine learning and it's helping them to drive enormous throughput of claims, which was very hard to do prior to this, and has

been really driving up their account sales, their revenue and their ability to identify more targeted savings, their savings rates, their margins, the last three, four quarters they've finally had these investments play themselves out.

So we call it kind of a big data model where AI and machine learning are helping you with data analytics, so if used properly, I cannot imagine that it wouldn't be useful. Athena Health just got sold to Veritas Capital, a private equity firm and they also bought another company I covered called Cotiviti in payment integrity, and they're planning to combine some of these platforms they have, the healthcare... Vertias and maybe some of the payer risk solutions that Cotiviti had to stratify providers by their ability to take risk and you need the ability to have very strong computational mechanisms otherwise you cannot use the kind of data assets that we have out there, so it's got to help. And value based care eventually, beyond administrative, it's going to get into clinical solutions I think.

Paul Ginsburg: Thank you, could you speak more about transcendental healthcare?

Ana Gupte: Yeah, so from several angles. I cover UHS, Universal Health Services and Acadia just as Matt does, and the trends there, the broader angle there is demand still exceeds supply, both bed supply and clinical staffing, so there's massive shortages on both ends. The reason being, mostly we have a shortage and paucity of mental health providers, especially psychiatrists who want to work in a very challenging in patient setting, it’s extremely hard.

Secondly, when we look at capx, hospitals systems are getting better reimbursement and reimbursement’s hugely challenging for behavioral. In the acute care model versus behavioral, I literally hear things like, "Unless someone's going to kill themselves, or kill someone else, we're not admitting him." Whereas if someone is physically ill, they get admitted. So there's massive reimbursement challenges on who they admit; they want to move them to outpatient if they do offer care and they put huge length of stay pressures, so day, to day, to day you have to justify inpatient care, which is why maybe people who need care don't get care.

So that's the provider angle. We downgraded behavioral health as a space last year, downgraded Acadia, kind of have a value call on UHS but I'm not bullish on behavioral health from an inpatient psych perspective. On the outpatient side, an addiction, eating disorder, substance abuse, there are definitely opportunities. So Acadia’s rumored right now on the brink of getting taken out, but the question is will it happen and will it be the right price and all of that. I would think the outpatient assets and the addiction assets of Acadia are what's driving interest in private equity.

The third angle is I cover Teladoc, which is a telemedicine company. The telemedicine adoption is all happening in mental health, and that's big more right now than even physical treatments. And maybe someday we'll actually get to that promise of longitudinal population health management for seniors first with home health care and digital health and all that, but right now it's mental health, but mental health supply even for virtual medicine is very, very challenged. So they're seeing wage inflation, which is putting pressure on everybody to use it. Those are kind of my thoughts I guess. Magellan is another one I cover and they have behavioral on the plan side. And UHS and Magellan obviously having a massive battle locally in Florida where Magellan is refusing to reimburse on their managed Medicaid. So seeing this you know, I cover two companies who are gridlocked right now with issues.

Paul Ginsburg: Thank you, I think we have time for one more question, maybe from the web?

Audience Question: Do you see large issuers getting more into the short-term plan landscape and when?

Ana Gupte: Very much so, yes. So much as I think that association health plans have more challenges than short term health plans actually. United has a subsidiary called Golden Rule and they still operate right? But those things got pretty challenged with Obamacare, and Cigna had their own suite of services, Anthem had a product called Tonic at the time. So I think all of them in different ways are going to come back into short term insurance, in fact especially because exchanges got challenged and Aetna, United and Humana all left the subsidized exchange marketplace because of how much they had to absorb losses on their balance sheet at the time.

They didn't come back in, so that market not is concentrated among only Centine, Molina, Anthem, and the not for profit Blue Cross Blue Shields, so this gives Aetna, Cigna, United and Anthem, which is very, very small in exchanges, a new opportunity to go after the retail market because they've been locked out of the retail market.

Paul Ginsburg: Thank you, this is has been a great conference and I want to thank the panelist for the phenomenal job they've done and I want to thank the JKTG foundation for not only its financial support of the conference, but for making the arrangements for the conference and thank its staff for the great job they've done and want to thank Alwyn Cassil for the important role that she's played in pulling this all together, we stand adjourned.