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Transcript

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P R O C E E D I N G S

Paul Ginsburg: I'd like to welcome you to the 19th Annual Wall Street Comes to Washington conference. I'm Paul Ginsburg now of the University of Southern California, at the Schaeffer Center for Health Policy and Economics. And almost 20 years ago, shortly after I became President of the Center for Studying Health System Change, I realized there was an information gap between the world of policy makers inside the Beltway and the world of equity and bond analysts on Wall Street. The Wall Street Comes to Washington Conference was created to help bridge that gap.

I'm delighted that the Jayne Koskinas Ted Giovanis Foundation for Health and Policy recognized the value of this conference by sponsoring it for the second 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. As I've already said the purpose is to give the Washington health policy community insights into market developments that are relevant to policy through a different source of information, specifically the equity and bond analysts. Equity analysts advise investors about which publicly traded companies will do well, which ones will not. Bond analysts advise about the likelihood of debt repayments. And along with a thorough understanding of healthcare markets and the companies they follow, good analysts closely follow public policy which often has important implications for these companies. So this is an opportunity for the equity and bond analysts to take a break from assessing the outlook for profitability or

solvency of companies and bring their understanding of market forces to bear on key health policy questions.

And our format this morning as it's always been will be a roundtable discussion based on a series of questions that have been shared with the panelists in advance. And we'll have two opportunities for audience questions. The first before we take a break at 10:30 and the second before we adjourn at noon. And there are blue question cards in your pocket and please fill them out and give them to a conference staff member. Of if you want to make sure your question is answered or asked properly you can use a microphone to ask the question. Note that the analysts are not permitted by their employers to answer questions about the outlook for specific companies. And again I want to thank the Jayne Koskinas Ted Giovanis Foundation for Health and Policy for sponsoring the conference. A transcript and webcast of this conference will be posted on the Foundation website next week. And before you leave today we'd appreciate it if you would take a moment to fill out the evaluation; it's on the yellow paper inside your packet, and leave it on the table outside the meeting room.

We have a terrific panel this morning. Some are veterans of previous Wall Street Comes to Washington Conferences, that's Carl McDonald of Citi Investment Research, and Jim LeBuhn of Fitch Ratings. Unfortunately Sheryl Skolnick was unable to attend at the last minute because of an emergency situation and she graciously recommended her former colleague Nick Leventis to step in. Nick started covering healthcare services in 2008 when he first went to work on Wall Street for CRT Capital Group LLC, which is the firm Sheryl was with, and he has worked on both the sales side and the buy side. He is currently working as a private investor managing his own capital. And we're delighted to welcome another new panelist, Ralph Giacobbe of Credit Suisse.

So let's get right into the discussion. Let me give you just a brief context. A year ago the context was uncertainty about the functioning of federal and state exchanges, especially in light of cancellation of individual insurance policies that did not meet ACA standards, political reactions to the sticker shock from community rating approaches, and higher standards for health insurance plans, and the degree of adverse selection by individuals opting into the exchanges. I wrote a whole thing about the context this year and I decided you don't want to hear anymore from me, you want to hear from these people. So let me jump right in and I will be rotating the questions between insurance market questions and provider market questions. And I'm going to start by asking analysts what's your outlook on enrollment through the ACA exchanges in 2015 and 2016. Carl, you want to start?

Carl McDonald: Sure. Great. So on the exchange enrollment outlook we actually just did a survey of our institutional clients back in October. So it was roughly 100 investors and the conclusion from that was an increase of between of 4 million -4.2 million people in 2015. So that would bring the overall enrollment, at least based on those historical HHS enrollment numbers, to something over 11 million. Of that 4-4.2 the expectation was roughly 2.5 million of those would be previously uninsured.

Relative to the HHS projection of 9-9.2 million, I'm more optimistic than that. I think there are a couple of things that they may not be factoring in. So one is that I think we have seen small group dumping in 2014 into exchanges. I think that will increase in 2015.

There's certain one-off situations; so as an example there's something like 300,000 lives in Massachusetts that will be -- I think they're technically qualified as Medicaid today that will be moved into exchanges next year.

And then the last point would be either certain states or certain health plans are no longer going to allow people in noncompliant plans to stay that way in 2015. So similar to last year you will have some plan cancellations and people that will have to move from those noncompliant plans and some portion of those will end up in an exchange policy.

Ralph Giacobbe: And maybe just to add to that, so I would echo a lot of Carl's comments. We also expect to have a pretty sort of robust 2015 over '14. Again with the botched roll out early in the year I think a lot of companies pulled back a bit in terms of even outreach efforts to individuals, and we're certainly hearing it across the publicly traded space. A lot more sort of aggressive tactics if you will or outreach efforts, just trying to get more people enrolled which we would think would certainly help. We haven't had any glitches to this point within the healthcare.gov site obviously, or certainly more minimal than what we had last year. So, I think those factors certainly play into why there could be -- and then to Carl's point as well, there's sort of the two elements of this which is the previously uninsured piece and sort of the dumping piece or the change of previously insured moving on to the exchanges. So I think from most estimates we all look at the headline number. On the provider side, the important question is more of what was previously uninsured gaining coverage. So, to the extent that we get more clarity on that I think that's going to be an important topic for all of use that we're looking out for going into 2015.

Paul Ginsburg: And any sense about the demographic mix of people who are enrolling and the effect the individual mandate has been having?

Ralph Giacobbe: So I would say the individual mandate probably hasn't had much of an effect. I think there's a learning curve here when you start thinking about individuals and understanding what the ramifications are of not having, you know. So year one was that \$95 penalty and/or the greater of \$95 or one percent of income above a tax threshold limit. So no one has really had to face that. And when you go do your taxes this year, there are some that are going to be hit with some sort of incremental dollar penalty. The question is once they learn that, this year does it really help this open enrollment season or are we really going to start facing it for 2016? The penalties do increase as some of you probably know from that \$95 up to \$325 in year two and/or two percent of income again above a tax threshold. So do I think it's really had a meaningful impact in year one? No. Do I think it will have a more meaningful impact in years two and three? Yes, which is another reason why we should get more people coming on to the exchanges.

In terms of the demographic mix, I think it's more logical than anything else that year one probably had an older, sicker population joining. It remains to be seen in year two exactly who comes on, but I think just almost by definition you'd have to expect that it would be some level of younger, healthier, certainly relative to year one.

Carl McDonald: And I would just say from a demographic perspective, so the analysis that I had done is that at the end of open enrollment, the average age of the exchange population was about 41. Compare that to the average age of the uninsured

population which is closer to 30 or 31. So they're 10 years older on the exchange. Most of the insurers had assumed that it would be an older mix, but the vast majority of them did not assume it was going to be 10 years older, which is why so many of them have ended up losing money this year. I think relative to that average age and a caveat here is average age does not necessarily equal health status, but sort of the best measure that we have. Since the end of open enrollment it's likely that that health status has deteriorated. So if you think about the HHS enrollment at one point was 8 million, it's now down to 6.7. Those people that are falling off the rolls are presumably not sick people that are in the hospital every day. That's people that either didn't find value or didn't think they were going to use the services. As a more recent data point, WellPoint's individual enrollment in the third quarter was down about five percent to give you a sense of what the attrition rate looks like past open enrollment. In terms of next year I don't have a lot of data points, but one is Health Net out in California, their assumption is that the people coming on in 2015 are going to be about 15 percent better from a health status, so morbidity 15 percent better next year. It's been interesting the reaction from the health insurers to that HHS enrollment number. The HHS enrollment number obviously substantially lower than CBO. Some of the insurers basically said we don't care, we priced based on our book of business this year; we weren't assuming an improvement in the market next year where some of the insurers were much more concerned about their pricing next year if they'd factored in a big improvement in the pool. So if the overall enrollment doesn't grow as much as the CBO expected that potentially will put some pressure on the earnings.

Paul Ginsburg: A good point. Let me skip down to if Republicans are able to cut off funding for the risk corridors, how large an impact would this have on exchange products?

Carl McDonald: I think it would be a significant impact overall. So I did an analysis as of mid-year, June 30th, to try to project what the risk corridor amount was. My assumption was across the industry plans were assuming receivables that they're going to get \$1 billion give or take in risk corridor payments this year. The problem is that across at least the plans that I looked at there was one single one that was assuming that they were going to pay into the risk corridor program. So if you have one going in that thinks they're going to pay a couple of million and all the rest thinking the money is coming out and it's going to be a billion dollars, the only way that is going to happen is either if HHS can come up with the funding in their budget, or they get an appropriation from Congress. Given the makeup of Congress right now the chances of an appropriation are zero. So, unless HHS can come up with it in the budget, it's going to have to be rolled over to the following year. So to put that in context the individual business this year is probably -- it's certainly north of \$50 billion in revenue so, a billion dollars is a significant chunk and would have a material impact on pricing if the plans didn't know that it wasn't going to come.

Ralph Giacobbe: The only thing I guess I'd add to that is a lot of this comes down to timing on when it would be cut off to the extent that it's cut off sooner obviously. It's more of an issue to Carl's point to the extent that it doesn't and it's just sort of rhetoric if you will or headlines. The risk corridor program goes away in three years so we're already sort of down sort of one year. So obviously there's receivables built up. It sort of matters

whether or not that gets funded to this point and then sort of going forward it gets cut off. So this is a little bit of a timing element to this as well just as it relates to whether or not it's going to be defunded because ultimately this program goes away in three years anyway.

Paul Ginsburg: Yes. I think a big issue for a policy maker would be what happens for 2016 rates. In a sense does this really affect how the insurers price for 2016?

Ralph Giacobbe: Yes, absolutely. So to the extent that it goes away it's going to be a big issue for managed care because clearly that was one level of assumption in year two that it's hard to price without having made some assumption around, any of the three Rs essentially in year two. Maybe not as aggressive as you were in year one because ultimately again aside from the risk adjuster payment, the other two are going away. So you would seemingly believe that as you move through each year, the pricing is going to better reflect a more sort of normalized rate on a going forward basis without the reliance of two of the three Rs.

Carl McDonald: And just from a pricing perspective, so if you think about a billion dollars -- and I'm making this number up, but let's just say individual premiums are 50 billion that would give you a sense of what the rate increase would look like. I wouldn't expect to see that much of an increase in 2016, though, just because you are going to have some plans even today who would say look, we're not going to get a penny from the risk corridor program. So we're not putting it into our 2014 pricing, we're not putting it into our 2015 pricing. So some of that is already reflected in the rates that the plans have put out there.

Paul Ginsburg: Sure. Good. Do you see any impact of the Supreme Court's taking up the King vs. Burwell on insurance companies between now and June before the decision comes out, or are they just going to wait and see?

Nick Leventis: So in my conversations with providers and plans it seems like everybody is operating under the status quo that whatever happens is somewhat irrelevant. I think the media is making a big deal out of this, but CMS can easily give some type of waiver or agreement to the states that would allow them to essentially shift the state from being a federally run exchange to a state based exchange. So I don't think anybody is really concerned about that. I think the media is making it into a very large deal just because of the election and whatnot, but my talking to the providers and the payers, I don't see anybody acting irrationally or worried about it.

Carl McDonald: I'd add to that from the insurer perspective I think what they're focused on they are assuming that everything will stay the same, that there won't be any significant changes. But I think the things that they're thinking about, so one is around the timing. So let's just say Supreme Court rules that it's unconstitutional and subsidies end immediately. One thing the insurers want to do is make sure you hold consumers harmless. They didn't do anything wrong so make sure that when they file their tax return for the next year those premium credits that they got either for the first half or the full year, that they don't have to give those back. I think that's one thing they're doing. Second thing is around reinsurance and deductibles. So the reinsurance you only get the reinsurance benefit when claims this year exceed \$45,000. If you're only going to have the people for half the year, you're going to have far fewer people that are going to reach that \$45,000

threshold so that's a consideration. Third is just from a consumer perspective, deductibles. So you start in your exchange plan, you pay or \$5,000 or \$3,000, whatever the deductible is, and then let's say it gets cut off at mid-year, if you switch to a new plan at that point you start up with a new deductible. So is there a way to try to mitigate that. They are also sharing work around plans with the states.

So as Nick said it's very easy for a state to just sign a document saying we're outsourcing the running of our exchange to the federal government. It's now a state-based exchange, we're outsourcing it to the federal government. The problem that you have is that the governors and the legislature that you need to sign those documents -- it's highly unlikely in some states that they would be willing to do anything to help health reform. So in that scenario where it goes away entirely, the exchange markets, if there were no subsidies, it would just cease to function. Plans would pull out of the exchange because you would still have guaranteed issue, you'd still have to offer the product to everybody but you wouldn't have subsidies and, very few people would be buying except those that were sick. So it would essentially turn it into a high-risk pool that the insurers wouldn't have a lot of interest in serving.

Ralph Giacobbe: I was just going to say that would be the more interesting aspect of this is if it goes against the administration, whether you really do have sort of the Republican governors sort of not extending or not look for ways to extend insurance. It's sort of easy to say from a governor's perspective, in our opinion at least, we're not willing to expand Medicaid -- we never gave insurance to anybody to begin with -- so we're not pulling anything away per se. So no one has had the benefit. I think it's a whole other debate and argument when you've had people that are utilizing services that have subsidies and for a governor now to actually take that away. So I think that's going to be one of the more interesting situations. And I just think it's going to be -- again maybe I'm using too much logic here over politics, but I just think it's going to be very difficult for that to happen. So, we continue to believe that whether it's in favor of the administration or against the administration that things are going -- this is not going to derail the ACA in our opinion.

Carl McDonald: There's a lot of attention on Arkansas right now from some of those Republican governors. So Arkansas did a Medicaid expansion through the exchange and you've had a turnover in the leadership in the state. There's an ongoing debate right now about whether that's going to get extended or killed. So to the extent that program ends and you have a situation where you did give coverage to people and now you're taking it away, I think there's going to be a lot of interest in seeing what the political reaction to that is as an indicator for what could potentially happen in some of the other Republican states.

Paul Ginsburg: Good. That is a good transition to Medicaid. Because I've got a question if you look at the waivers granted to Arkansas, Michigan, Pennsylvania, some other states, what does it tell you as far as potential future changes in the direction of the Medicaid program? If we start talking about 2017 with new leadership, whether it's a Republican president or Democratic, having a different perspective on Medicaid from having gone through the process of negotiating these waivers. So any of you have a sense in your crystal ball about broad directions in Medicaid?

James LeBuhn: My sense is that you're going to see Medicaid expansion with the

waivers and with some of the changes in some of the state houses and some of the legislatures. I think you're going to see an expansion as long as it can be done on Republican terms. I think CMS is understanding, the administration is understanding the change in Washington, I think that they've shown a willingness to look at some different plans in granting those waivers. And I think given the political reality in Washington or within the country I think that they are going to be more willing to look at different alternatives to expand Medicaid coverage. But I think going forward there's a lot of political pressure within those states to provide that coverage. So I think you will see an expansion but it will be done under an increase in the waiver programs that are granted.

Nick Leventis: I'd also piggy back on that comment and just say that having watched the Arkansas model as it was coming about seems from my perspective that HHS is willing to bend over backwards and let the states -- if they can pass any kind of Medicaid expansion they will take it in whatever form or fashion they can get. I don't see that changing anytime soon. And I think especially the states that are kind of on the fence, like Tennessee, which is also funny because it's one of the largest states for healthcare of all the providers being located there except for one on the publicly traded side. I think for the rest of the states who have not expanded it's definitely going to be through a waiver program where they get some kind of concession from the feds.

Ralph Giacobbe: And then let me just -- I guess I should add, we did a report early in the year and we sort of laid out the arguments of why we think every state will ultimately expand Medicaid, and it goes beyond just the 100 percent funding by the federal government. As more examples come up, again I talked about learning curves, I think as there's more understanding of exactly what's happening here because you're leaving sort of a piece of population bare. So we did an analysis for example in an area in Florida, somebody that's making \$21,000 a year has access to a zero premium plan. Somebody that makes \$10,000 a year, so half that, has to pay \$177 per member per month, right. So that's their monthly premium. So just to give you a sense of kind of the discrepancy there just based on how the math works about subsidies being available down to 100 percent of FPL. Let's not also forget that states are essentially paying for Medicaid expansion so to the extent that you haven't expanded Medicaid you're essentially paying for other states. It's not like you're off the hook on that.

So the reason I bring it up is I think as you move forward I think more of these points are going to be brought to light and yes, I think from a Republican standpoint it's more palatable to come up with some alternative to expanding Medicaid. I think the problem and the challenge with that is exactly what we're seeing -- and Carl brought it up -- in Arkansas, which is essentially when you start shifting to a private option I would agree with some of the headlines out there almost by definition has to be more expensive than the Medicaid option. And so that's the debate. And to the extent that CMS is willing to do that ultimately at some point that needs to be funded and that becomes another sort of pressure point going forward.

Nick Leventis: I would just add to that I think everything you just said is correct, but I think from the fed's perspective is get these people into some type of program now because once they have the entitlement no matter what happens in the political landscape

it's very hard to pull those entitlements back. So it's great political theater, but I think that's why the government is so willing to give these governors a victory if you will in terms of coming up with their own type of privatized plan.

Ralph Giacobbe: And that's essentially better for both the payers and providers ultimately, right? The more open market we can have the more opportunity there is for both the hospital side as well as the insurance side.

James LeBuhn: And I was going to say I think you're seeing the benefit on the provider side in those states that have expanded Medicaid. They're really beginning to see that benefit and I think it's going to be more and more difficult in those states that choose not to expand. The providers in those states are really going to struggle relative to the rest of the industry and I think that's an additional pressure that's going to be put upon governors and legislatures by the provider community in those states that choose not to expand.

Paul Ginsburg: Let's move forward to 2017 and let's say we've had an additional five, eight Medicaid waivers and we have either a Republican or Democratic president, what happens to the overall Medicaid program at that point. In a sense what I'm really getting at is has the experience of granting the waivers and seeing what happens with the waivers, is that going to change Medicaid? Or if you had a Democratic president will Medicaid just remain as it is with various concessions to pull states in? Or would a Democratic president change it or would a Republican president change it?

Carl McDonald: Well, I think there's a rewrite of the Medicaid regulations that's happening right now and I think is going to be out in the next couple of months. So I think as you look at some of the recent waivers it gives you some indications of some of the things that will be in there that will potentially change the Medicaid program. So for example, much more focus on quality than I've seen previously. So as an example as opposed to just allocating members you have three plans, each one of them gets a third of market giving more members to the plans that show higher quality ratings. So, as an example by 2017, will there be a STAR program for Medicaid? It may not be the STAR program, but something sort of moving in that direction I think is likely. One thing I think you're going to see that's going to change in Medicaid is you will have a national minimum medical loss ratio for Medicaid the same way that you do in the commercial and the Medicare business. It won't be that impactful in Medicaid because most of them are well above that threshold, but for those markets that have been extraordinarily profitable for health plans, think of places now like Kentucky, Tennessee, it will be more difficult for the plans to generate that.

And then I think one other difference is there's going to be I think much more national view on provider availability. So what does the definition have to be of an available provider across -- to give some standardization to what is today significant variance across the states.

Paul Ginsburg: Good. Let me move on to spending trends. And since our conference last year the low spending trends have continued and have received quite a bit of attention in the research community. Much of the debate is focused on the relative importance of the recession and the timing of its impact versus other factors that might prove

more long standing. From your perspective what have been the key factors behind the last few years of relatively low spending trends and what about your outlook for the next five years?

Nick Leventis: I'll kick this one off.

Paul Ginsburg: Sure.

Nick Leventis: So I think you have to look at it from the payer perspective and the provider perspective, but first if you just tackle it from the provider perspective, I mean you had obviously a recession ... elective procedures generally went away. That was to be expected. It happened. Another reason I think spending was less is you had a big push from the RACs in terms of going after site of service.

Paul Ginsburg: RACs, you mean the recovery --

Nick Leventis: Audit contractors. Yeah. So going after short stays versus whether or not they should be in outpatient observation and whatnot. So the reimbursement levels between those two are quite significant. So as the RACs were in there giving the hospitals a hard time on the claim side, you saw a dramatic shift in terms of the way in which providers were categorizing patients, whether they were inpatient or they were outpatient. That happened at the exact same time as the recession. So I think that also -- like when you just look at the numbers made it look smaller.

The other thing I think you saw was the high deductible plans have grown exponentially year over year and the level of the deductible is also growing exponentially. So, people are thinking twice before they go to the doctor. And when you look at some of these plans, I mean take for instance a bronze plan with a family and you've got a deductible north of \$8,000. Average household income is in the \$50,000 range. You're talking almost 10 percent, 20 percent of people's income after tax to go to healthcare. People are really thinking twice before they go to the doctor. And now you're seeing in the hospitals the people who are there are there because they have to be there, your very sick, very old patients that are really driving the occupancy levels in the hospital. So I'd say when you kind of combine all those and the impact, medication therapy management programs that all the payers have been pushing, there's more reason to keep people out of the hospital. And that I think is why you've seen the spending trends decline.

James LeBuhn: Yeah, I'd agree with that. I think from the provider side, which is where I spend most time on the hospital side, I think as you said if you look on the government side with Medicare, I mean there's just been cuts in terms of reimbursement. And the two-midnight rule, it's essentially a reimbursement cut. And I think that that's had a profound impact and I think also some of the quality efforts in terms of reducing readmission rates has had an impact in terms of the growth and spending.

And then on the commercial side, the high deductible plans have had a dramatic impact. We saw that in 2013 when we saw inpatient volumes really materially change. What it means going forward is we sort of hit that equilibrium point where maybe we're at stasis and we're going to begin to see growth going forward. I guess that's the \$64,000 question, but I think to this point we have seen that spending trend being bent my Medicare and then also plan redesigns. And the creation of high deductible plans has really impacted volume.

Ralph Giacobbe: I guess I would just add that while there are cyclical elements we are firmly in the camp that believes it's been more structural than it's been cyclical in terms of lower spending. You look back over the last four or five years, I think national health expenditure growth has been in that sort of four percent range down from "high-single digits." So, essentially cut in half if you will in terms of growth rate. And I think some of it is clearly some level of economics. So could you get a little bounce off that bottom? Sure, but I think when you look at the projections from HHS on a long-term basis I think the estimation sort of outside of this year with that sort of pop related to reform over the next couple of years the steady state growth rate seems to be in the six percent-ish range. And I guess from our perspective we think that . . . From a utilization perspective I think generally speaking once we normalize for the new populations coming in inpatient utilization has been running in the negative territory. Adjusted admission including -- adjusting for the outpatient side has probably been zero to one percent type growth. And then on the pricing side, I mean pricing is likely to go only in one direction and so you're going to get further pressure on the pricing side. When you add those two elements together you're probably looking, our guess would probably be somewhere in the four to five percent range as opposed to sort of a jump to six or seven percent.

Carl McDonald: Yes, I was just going to say the problem I have with the structural arguments-- sort of a couple of things. So number one is high-deductible plans have grown, but they are still depending on what source you want use under 20 percent of the population. So, is that big enough to drive what we've seen nationally? Cost sharing has increased but deductibles and cost sharing generally have been rising forever, so what is it about the last couple of years that -- did we just hit a tipping point where people just suddenly stopped spending? When you put it in the context of the economy being down, then those higher cost sharing could make more sense.

I guess the other argument I would make is all of these things that have been mentioned have continued the last couple of years, in many cases have increased the last couple of years, and yet as you look at overall cost trends which decelerated for about a decade, stabilized in 2013, I would argue have started to pick up in 2014. So if all of these other structural changes are having the impact that they've had, why have costs trends not continued to decelerate? And, thinking here specifically about the commercial business in '13 and '14, and as I said in some cases in '14 have actually started to pick up again.

Nick Leventis: And I would just add to that if you talk to the publicly traded hospitals, the majority of them are citing cost growth is driving their performance recently. It's not from -- they're trying to downplay the new populations, whether it be through Medicaid or whether through the exchanges. So I think you're right; I think we are starting to see a turn. I think we've hit the trough level. The real question is how steep is that curve off the bottom. And that's what's going to be debated going forward because like Carl said, the trend is definitely changing. There's no doubt about that, but the question is is it going to reaccelerate and get a level where it was pre the great recession? I would say it probably looks a little bit different just because in 2007 or so the health insurance marketplace just -- the products that are offered out there today look a whole lot different than they did a few years ago.

Ralph Giacobbe: So the only other thing I was going to say is that I'd agree on the debate of sort of the bounce of the bottom. So certainly costs have come up. The question of whether sort of cost versus performance is a more difficult one to answer. So whereas the providers have sort of the argument of seeing cost growth managed care continues to suggest that their underlying costs remains sort of flat or even negative. And, from their perspective I think the argument is that they're looking at the same 100 people that had insurance last year to the same 100 people that have insurance this year and sort of comparing those trends and making the argument that what they're seeing at least to this point is flat to down. We can certainly debate whether that's true or not. From a provider's I think there certainly seems some level, but it's harder for them to measure because you don't necessarily have the same patients coming in on a year to year basis. So I think there are some considerations there.

I think the other element to this, and again it goes back to sort of the -- I keep coming back to this learning curve. So, yes, it's not a new phenomenon in terms of having higher deductibles coming into play. Those higher deductibles though, you have to utilize healthcare in order to sort of get hit with those higher deductibles. So to the extent that, you start to actually utilize the system above and beyond going to your doctor and having other complications which may take a year, two years, three years to actually come up, the learning curve then is understanding what the actual cost is. And then the argument to the other side is whether or not you have sort of the transparency element of individuals actually looking for lower cost sources of care, right, trying to avoid the ER and utilizing urgent care. There's obviously a robust growth in urgent care and freestanding EDs as sort of cheaper alternatives. So I just think that's the other angle to this, is that yes, this is not necessarily a new phenomenon, but I would just wonder whether or not individuals are starting to understand that and starting to be more conscious of it and looking for alternatives to try and lower costs given that it's pretty significant obviously and just rising.

Paul Ginsburg: Okay. Let me move on to one aspect of cost trends is specialty pharmacy. That's growing robustly. I understand that Sovaldi treatment for Hepatitis C is having a large enough effect on spending that you can notice it in the overall trends. And are there other blockbuster specialty drugs approaching introduction that are going to just compound this phenomenon?

Nick Leventis: Well, I would just say first of all Sovaldi -- the reason why Sovaldi is as powerful as it is is that it's a cure. So you're not just talking a specialty pharma drug that treats X, Y, Z symptoms, you're talking about something that cures something. So it's very hard for a payer to say no, I'm not going to cure you. That doesn't really sit well with people. What you have seen though in terms of trying to slow down the trend because it's come out of nowhere, they're requiring more biopsies, they're requiring much more documentation, specialists, ahead of time before they actually prescribe that therapy.

In terms of specialty pharma going forward, I think it's north of 50 percent of the pipeline right now at FDA is full of specialty pharma drugs, whether it biologics, class similar. So that trend is here to stay I believe. I just think the managed care companies are going to be much more aggressive in terms of getting prior authorizations and trying to manage how those therapies are utilized.

Carl McDonald: I would just say what struck me earlier in there is so WellPoint is the company in the publicly traded universe most exposed to reform. And their CEO was on a panel earlier in the year and he got that ubiquitous question of what is it that keeps you up at night. And so you expect he's going to say it's reform and all the uncertainty. And his response, specialty pharma. That's the thing that I worry about the most over the next few years. So I thought that was kind of striking. I think one of the challenges that the insurance companies have is that specialty pharma is extremely difficult for them to manage. Part of it is because it's delivered in many cases through the medical benefit as opposed to pharma benefit, but even more fundamentally all of the normal cost sharing mechanisms that the plans use they don't really use for specialty pharma. So for example you think about -- we've talked about deductible, cost sharing generally. With specialty pharma you get one dose and you've hit your out-of-pocket max. So that doesn't work anymore. So trying to find different ways to manage, whether it is prior authorization, step therapy, all of the things that the plans have done historically, there aren't, at least from what I've seen -- a lot of new and interesting things that have been really effective to this point.

Ralph Giacobbe: And the only thing I'd add, so HealthNet's CEO said the same thing when we had them out on the road in terms of what keeps him up at night, the same things, specialty pharma. So obviously there's a trend here and something to keep an eye on. Just to think about the numbers, there's estimates out there that total spending on specialty pharma I think is in the \$130 billion range going to \$250 billion by I think 2018. So that's something like 15-20 percent per year, on a very big number. So this is an issue and again how to tackle it. It gets more difficult certainly from the payer side of things. And so that's certainly going to influence, premiums as you think about some of the trends going forward, that plans are going to have to price it.

Paul Ginsburg: And, outside of specialty drugs are there any new technologies coming down the pike that have gotten your attention as far as something which could have a big increase, positive or negative, on the spending trends?

James LeBuhn: Well, I was going to say I think there's a lot going on in terms of price transparency and consumerism. I think that's from a provider standpoint as you look out over the next four to five years is the whole idea of your cell phones and providing transparency data to allow people to get that information to make those decisions. If you believe on the commercial side that we're going to continue to see an increase in high-deductible plans I think the consumerism and the ability to shop for pricing for various procedures I think is something that keeps a lot of providers up at night in terms of how they're going to tackle that. And from a pricing standpoint how they're going to move from the wholesale side of the business into the retail side of the business.

Paul Ginsburg: Let's get back to that a little bit later. I'm not surprised that people didn't come up because I've never known anyone who could identify the next major technology before it actually hits. (Laughter)

Carl McDonald: Yeah. I mean not a new technology, but I'd say one thing that I've seen more from the plans in terms of management focus is pain management. So, yeah, sort of started with imaging and radiology a couple of years ago and now it seems like focus is shifting to predominantly back pain. But in terms of resources where they're reporting their

resources make a number up. It seems like 90 or 95 percent of the focus is specialty pharma and the rest is elsewhere.

Paul Ginsburg: Does anyone see much potential for increasing emphasis on wellness to actually make a dent in the spending trends?

Carl McDonald: I mean I'm not a believer. (Laughter) It's interesting if you survey benefit managers, one of the things that will come up most frequently is interest in wellness programs. It seems very reminiscent of a decade ago give or take when you did the same thing and everybody was focused on disease management. It seems like sort of the thing that they want to focus on, but when you get to the next question of well, how much money does it save you, I don't know. Do you have any way to measure it? Not really. So, you know, it just feels like one of those things that interesting to have, but wellness by itself doesn't get you anywhere in a sense. Like people that smoke know they should stop smoking. Or if you're overweight, you know you should exercise and take better care of yourself. And the wellness program will help educate you that you should do that, but what is it that actually makes you start doing those things? And, I don't think there has been a lot out there that's shown the ability to actually make that happen. I think one of the frustrations that our benefit manager has every single year is we'll do health risk assessments and various things like that, and the frustrating piece is that it's the marathon runners and all the people that are in really good shape that are willing to fill out the health risk assessment. (Laughter) And, all those that are not, it's much harder to get that compliance. So, as I said I'm not a huge believer in that being a real cost trend driver.

Ralph Giacobbe: I think the issue for that is just, again to Carl's point, is how do you measure return for making an investment in that? I think it's difficult because you could certainly have a population base and you could potentially see your trend down, but to directly associate it with wellness I think is what most firms including our own -- we've talked to our benefit managers as well and there's a line you want to draw of sort of the carrot and the stick type argument. How far do you want to go where you start to actually punish employees for not complying. And I think for the most part corporations have been unwilling to go there or if they went there very slowly making that transition. And I don't know that that's really going to take hold much.

Paul Ginsburg: Yes. I guess another factor which I'm sure you also have in mind is the turnover issues. The fact that wellness is an investment based on your employer plan and your subscribers or your employees are going to turn over it. So you're not going to realize all the fruits of any investment.

Next section is on innovating contracting between Medicare, private health plans, and providers. I want to begin by asking you about what are the provider perspectives on ACOs, accountable care organizations? How do they perceive the opportunity of this type of contracting?

James LeBuhn: Well, I would say at least on the not-for-profit side, the pioneer ACO product has been something that clearly -- I think there were 32 original pioneer programs -- there might have been more but they've since you know you've seen a lot of organizations pull back on that. I think the structure of the plan and the fact that there's no attribution within the pioneer ACO makes it very difficult for organizations to stay in that

program. I think the Medicare shared savings program has been something that you're seeing a gravitation toward. And I think there has been a movement there and an acceptance and more to get the providers to build up that experience in regards to, working with populations, managing populations, and really putting into place -- it's more sort of testing different things in terms of delivery of care that has been beneficial for them. So I don't think it's so much the financial incentives, but it's really being able to test out some things and work as an organization toward more population health management approaches.

Nick Leventis: So I think the pioneer specifically -- so I think we just have to step back for a second. So when people mention ACOs there are several different forms and fashions. The one that we know the most about would be the pioneer ACO model. The managed care companies talk about ACOs all the time, but unfortunately we don't get to see the way those contracts are written and they like to boast about them, but we don't actually know if they work or they don't work because they don't like to talk about when things don't work. (Laughter) But we know that half of the pioneer -- call it half, have dropped out, which is highly significant when you think about it because the 32 that were originally there were your very large name brand delivery systems, and if they can't do it then how can you expect a hospital out in rural America to be able to do it as well? That would be point number one.

Point number two, the ACOs are a great concept. I think only good can come from them, but from a financial perspective for the hospitals, it doesn't really make much sense because what you're essentially doing is -- look at the pioneers for example, there's no managed care company that's driving it. The hospital is not very good at taking risk. We've seen that before; they fail. There's no reimbursement that I know of inside the pioneer model that compensates them for the back office. So all of the infrastructure that's needed to manage this population, that's all under the umbrella of the health plan and they're not getting reimbursed for that. And what's happening is as they're taking money out of the system, that's great, you've helped people and you went from \$100 to \$90, I get \$5, you get \$5, that's great. But then the benchmark starts to fall and then what happens is the hospital is essentially losing margin on the next customer that comes in the door. So the only way in which it makes financial sense for a hospital is you need more market share. So you're either going to buy the next hospital, you're going to buy the next doctor group, and you have to keep feeding that system in order to make it financially viable for them. And, we're talking in times where we've talked about health trends and spending trends here coming down with everything we've talked about before, inpatient, outpatient, RACs, and, other aggressive treatments from the managed care companies, and I think that if the ACOs were working you wouldn't have had half the pioneers drop out. So there's an inherent flaw in the model.

Paul Ginsburg: Yeah. See actually that's what I wanted to probe is to how much of it is inherent in the model and how much of it is the specifics of the model at this point? For example, we're expecting today or next week, new regulations for at least Medicare shared savings programs and it's in a sense to agree to fix some of the issues like attribution. But I think what you're saying is that it probably goes beyond that to something more inherent?

Nick Leventis: Yeah. Well, I mean just take a pioneer for example. To my knowledge -- I don't know if this has been changed or if I think -- they tried to mitigate it but you're retroactively assigning populations to a health system that's not even good at taking risk in the first place. So how can you manage a population if you don't know who's in your population? It just -- it doesn't make sense.

Paul Ginsburg: I think that's one of the things that I think will be fixed.

Nick Leventis: But in order for it to work you have to keep them in that network, a very tight, restrictive HMO style network which does not sit well with people. So how do you strike that balance? We saw the HMOs, the real restrictive HMOs in the '90s all fail because people didn't like just having to stay with that one gatekeeper who tells them what they can and cannot do. So I think until people can accept that reality that model doesn't really work.

James LeBuhn: I was going to say I think the pioneer ACO model didn't work because the fragmentation of the provider -- I mean because you're not attributing those lives and the fragmentation in terms of the providers within the country it just doesn't work. I think what I hear a lot from the provider side is that the Medicare advantage plans, they like that because you are attributed lives and you can keep them -- you know who they are and you can identify them. With the pioneer ACO it's retroactive and people move in, move out, but there's no way you can keep them within your organization or within your network. And I think from a design standpoint it's flawed, unless you're in a market where you've got -- but even Banner was in the pioneer ACO and they've got a fairly large market share in the Phoenix market and still I think without having the ability to know who those lives are that you're taking care of, it just didn't work for them.

Ralph Giacobbe: The only thing I'd add I guess is that hospitals and most providers are very revenue protected. So again to Nick's point, if the argument is you have \$100 million of revenue and save \$10 million and you get \$5 million back, so great, now I have \$95 million versus \$100 million before, right. So it just -- that's the inherent flaw one for an industry that again is revenue protected. Now again the argument on the other side would be you have to become more efficient, you have to take more costs out because it's not a revenue gain, it's an even gain or an earnings gain. But I think to the point, with a high fixed cost infrastructure I think they're finding, and it's been more challenging to actually get the cost to net out sort of positive above and beyond where you were before. So then it brings up the other element which is market share gains and/or exclusion of somebody out of network, right. So to the extent you have five hospitals in an area, each one generating \$20 million of revenue, if you knock one out then there's four hospitals with \$25 million arguably of revenue. And so to the extent that there's savings even for a couple of few million dollars off of that number, the system essentially saves but there is one hospital essentially left out. So I think these are all things that are going to have to be sort of worked on or understood. I mean we do conferences every year and I think for the last three or four years we've had consultants come up and talk about ACOs and they leave and I'm more confused about an ACO than I was going in. (Laughter) So I think part of the issue is that there's no one definition or structure of it. Ultimately, again I think the end result has to be a provider system that's incentive is more on savings than it is on revenue generation.

Paul Ginsburg: Yeah. That's a good point. Actually with the model you're mentioning that's what I've seen in California as a typical way ACOs are employed. It's usually as part of a tiered-network approach, where there are actually incentives for the enrollees to use the ACO providers and they're already HMO patients, so they're already attributed. But it's a good point that perhaps this early stage of complete volunteerism, it's a very difficult stage to get through. And in commercial ACOs or similar things maybe they will be more effective with engaging consumers on a network basis. And then Medicare probably comes down to actually giving bonuses or penalties for whether a provider is an ACO or not, so that it's not completely voluntary. And you have this very challenging benchmark problem that Nick has mentioned.

Nick Leventis: Well, I think it just works a lot better if a managed care plan is in charge of managing a population. That's their business, they're good at it. To make a hospital responsible for that and then not even reimburse -- Ralph was talking about the cost side and I think your point was on in terms of how much they're spending in terms of caring for the patient, but the costs are also going up for them on the other side of all of these things that go into running one of these models. And where's the reimbursement for that? So, maybe they should just run their own health plans. I mean I don't know but I just -- the pioneer model as it exists today, I just don't see it working.

Paul Ginsburg: All right. Well, what about bundled payment? Is that pretty much the same as ACOs or do you think there is some distinction and whether they're attractive to providers?

Nick Leventis: There's a lot of debate about this. If you talk to a company like Kindred Healthcare, they think that the bundle is the way of the future and that everything is going to be paid through a bundle basis. There's just so many questions about bundles. We don't know who runs the bundle. Is it the hospital, is it a health insurance plan? Who gets what cut from the bundle? Does the ER get 20 percent, does the hospital get 50 percent? I mean there are just so many unknowns in terms of working those kinks out that I don't see the bundle really taking off. I think it comes maybe with -- they try it with certain DRGs and whatnot, but on a broad basis anytime soon I don't see it proliferating into the market.

Paul Ginsburg: Jim?

James LeBuhn: Well, I was going to say I think the -- again, we've seen it where some of the hospital providers that are more integrated that they've got a large employed physician base that are trying the bundles. I don't think that they're in -- to be quite honest with you, I don't think they're real excited about it. I think they think that this is the future, but again you've got a medical staff that's largely fee for service that you're trying to, trying these bundles and it gets really difficult in terms of how you're going to start to cut up the pie and how you incent physicians, to accept on these bundles and move forward with it. So, again, I think that they're trying it because they know that it's the way of the future; I'm not sure at this point that you're going to see a lot of growth without some sort of incentive or it being forced up on them.

Paul Ginsburg: Good. Do you see much activity for those that are doing bundles, particularly doing bundles in Medicare? Do you see much activity in the post-acute area?

That attempt to manage post-acute care to partner with post-acute providers and is there anyone good to partner with if they're doing that?

Ralph Giacobbe: I think -- I mean, yeah. I think on the post-acute side we're -- I think what we're seeing a lot of is joint venturing and part of that is -- I don't know if that's directly related to the bundle or not, but I think certainly from the hospital side, from the home health side, some of the outsourcing providers envision team health. There's more of a sort of a willingness to joint venture with providers, and in some of those scenarios I think the winning argument is ultimately that sort of you control the whole continuum there, but you're not solely responsible. So from a hospital side you're not really necessarily taking on the risk. You join in some level of earnings, but at the same time you don't necessarily even provide that service, it's sort of outsourced someplace else. So I think we're seeing more of that coming up as opposed to a real effort on the bundling side. Maybe aside from Kindred. I mean Kindred is sort of the most public in terms of bundling payments. I think part of the problem even with bundling is again given the fragmentation of healthcare. Sure there are areas where you have large integrated health systems, but by and large when you look across the country you don't necessarily have that. So I think there's going to be more partnerships going forward, maybe as opposed to thinking that, hospitals are going to try to sort of run it, run it all. Because I think in the past we've just come off of -- in the last decade we've come off hospitals sort of unraveling all these sort of post-acute services. I don't know that they're just going to run back in to sort of start acquiring them. So I think the route is more via joint venture which sort of limits some level of risk on the provider side.

Nick Leventis: Yeah. I think that's a really good point and I would just also point out hospitals I think are also really incentivized to want to joint venture or do something because they're ultimately responsible if there's an unnecessary readmission. They're getting penalized from the government from that. So on one hand the hospital doesn't own those services downstream, but they're also incentive to try to help that patient navigate so that if they do boomerang back they don't -- whether they try to prevent them from boomeranging back that way they don't get a penalty if they do come back.

Paul Ginsburg: Good. Have you seen much in the area of hospitals actually getting into the insurance business either on their own or as a joint venture with an insurance company?

James LeBuhn: I would say you're beginning to see that. I think some of the hospital systems that I talked to it wasn't too long ago that you were seeing them move out of the insurance business and sell that off. I think some of the hospitals -- and again it sort of depends on each market, it depends on your size and scale within a market. I think that there's also of interest among hospital providers in terms of developing that insurance capability, but a lot of it's going to depend on what sort of scale you have in a market. I think that there is some interest among providers assuming you've got that scale to entering into some direct contracting if you've got large employer groups where they can come in and on those self-insured employers where they can come in and look at the claims data and maybe enter into a contract. I think that it's a trend that's going to continue to move forward because I keep coming back to the hospitals. the whole idea of reducing

readmissions, improving clinical outcomes, managing chronic conditions, without controlling that premium dollar over the longer term I think you're going to see revenues coming down, you're going to see margins get compressed if you're sharing with that, sharing that savings. And then every year that sort of gets reset. So I think that there is interest among the providers to develop the insurance capability. Whether or not they need to do that all on their own or whether they can partner with some of the large insurance plans; I think every market is a little different. I think the insurers are seeing that as well. I think in certain markets you're seeing them come together with large providers to maybe develop a joint insurance plan where they can share that.

Carl McDonald: Yeah, I mean you've seen some hospitals form insurers. So Long Island Jewish is one in New York that has started up. But for the most part not really. It's more one of those things that sounds interesting in theory and then when you actually start putting it into practice beyond the capital that's required to run an insurance operation, you need experts in product design, distribution, all the regulatory compliance. Particularly, in most cases the hospitals would be interested in getting into the Medicare business. So I think the challenge for a lot of hospital executives is you get to the point where you say okay, basically every core competency we're going to outsource to some vendor except for the network contracting piece. So, we're getting into this business we don't understand, we're outsourcing pretty much everything, is this really the direction we want to go. I think a slightly different angle, to that question is, if you look at some of the acquisitions that managed care companies have done, I think if it hasn't I think it should make, hospitals pause as they think about getting into the insurance business. So think about Cigna buys HealthSpring which is a Medicare company, really innovative, risk sharing relationships with providers. The idea is to take that HealthSpring model, roll it out all across Cigna's geographies. That deal was done years ago, there's been very minimal expansion. And DaVita buys Healthcare Partners, one of the best risk takers out in California. The idea is you're going to roll that out into a lot of new markets. DaVita has tried to do that and that's one of the reasons why they have ended up losing so much money on that deal.

The point that I make is that you have health plans buying companies that are really, really good at what they do from a risk taking perspective, and when they try to roll it out in new geographies it either takes a very long time or it just doesn't work. So if you're taking companies that are really good at what they're doing and they have trouble rolling out in new geographies, if you're a hospital or a provider group generally and you're starting from zero, why do you expect that you're going to be successful? There has to be a very specific reason or competitive advantage that the hospital thinks they bring to the table to really make that work.

Ralph Giacobbe: And I guess just to add to that, vertical integration certainly is interesting. I mean, to Carl's point, I think part of the issue is fragmentation within just healthcare again and the ability to actually sort of roll this out broader, clearly is a challenge. That said, from the public hospital perspective we did have one Universal Services, UHS, recently bought a small plan out in Nevada and in talking to the management team it's clear they're just sort of putting their toe in the water, just seeing if

they can kind of operate it. So I think, yes, generally speaking most hospitals are saying they're not interested or that's not their core competency or business, and the other side of it is you are starting to see some signals out there of some just taking that little step and maybe seeing if they can make it work. Again all the dynamics that we talked about earlier, all the pressures that we talked about earlier, I think hospitals are aware and understand that their business models needs to change. And they're maybe not exactly sure how it's going to change, but they want to be and play in a part of that to see if this can work and translate to something more successful.

Paul Ginsburg: Let me move on. Carl, you had mentioned before that your skepticism of what plans were telling you about their experience with payment reform. What's your sense about how interested are they in pursuing these initiatives and to what extent is self-insurance getting in the way as far as their ability to contract with providers on ACO like or bundle payment bases?

Carl McDonald: Sure. Yes, I think the health insurers in general are extremely interested in ACOs, risk sharing in any kind of payment reform. So a couple of points to think about. So one is if cost trends are at cyclical lows why wouldn't you want to outsource, put all the risk on somebody else. That way if cost trends rebound you're not going to foot the full bill. So, I think that's one angle. Second, is that health insurance is a spread business, right. You're trying to price more than what your costs are going to be. The more costs that you know on January 1 of every year, the easier it is to price your business. And if you think about that from sort of the way that we would look at it, the less risk that a managed care company has, the higher valuation multiple that they're going to get. So if you can generate a similar amount of earnings, but you're taking on less risk to do it, that's going to translate into a higher valuation for the industry. So, I think there's a lot of interest. I think there's also proven success if you do this right. So if you look at most utilization metrics in California where there is a high level of risk sharing with providers, pretty much every utilization metric is 20-40 percent lower in California than it is the rest of the country. The one where it's not is pharmacy, but that makes sense that pharmacy should be higher. So, I think plans would look at that and say, if we're looking at a steady drop in medical cost trends over the next couple of years because we're outsourcing, the cost trend is going down, that's good thing for managed care earnings. So I think there's a ton of interest. The hold-up is, we've touched on here, is that my argument at least would be very few providers in the country have the capability to take on risk and do it effectively. You can't just assume risk, you have to completely change your practice patterns. So you need step one, an electronic medical record. But on top of that you've got to have some analytical capability that tells the doctor what they should do. So there's an analytics company -- I'm going to make these numbers up a little bit, but what they said is that if you just leave a doctor on their own and there's something that they should recommend a patient do, something like -- I don't remember the numbers, three percent or eight percent of the time the doctor will tell the patient they should do that. If you actually have an analytic system that flags it, 70-80 percent of the time the doctor will do what's best for the patient. It's not because doctors are bad at their jobs, it's just they're seeing 30 or 40 patients a day, and that 3 minutes that they spend in the office, it's just tough to have a lot of effect

there. So, I think you do need a fundamental reworking of the practice patterns and, something that Nick mentioned, there's a lot of back office administrative costs that goes into that that the providers would have to foot the bill for.

Paul Ginsburg: Good. Let me move on to narrow-network plans. And I want to just pose a big question first. What kind of influence is the growth of these products been having on the marketplace?

Carl McDonald: I mean I think the -- I mean it's been a very significant impact. I think, particularly in some of the more retail offerings like the exchange products. A couple of things I would think about for narrow networks to grow in importance. So one of those things, there's absolutely nothing wrong with a narrow network. The problem that you ran into in 2014 is that many times consumers didn't know they were buying a narrow network and had no ability to find out. Now I remember going on either some of the state or healthcare.gov and trying to find a provider directory. It was a near impossibility. And then if you did find a provider directory it was one of fifty and it was very difficult to tell who was actually in one network. So I think the plans need to do a much better job of being transparent with consumers and for them to understand who is actually in that narrow network.

I think the other issue that you often run into and this is more on the group side of the business is that narrow networks can't take off until you get more savings for cutting out the network. And again I'm going to make these numbers up a little bit but if you moved to a narrow network that has 80 percent of the physicians in it you can save maybe 5-15 percent. If you want to save 15-20-25 percent, you'd have to cut out something like 60-80 percent of the provider network. So you've got to get a point from the insurer perspective where the reduction in the provider network don't have to be that significant to generate real savings for it to work in a group setting.

Paul Ginsburg: To what extent are these networks being built on strictly low unit prices versus a more sophisticated assessment system to how expensive different providers are?

Carl McDonald: I would say at this point initially I think it is very much driven by unit price as opposed to quality metrics. I mean I think the hope is that ultimately you can get to a point where there is a mix of the two, but at this point I think it's very much unit price drive.

Ralph Giacobbe: But, I think managed care plans are actually onto that point or suggest they're onto that point. United certainly talked about it where you're just not looking for cheap, you want quality ahead, right. Because to the extent that somebody is treating an illness via of one admission versus somebody else treating him via three admissions for that same procedure obviously, you'd want the one with the higher quality. So to Carl's point I would absolutely agree. I think right now it's largely all price driven. But I think there are analytical tools and I think managed care is trying to put those in place where you maybe want the larger more sophisticated system over sort of the smaller potentially not for profit to the extent that that larger system has better quality data. Again, whether or not that's true in every market is going to vary, but I do think that something that's going to evolve and going to become incrementally more important. And I think

that's why on the provider side there's more of an effort to sort of enhance those quality metrics to make sure there is some level of differentiation so that they can sort of make that case when you go to managed care as yeah, maybe I'm priced a little bit more but look at these quality indicators, look at my readmissions, sort of make that sales point that you want me in the network as opposed to an inefficient provider. I just still think it's early for that.

Carl McDonald: Okay. One of the inherent challenges to that though is that just because a hospital is good at oncology does not mean they're good at cardiology. And so you sort of have to do it on average and you can end up in some situations where, on average it may be the, the highest quality provider in the market, but has some really, really terrible outcomes in certain pieces of the facility. So it does get very complicated when you start trying to get down to specific procedure levels.

Paul Ginsburg: This would be a good time to pause for those people that have questions, if you could write them down and send your blue card over. People will start coming by to collect them.

We'll start the questions in a couple of minutes. Let me see, actually the issue of network adequacy. I read where National Association of Insurance Commissioners just came out with something. Sounds like states will have a lot of decisions to make rather than just blindly follow the model law. I had a question about how -- one of the things that I guess everyone agrees on, the point that Carl made, is the transparency. And now that insurers realize that this is an issue, how capable are they at providing the transparency that people are looking for?

Carl McDonald: I mean I think it's a very, very significant challenge for them. I think just a report out in California earlier this week looking at WellPoint and Blue Shield and, over 10 percent of the providers listed in the directory, aren't in the location that the directory says they are. Another 10-15 percent of providers don't actually accept the insurance. And then a whole host of things where they do take the insurance but they're not accepting new patients. So, the quality of the provider directories, I think has been pretty poor. I think this is one thing where the plans need some big improvements, where they all like to talk about how they're becoming much more consumer focused and going to sell at the retail level. But when it gets to situations like this, a lot of times the plans say well it's not our fault. Like, we send the information to the providers, we have to rely on them to be accurate. We also have to rely on the front office staff to know who's actually in the insurance plan and whether they're taking it and they just make lots of mistakes, like nothing we can do about it. But the plans needs to basically accept that there's lots of things that are out of their control but they need to find a way to work around them.

Ralph Giacobbe: I would absolutely agree and I actually think there have been some improvements. I mean I did the same thing Carl did last year, going on and trying to find provider networks, right, because I cover managed care. I'm a hospital guy so it's important to figure out who's in network and who's out of network. And I clearly could not figure that out at all last year. And this year there's some that are still challenging for some plans, but there are others that are much more, sort of transparent if you will. It's in there. Now again whether or not they're truly in or not, or if there's issues, ultimately after you

get somebody in and then sort of say they're not in network, I think there's been some of those gains if you will, or some concerns around that is a whole other debate. But just from a sense or an ability to actually find whether plans are in or out it's certainly been better, at least on the exchange what we found, this year over last year.

Nick Leventis: I'd also piggy back on that and say you really also have to look at it from the perspective of somebody with commercial insurance versus somebody who has Medicaid because to Carl's point you may find somebody who participates but they're not accepting new patients. And then the question becomes is that physician going to then -- how much are they going to change their mix of their patient base, especially when you're reimbursement level is significantly lower for Medicaid. And I think with Medicaid expansion and all these people gaining access to the system that it becomes an even larger issue that the system is going to have to sort out.

Paul Ginsburg: Thanks. Let me start asking questions they -- this is a good one. I'm finding some of the questions are actually more like judgment of that policy rather than judgment of that market. (Laughter) Obviously you admire these panelists knowing everything, but I'm not going to ask those. Here's a question. We've seen a correlation between Medicaid expansions and improved hospital bottom lines. How strong is the connection and would it create pressure for further expansion?

James LeBuhn: Well, I think from a hospital standpoint, again I cover the not for profits so we've got 300 different hospitals that we cover and a lot of systems and stand alones, but it's been pretty unanimous or consistent that those providers in expansion states are really seeing some improvement. It's not so much you're seeing a reduction in bad debt, but a drop in charity care. So you're actually seeing that increased revenue, that reimbursement is helping their bottom line. It helps offset some of the other pressures that they're grappling, some of the things that we've talked about, such as the two-midnight rule and some of the lower volumes. So yes, I would say we'll be able to have a much better sense as we're getting year end audits. And I think for some of the fellows here that cover the for profits, I think that they've seen for the facilities in the expansion states I think it's been pretty uniform that it's been a fairly strong benefit for them.

Paul Ginsburg: I guess this means that Medicaid payments which tend to be lower are higher than costs? Otherwise this wouldn't have happened.

Ralph Giacobbe: So I think the argument is it's some payment versus no payment. So that's the end result is that, yeah, if you bring on incremental volume at Medicaid, we can certainly sort of have the debate on whether that's margin profitable or not, but from a standpoint of getting paid from an insured zero dollars and then just to give a sense of magnitude, on an inpatient admit the average revenue is about \$5000 for Medicaid. So it's a difference between getting zero versus five thousand. That payer mix shift obviously has impact to the bottom line because you were treating that patient arguably last year as well.

Carl McDonald: Yeah. And I think, I mean part of the answer too I think as always is it depends where you are from the perspective of if you're a hospital in a state that didn't expand Medicaid, the bad news is you're still getting no reimbursement for your Medicaid patients, but there's also a whole host of people that would have been Medicaid eligible that are now eligible for exchange products and the reimbursement is much higher on the

exchange products than it is on the Medicaid products. So it's theoretically possible if you're the rightly positioned hospital to be in a state that didn't expand Medicaid where it's beneficial. Now if you're a safety net hospital and you have no commercial admissions then, yeah, not expanding Medicaid is obviously a huge challenge.

Paul Ginsburg: I've got a question here that was coming off our discussion about networks, and it's about academic medical centers that often presumably many academic medical centers won't be included in these networks. I guess with high deductibles and transparency that might steer some patients away from academic medical centers. So the question is what are the academic medical centers doing to survive in the more challenging environment. And, Jim, if you have any thoughts at this time to offer?

James LeBuhn: Well, I think what we've seen is a lot of the academics are building out their network, whether it's through acquisition or through alignment with community hospitals. So I think that that is sort of their first step. I think the other question is in terms of network design, depending on what market you're looking at. I'm from Chicago; you've got five academic medical centers. Most people would say that's probably too many. But I think also if you look at a place like Denver, you've got University of Colorado Health System, they've acquired some community hospitals in Fort Collins, down in Colorado Springs. Question becomes is they're the only academic medical center, so from a provider standpoint can you afford to not have them in your network? So I think it sort of depends on your marketplace, but clearly the academics are working to make sure that they either through acquisition or through -- probably more through acquisition, but through alignment make sure that they are getting big enough and are a large enough part of the marketplace where they're a must have in terms of network design. I don't know how you guys feel.

Carl McDonald: Yeah, I was going to say, I mean one thing that I've seen from the academic medical centers, so I guess first point is individual is still a relatively small piece of the market. So, academic medical centers are generally going to be in all the commercial networks and most of the Medicare networks. So, yeah, part of it is them saying it's not a huge impact. Maybe individual won't grow as quickly as everybody says it's going to. Absent that I think where they're going is really to focus on quality to say, if you're the Cleveland Clinic, say we are by far the most expensive hospital in this market, but here's some data showing our quality is this much better than everybody else. And so even though we seem more expensive, at the end of the day we're really not because we will have zero readmissions and there will be nobody coming back in for another procedure. Otherwise I think it would be a challenge to make the case for them to be in.

Ralph Giacobbe: And I guess I would just say, I mean it really depends on their existing position and their acknowledgment of where they are. In other words, with the individual and with the exchanges, I mean there are renewals every year. So to the extent that somebody gets sick intra year and wants a more expensive higher priced plan that includes that academic medical center you'll have a year to sort of re-up every year. So I think it just depends on the strategy for the academic medical center and how important that small individual piece is relative to their broader book, assuming that that broader book still exists and they can continue to sort of price for their existing business.

Nick Leventis: The only other thing I would add is simply the leverage for a hospital in a negotiation is market share. So to the extent that you have the most market share, you can really try to make sure you -- it's very difficult for a managed care company to push out somebody with the largest market share just because price is high. So, definitely an academic medical center who does not have large market share, then all of those other issues are much more important for them.

Paul Ginsburg: Okay. Well, let's take our break now. We'll reconvene at 10:45 to have our second session.

(Recess)

Paul Ginsburg: Welcome to the second half of the session. The first question I'm going to ask is actually what someone wrote on the question card there -- they were just one question too early, and I want to talk about large employer benefit strategies and begin with, to what extent are large employers taking steps now to prepare for the Cadillac tax?

Carl McDonald: I think there's a lot of conversation, I think everybody is aware of it, I think there's been a lot less in terms of actual activity or conclusions from that, I think part of the issue there is that a lot of the employers most impacted by Cadillac tax also happen to have a lot of unions and collective bargaining, so it's not something that the employers can just do unilaterally, it's something that has to be negotiated, and so that slows the process down considerably.

So, I think there's an understanding and there's conversation. I'm not sure there's been really widespread activity.

Paul Ginsburg: Let me -- I'm going to ask -- hasn't it been one of the drivers on the move towards high-deductible plans has been employers sort of positioning themselves, particularly in the service industry where maybe you don't have the unionization?

Carl McDonald: I think there's a thought, I guess the point I would make is that the growth that we've seen in high-deductible plans this year, or sort of post the Cadillac tax, I wouldn't say has been considerably larger than the growth was in the years before Cadillac tax was introduced. So, I think you've definitely seen a trend and I think that's one of the factors, but if that was a really material driver I would expect to see a bigger increase.

Paul Ginsburg: And what role do you think private exchanges will play with employer-based coverage, either large or small employers? The news you read is that how they're growing rapidly and are going to become a major part of the landscape. What do you think?

Ralph Giacobbe: I mean, it was a hot topic last year when Walgreens made the choice and made the headlines and it had, certainly, ramifications within the markets. I think it's been quieter so far this year. Sure, there's been big growth, but it's been big growth on a very low base of people that have actually chosen private exchanges. I think if you talk to most of the plans they would tell you that interest level is very high, so a lot of employers are asking to see it, but the actual sort of pull through of those making that decision has been relatively low at this point.

I certainly expect and would expect private exchanges to continue to grow, again, off of a small base. We're not necessarily in the camp of seeing some of the numbers or thinking that some of the projections are going to play themselves out in terms of, 25, 30

percent of the market, shifting over to private exchanges. We simply don't think that's going to happen. And a lot of it is just related to employers and their ability to sort of, whether you believe they're able to sort of manage costs will collaborate more with their existing insurance company. I think we've seen some level of successes within that.

So, again, I expect some level of growth, but I don't know that we're going to get to the level that some of the projections have been put out.

Nick Leventis: I would agree with that. I would also just point out the fact that we're definitely going from a defined benefit to a defined contribution model and there's just going to be more costs levied to the consumer as time goes on, whether it be through private exchanges or some other medium of high deductibles, et cetera.

Carl McDonald: Yeah, I'm not really a big believer in the private exchanges, so -- a couple things to think about. So, one is that it's not entirely clear what private exchanges do to lower the underlying growth in healthcare costs. I understand how private exchanges push a lot of costs onto consumers and that can have some benefits, but there's no real underlying -- think about it in relation to if you can get providers to change the way they practice, that can drive some pretty significant savings.

so I think that's one issue and that's part of the reason why high deductible plans haven't grown the way everybody projected they would ten years ago, because you get that year one improvement in the cost trend and then generally high deductible cost trends grow, in line with other healthcare inflation.

I think the second issue is, at least as you think about the risk private exchange, so the model offered by AON, for a lot of employers it will cost them more to move to that risk private exchange with AON than it would to, say, self-fund it and the reason is that when you become fully insured, you now pay the health insurance industry fee, you now pay state premium taxes, you are subject to state mandated benefits, which you're exempt from as a self-funded plan, so is there a 5 to 15 percent increase because of that?

So, when I talk to -- I should say, having said all that, I think private exchanges could be interesting for certain employers, low-wage, high-turnover workforces, if you think about some of the marquee clients in AON today, Sears, Walgreens, Darden, which is a restaurant company, yeah, I think that makes sense. For larger employers, higher paid workforces, less turnover, I think it's more of a challenge. When I bring the idea to Citi's benefit manager, what she'll say is, all right, well, first of all, it's going to cost us more, so I don't like that, second of all, the idea behind a private exchange is that you're going to give your employees a set amount of money, I'm going to give you \$300 a month to buy your health insurance. Five years from now, I'm going to give you \$300 a month to buy your health insurance. It's not going to increase. So, as the employer I'm capping my healthcare costs.

If you are an employer like Citi, one of the concerns you'd have is competitive workforce. If we start losing employees to Morgan, Merrill, Goldman and the CEO says we need to do a better job retaining people, well, one of the things that's going to be on the table is raising that healthcare contribution.

So, benefit manager would say, we're going to pay more up front and we also don't have that certainty about the long-term cost because we very well could have to raise that

contribution if the competitive market demands it.

Ralph Giacobbe: We've talked about the Cadillac tax before, it does really nothing to control that other than, again, push more costs onto the individual but doesn't necessarily mean, premiums aren't going to go higher at the end of the day. So, from that perspective it doesn't help. And to Carl's point, the other angle of this is once you go risk, you have to pay somebody else, so beyond just the tax implications it's just that you're paying somebody else a profit, right, so think of it this way, for any self-funded organization, the argument would be to pull in premiums that equal costs, right, in a perfect theoretical world, if I bring in a million dollars of healthcare premium, I want to have a million dollars of healthcare costs.

To the extent that that goes risk, all the sudden that million dollars of premium needs to be a million-fifty or a million -- 1.1 -- whatever that incremental sort of margin opportunity is for that company taking on the risk.

So, I think once you add in all those elements, and I think sort of you peel back the onion a little bit, sure, you can get savings. The savings, though, is not apples to apples, in some ways, to Carl's point, it's just pushing more onto the consumer and pushing more consumers onto higher deductible plans is sort of the argument, and I think from a self-funded perspective, you can do that now. You don't need to go through a private exchange, per se, to do that.

James LeBuhn: Well, and I think the other thing, too, don't forget, is you've got HR departments and if you're going to push them on to a private exchange, you've probably got employees in the HR department who spend a lot of time in terms of that benefit that, you've put them in the private exchange it's, well, what do we need X, Y, and Z for?

Carl McDonald: One thing that I do think is interesting about private exchanges is it does allow you to buy best in class by market. So, as an example, Citi uses Aetna. It's our national ASO vendor. Aetna's great in some markets from a unit cost perspective. They're not so good in other markets, but on average, they serve our needs as lowest cost.

If you're in a private exchange, you can literally go market-by-market and pick the plan, or at least the employees can pick the plan that has the best unit costs in that market.

So, there are some opportunities for private exchanges, so I don't mean to say they're evil and they don't serve any purpose, there are some benefits to them, just broadly speaking I think the growth will be a lot slower than what some of the consultants have projected.

Paul Ginsburg: Carl, for that model of just going -- picking different plans, different areas, would that mean that Citi would have to go to a fully insured model? Or is there a way to get that through the self-insured model?

Carl McDonald: No, I mean, you can do it through the self-funded model. It doesn't have to be a fully insured model.

Paul Ginsburg: Yeah, so I guess the single carrier exchanges that, you give up that potential to select by market, so is that just another way of outsourcing a little HR and getting more choices into your plan to go to a single carrier exchange?

Carl McDonald: Yeah. I mean, I think the -- I'm not sure the single carrier exchanges will -- I guess the point I'm making is that single carrier exchanges are not that

much different than what we're doing today in a sense. Again, we use Aetna and within Aetna we can pick a high- deductible plan, we can pick the broad network PPO, we can pick the more limited network PPO. It's just really a variation on --

Paul Ginsburg: It's just whether you call it an exchange or not.

Carl McDonald: Right.

Paul Ginsburg: Yeah. Good point. I want to talk about health plan provider leverage and the first question is, has there been a trend in the relative leverage between health plans and providers?

Carl McDonald: Yeah, I mean, I would say I think there has been a little bit of a trend there. So, I mean, my underlying belief is hospitals always have the leverage, right, I mean, most people could care less whose insurance card they have, they care very much if they can't get into the academic medical center or the provider that's closest to them, whoever happens to specialize in the disease that you end up getting.

So, I think hospitals always have the leverage. That being said, you have seen the unit prices that managed care companies paying to hospitals have come in, not by a huge amount, but it used to be we'd talk about providers getting 5 to 7 percent price increases every single year, and now more common to see, 3 to 5. I think part of that is that historically when hospitals would come in and ask for 50 or 100 percent rate increases, often time they would get those, whereas today I think there's much greater willingness on the part of the plans to push back against that even if it means going into a public battle over it.

So, I think that's been one nuance. But, the unit pricing for hospitals has come in a little bit.

Nick Leventis: I would also add to that that on the contracting side, it seems like there's much more stipulations in the contracts around quality metrics. They're definitely starting to slip in and be tied to those rate increases.

Ralph Giacobbe: And I also think that -- I think employers are getting in the fray as well, to Carl's point, I think there was an acceptance over time of -- and I would argue, I don't know that managed care really did a good job historically of truly managing cost. It was really a pass through element, right, it was, I need to give my hospital guys 7, 8, 9 percent rate increases, so I need a 10 percent rate increase to sort of make that spread for myself, and everybody was sort of happy, if you will, margins were fair in a higher premium dollar amount.

So, I think as employers have started to sort of push back and as the system started to push back, that's why we arguably have reform, I think more employers are getting into the mix unwilling to, give those levels of price increases. So, it's a pressure point across the system and across networks.

James LeBuhn: Yes, and I would just add along with that, I think, because Medicare sort of sets the tone, realistically I think on the provider side there's a realization that you can't have high single-digit rate increases, just ongoing on your commercial side given where Medicare is going. So, I think there's a realization that they need to work with insurers and employers in terms of reigning in those costs over time.

Paul Ginsburg: Yeah, often I hear about there's more pressure on plans from

employers against premium increases, although, it's one thing to just ask for it. It's not clear to me how the pressure is actually applied.

Carl McDonald: Yeah, I mean, I would say employers have very, very little leverage in terms of their rate negotiations with managed care companies. So, if you think about all of your largest employers, the Cities, they're all self-funded. So, there is no negotiation.

When you look at the "large group market" that the health plans serve, a very significant portion of that large group market is employers that have 51 to 250 employees, they don't have a lot of leverage.

So, if you're a state government that happens to be fully insured or a municipality, okay, then you do have some leverage. That's a marquee account that somebody else would be willing to come in to try to build some scale in that market. But, I think in many cases employers don't necessarily have a tremendous amount of leverage other than putting an RFP out and hoping that they get more than one response.

James LeBuhn: I think also again from the provider side what employers can do is shift more of that increased cost onto their employees, whether it's through larger deductibles or through cost-sharing in terms of shifting that premium increase onto their employees and I think over the long-term, again, providers understand that that's a losing battle over the long-term because people are getting more price sensitive and scratching their head and as they're absorbing more of that cost increase, trying to understand why it's going up. And so I think over the long-term they understand that political pressure among people who are their patients and in their communities.

Paul Ginsburg: Good. In Washington you hear a lot about whether ACO contracting by Medicare is going to inevitably lead to greater provider leverage with private plans and from your understanding of healthcare markets, how significant is that concern?

Carl McDonald: I think there is -- a couple different angles to think about. So, one is that in conjunction with all this you've seen going on, you have hospitals buying up physician groups or employing physicians to a more significant extent. Physicians have historically had very little negotiating leverage with managed care companies. So, it would seem to make sense to me that from a hospital's perspective you are now going to jointly negotiate.

So, if you're a high-powered hospital in a market, why aren't you negotiating your physician rates along with your hospital unit costs to try to give those physicians some more leverage? There's also situations where physicians that were previously billing an outpatient rate, when they get acquired by the hospital, can now bill an inpatient rate and same procedure just getting a higher level of reimbursement from that.

So, I think there are some angles to think about, you know. Somewhat unrelated, it's interesting to me, AHIP, the health insurance industry group, has made a really, really big public relations push over the last year about how provider consolidation drives up costs. What's interesting about it is, I've never heard the managed care CEOs be more vocal about wanting to go out and do their own acquisitions, so, big, large-scale consolidation in the health insurance industry.

So, just kind of interesting that they're putting as much focus on consolidation drives up prices when we could be on the cusp of seeing some pretty sizable managed care acquisitions.

Paul Ginsburg: Good. You've got a sense of hospital employment of physicians and the first question I had is, how much further will the trend go, we'll say in five or ten years? Where will it be at the point where in most communities the majority of physicians are employed by hospitals or is this trend, somehow going to be limited after a while?

Nick Leventis: I think it definitely continues. I think that if you looked a couple of years ago, physicians that were being purchased were specialists and now it's primarily primary care and they're trying to protect their source of income, which is people in beds, and if you are the gatekeeper to the primary care physician and they refer you to the hospital, it just flows right to the P&L. So, I think that that definitely is going to continue. I think that it's, in one sense, a defensive mechanism because if the hospital across the street is buying up the doctors, then you also have to buy them up otherwise, again, they're going to shift where those patients ultimately go.

So, it's both an aggressive and a defensive mechanism.

James LeBuhn: I think it's -- I agree, I think it's a trend that's going to continue. I think we've kind of gotten through maybe where you saw a lot of hospitals going out and acquiring physicians and it obviously depends on each marketplace, but I think you've seen a lot of consolidation that's taken place. I think you're going to continue to see that trend, but right now with the pressures on hospitals, I think depending on who those specialist groups are, clearly, primary care is an area where they still have a lot of interest, but I think, hospitals, with the decline in inpatient volumes that's expected to continue, I think, on the specialist side, depending on how competitive that market is, how important that group is to your organization, I think there's other ways that they can align physicians, whether it's through IT, whether it's providing business services in terms of running their practices.

But I think what also is happening is you're seeing sort of a generational difference. The older physicians that are independent physicians are beginning to reach retirement age, the younger physicians coming out of medical school, from the surveys that have been done, greatly prefer the employed physician model, and so I think you'll begin -- that's another thing that's at work here. So, I think over time you're going to see more and more physicians that will be employed by health systems.

Carl McDonald: Yeah, I would say the limiting factor to it will be the while it's fun to talk about buying physicians and all the good things that can come of it, you actually have to execute on that. So, as a specific example, you're taking a doctor who previously earned based on what they did and now you're putting that doctor on salary. So, does that mean that golf goes from two days to three days? So, from the hospital perspective I think that would be the limiting factor is they invest all this money in buying up physicians and then realize they're not getting the financial benefit from it that they thought they did because the doctor productivity goes down.

Paul Ginsburg: That was actually going to be my next question about how are the hospitals doing that as far as using the physicians they employed effectively, both on productivity dimension, on generating more admissions and referrals, or down the road,

coordinating care, pursuing population health?

Ralph Giacobbe: It's a race to the doc right now, but that race isn't turning out so profitable for most hospitals. I think certainly some of the (inaudible) have talked about losing money on those physician practices and it takes a while to either turn it around or we'll have to see if they turn it around. Some of it's how you define the profitability. Do you just define it as it relates to sort of the practice in and of itself of what you bought and the bottom line result of that practice versus sort of intertwining that practice with your general sort of admission and hospital trends as well.

So, but yeah, I think it's largely been a losing proposition, but to Nick's point, I think many hospitals have been defensive in trying to go after the docs largely because other hospitals in the market have been doing it and they don't want to be left behind.

Nick Leventis: The other thing too is, I mean, we've seen this a few years back and it all failed, when you talk to the hospitals today about what you're doing differently, they'll tell you that the contracts are much more performance based and there's penalties, but time will tell if that actually plays out. That would be point number one. Point number two, you also see, take a tenant for example, they have a performance initiative, they used to call it, Medicare Performance Initiative, and health systems always had a difficult time telling the doctors what to do, especially from the administrative side to the doctors, take a hike. I'm the doctor, I'll care for my patient the way they want to -- or the way I want to care for them. But they actually had a -- it's a pretty interesting chart and it shows for X, Y, Z, D, R, G, here's what the national average cost is, here's what this hospital's cost is, and then it ranks all the doctors. And doctors are inherently competitive, so once a doctor sees that they're the last guy in line and everybody's picking on him in the lunch room, they're going to start to change their ways because it's not really the hospital administrator saying you're not doing this right, it's, whoa, wait a minute, this doctor down at the end of the table here is doing a much better job. I can't look like the slow poke at the end of the line.

So, you're seeing some innovative ways in which they're trying to interact, but, again, we'll ultimately see if, to Carl's point, golf goes from two days to three days.

James LeBuhn: I would agree with that. I think the difference this time is they're putting performance metrics in there and I think what we hear a lot is when they're employed it's much easier to sort of drive clinical change, which hospitals will tell you is where they're going to be able to reduce costs, unit costs, so for example, physician preference items when they're employed and you get surgeons in a room together and tell them how much certain items cost, a lot of them, when they were independent, didn't care; they wanted to come in, they wanted their items.

Now that they're part of the overall hospital and part of their compensation is going to be in terms of having that be their clinical line or turning over that OR and giving them some input in terms of what the cost of things are, you're beginning to see those physician preference items, for example, instead of having seven, eight, nine, ten, they're coming down to three or four, which is helping on the supply side.

Paul Ginsburg: Good. One more question. Carl had mentioned before that hospitals that employed physicians were getting higher payment rates for physician services. Question to the panel is, what about hospital rates? Does a hospital that employs a

lot of physicians, is that in a position to get higher hospital rates as well?

Nick Leventis: I think that's hard to tell. I think it really comes down to market share. And you look at the largest health systems out there, they're the ones generally driving the -- getting the best rates for managed care just simply because they have the market share. And, yeah, I think there's quality and what not that gets you there, so you could paint a picture where you have a hospital with poor quality ratings, they buy all the physicians, and then they work with those docs to improve quality, and then does that translate to a higher rate down the road? Sure, but I don't think that's driving -- the main driver of rates.

Ralph Giacobbe: Yeah, I don't think it is either. I mean, if the physicians had that much clout, they'd probably have that clout on a standalone basis too and probably wouldn't even want to partner with the hospitals.

Carl McDonald: I don't have a specific example for you, but you could think of a general example where, again, coming back to joint negotiations between the physicians and the hospitals, you think of a scenario where a hospital wants a 10 percent rate increased and managed care says 5, and the hospital says, well, that's fine, but if you don't agree to this 10 percent, we control 70 percent of the anesthesiologists in this market, they will no longer contract with you.

So, you could theoretically come up with a scenario, something along those lines where they use it to push up hospital rates, but like I said, I don't have a great specific example where that's happened.

Paul Ginsburg: Good. The question about insurer initiatives to slow the trend of hospital employment of physicians, how extensive are initiatives either to pay primary care physicians more in conjunction with, say, patient-centered medical homes or buying practices, employing physicians, or doing things to facilitate the formation of physician organizations? Is that something you just hear about at the cutting edge or is this more significant or broader?

Carl McDonald: I think it's very incremental. I mean, you have certain examples where managed care companies have gotten into the physician business, but that's been very limited to companies that have a retail presence, so you're focused on Medicare or the individual business.

The problem with a managed care company that serves large employers owning physicians is that no managed care company will ever employ enough physicians to satisfy an account like CitiGroup. We have 100,000 people, like how many doctors do CitiGroup employees use? No one's going to have an in-network physician group that's big enough to handle that. If you're just serving individuals then conceivably it does make more sense.

There's been some initiatives to pay primary care doctors, Care First, somewhat locally has done some patient-centered medical homes with much higher primary care reimbursement. So, there are some initiatives out there, but couldn't point to anything that's really widespread.

Paul Ginsburg: Good. One thought I've had in absorbing the discussions of the panel for a long time is that contrast between what you hear from consultants -- we're always talking about these phenomenal new things that are going to take over -- and what

you hear from these equity and bond analysts who are much more sober and much more nuanced, about, well, what's the magnitude of this. So, really good comments.

The question -- we've gotten into this a little bit before and -- but any other things you have to say about the, the combined or net effect of various Affordable Care Act impacts on hospital margins, more paying patients, but many at discounted rates, and some states not having expanded Medicaid -- anything beyond what you've said before?

James LeBuhn: I think from a hospital margin standpoint it's -- I think probably the benefit of the Affordable Care Act has just been -- I think it brought together, insurers, hospitals, and device makers, and I think, at least on the hospital side, in the not-for-profit side, my sense is that this time is different. They understand that, as you look at the long-term projections in terms of what Medicare is funded at and the population, I think that they really have taken it upon themselves to try and work to slow that cost growth, and so there's a lot of things that they're trying out there, they're dipping their toe into to see what works and what doesn't.

Clearly, they've got to maintain a bottom line, but I think that they've taken it upon themselves to look at how can we better control costs, how can we really look at our work processes, our clinical processes, to improve those. I think the incentive on IT has been a real game changer. I think if you look at healthcare relative to other industries, the adoption of IT has been -- come very, very late. It's still very fragmented, but I think that the information that they're getting out of there, the clinical data, is allowing them to identify best practices.

it's like Nick said, when physicians before -- when hospitals were acquiring physicians, they had no way to determine who was providing good clinical care and who wasn't. Now they're actually able to get the data to be able to see who's providing quality outcomes, at a lower cost and then be able to identify those practices and move those through the system.

Ralph Giacobbe: I would just say, I mean, we've seen some level of margin bump, I think that's fair to say, within the publicly traded arena, which, again, most of the industry -- 80 percent of the industry is not for profit, so, Jim could probably allude more to sort of the margin profiles there.

We've seen some bump. I would argue, I don't know that it's been sort of an outlandish type of increase to this point, and the argument, I think, for most of the hospitals is that, clearly the uninsured was on sort of their backs for a number of years and what we're getting to in terms of some of the improvement here is more of a normalization of where things arguably should have been historically as opposed to, some windfall opportunity for the hospitals, because we all know, pressures will continue kind of going forward and so there is going to be more consolidation. I think there is going to be a lot more hospital closures kind of going forward once things normalize.

So, I don't know that we should view this as some outlandish sort of margin pop within the hospital industry as opposed to some level of normalization for a population base that has historically paid zero.

Nick Leventis: I would also just comment on that and say when you look at hospitals P&L, one of the things you need to remember is that it's such a fixed cost

leveraged model that any incremental benefit from somebody showing up that is a some pay rather than a no pay, all flows right through to the bottom line. So, when we look at the impact on the statements, and if we really want to get granular, you really have to parse through what's going on in terms of the revenue recognition, in terms of the bad debts to kind of figure out what that benefit is, but every incremental person that uses -- hospitals have gotten much more efficient over the past few years in terms of staffing levels, in terms of supply costs, in terms of consolidating vender contracts, so now as you're starting to see the benefit of being at a trough level of utilization as it starts to tick up, it looks a little bit larger than it is just because it's such a fixed cost model now.

Paul Ginsburg: Good. I'd like to probe on this cost issue that -- and after I've maligned consultants, let me say that I was talking with someone who's quite prominent who just mentioned that he's been seeing more large hospital systems embarking on ambitious long-term initiatives to reduce costs than has been the case before in his memory. And I was wondering if this -- particularly, Jim, if you've seen something like this and after that just elaborating more on some of the things you were saying before about, well, what are the tools that hospitals are using to address costs?

James LeBuhn: Well, I was going to say, I was recently at a conference with 20 of the largest not-for-profit health systems and they did a survey and they said what are your biggest concerns or what's your biggest emphasis in consumerism, physician alignment, and it was cost containment was number one, and so that is where the focus is in -- as they look at, okay, how are we going to reduce our unit costs.

I think one of the ways that they've done it is through consolidation. I mean, I think, economies of scale, adding organizations where you can spread sort of those fixed costs across a larger revenue base, you're seeing that in the not-for-profit space. I think that's one of the things the for-profits have been able to use to their advantage, they've generally been much larger in terms of the number of hospitals and revenues and they tend to run very thin in terms of the shared service or corporate overhead.

So, on the not-for-profit space, that consolidation is providing benefit. I think some of the other things -- it's a lot of small things -- blocking and tackling, it's consolidating, supply -- vender relationships, and looking at supply costs, a lot of time being spent on revenue cycle, making sure that in terms of coding and what they're getting paid is appropriate.

I think that the other area that we're seeing is this whole idea of clinical redesign and really looking at, okay, how do we -- if we look at our different clinical service lines, how are we going to be able to provide those services more efficiently? And so I think it's a wide variety of small things that together are providing them an ability to better control costs.

Nick Leventis: I would just add that there's definitely a lot more collaboration between hospitals and GPOs and physicians, conversations with medical device companies to enhance the products that are out there and make those more efficient to reduce cost and then by doing that, they're reducing the number of stents in the OR from ten different vendors to two and they're really collaborating with the two that they have.

Ralph Giacobbe: I think the focus on cost is directly relatable to top line pressures

that I think all hospitals see and even more so kind of moving forward on price specifically, price goes straight to the bottom line. Incremental volume has costs associated with it. So, to the extent that pressures going forward will be more on the pricing side, which inevitably it will be, hospitals just have to become more efficient.

So, the focus on cost is really sort of a survival tactic, I think, moving forward because I don't know a lot of hospitals out there that really believe that they're going to be able to generate any significant top line and/or as we move away from fee-for-service and value-based purchasing, et cetera, that they're going to be able to sort of sustain the level of top line that's needed to, continue to grow earnings.

James LeBuhn: Yeah, I was going to say, one of the things, in terms of the emphasis on clinical quality, we've seen with a lot of the hospitals that we rate their insurance costs, so their liability costs. You've seen that come down pretty dramatically and that's provided some savings in terms of what they're spending on insurance costs.

Paul Ginsburg: Is that because they're really reducing errors?

James LeBuhn: Yes. Yeah.

Paul Ginsburg: I didn't mean to interrupt you.

James LeBuhn: No, I was going to say, that's been a strong area of benefit. Obviously, there are some things that have been beneficial. Our concern from a ratings standpoint is you sort of pick the low hanging fruit and in terms of continuing to get cost reductions, some of those things -- I think the ability to continue to reduce costs in those areas is going to be -- there is a marginal -- a smaller return there, and so I think then you've really got to get at the clinical design and clinical practice patterns.

Paul Ginsburg: Good. Well, to follow up on this optimism of that more significant attention to cost is a question that gets asked here in Washington often, which is the Medicare and hospital cuts in the Affordable Care Act that start in 2017, the issue has been, will these be sustainable, in a sense, can hospitals get their costs down like increasing their productivity 1 percent a year? Do you have any sense of whether that's going to be feasible to sustain for more than a few years?

Nick Leventis: Well, specifically as it relates to the dish cuts, it all depends on the level of uninsured.

Paul Ginsburg: Well, yeah, that's a separate question and that's a good one, is that clearly that was, you could say, calibrated to reducing the numbers of uninsured and, the uneven Medicaid expansions have certainly thrown a monkey wrench into that, but I guess the national issue is really going to depend on ultimately a few years down the road, how many uninsured do we have?

Nick Leventis: I think that's going to be a determining factor as when CMS evaluates rates, if the level of uninsured hasn't come down, it's going to be a lot harder for them to reduce rates if they don't want to sacrifice on the quality side.

Paul Ginsburg: Now I see why you were bringing that up. Yeah.

Ralph Giacobbe: I just think all the hospitals, certainly in the publicly traded realm, when you ask them sort of what the expectation is around Medicare rate increases going forward, I don't know anybody expects it to sort of keep in line with sort of core medical inflation.

So, I think most of the mindset for the hospitals, again going back to sort of the cost argument is how do we continue to operate when pricing on, let's call it 40 percent if not more, of our business on the both Medicare and Medicaid side are basically essentially flat and arguably you don't have the type of leverage that you've had historically with managed care as it relates to funding or helping to subsidize the uninsured. And so, you're trying to balance all that. So, from a standpoint of the hospital side, I think most in their budgets going forward are assuming, if I could just get zero to up as opposed to down on the Medicare side, I've got a -- that's my operating model going forward plus sort of a managed care rate increase of, I don't know, three to five, four to six in that range, to the extent that I can do that, I think that's the operating model that has to work. To the extent that you can't get that to work from a cost perspective, you're not going to be in business that much longer.

Paul Ginsburg: Sounds like the -- they're taking this very seriously and they have a model that they're going to try to follow to do that?

Ralph Giacobbe: Yeah, I mean, I think so. And, again, we're even seeing greater sort of outsourcing as a good example of that more and more hospitals looking to outsource certain things and not pay. And bundling some of the outpatient or these outsourced services, so whether it's ED Staffing, anesthesiology, NICU, hospital lists, all these programs I think historically they've paid for with no essential return. I think there's a more -- and sort of greater willingness, to outsource that to somebody else whether there's a JV structure and/or just outsource that and have somebody else deal with that sort of physician component of it, I think you're seeing some of that happening as well in terms of hospitals trying to become more efficient with things that historically have been money losers for them.

Paul Ginsburg: Jim, what's your perspective? Can hospitals actually sustain those type of Medicare rate increases?

James LeBuhn: I think there's going to become an inflection point at which point politically it's going to be very difficult to hold Medicare at just zero rate increase. I think as you look at the aging of the population and, we've always felt that from a political standpoint, as everybody knows, it's easy to talk about cuts in a broad sense, but once it starts hitting local hospitals -- I saw an interesting map that hospital employment or medical healthcare employment in the United States, if you go through -- and I can't remember how many states, but it was the vast majority of states -- is the largest employer. It employs more people in states than a map that you looked at 30 years ago.

And so, there are public policy questions in regards to how much can you cut, whether it's to hospitals, and what impact that's going to have.

I think the other thing is, is, how well can Medicare control costs rather -- in terms of controlling care? End of life care, as we know, is where a lot of the monies are spent, and that's for the Medicare population, and you can't -- until you sort of get to that and begin to change those behaviors, it's going to be really difficult to have a meaningful impact in terms of what we're spending on the Medicare side.

Ralph Giacobbe: The only other thing I'd say is I think there are two sort of arguments here, one is, how are hospitals approaching this and what's actually going to

happen, right? I think from a hospital perspective, anything more -- if you're basing your operating budget going forward that you're going to get 3, 4 percent rate increase from Medicare, maybe at some point you do, but if that's where your game plan is or your budget is, there's going to be a lot of pressure points sort of early on.

So, I think most are sort of preparing for the worst and essentially hoping for the best.

Paul Ginsburg: Good. Let me change the topic now. We have a lot of demonstrations going on in some states of managed care for dual eligibles, and I was wondering if any of you were familiar with this and could answer, how prepared are managed care plans for the challenges of this population that is new to them and the greater scope of long-term services and supports as well as acute care?

Carl McDonald: Yeah, so the dual demonstration has been interesting from the perspective that the company's best position to win the business and get into it are Medicaid plans. That's partly because certain states are only giving dual business to existing Medicaid plans, so California would be one. It's also because in the states that do RFPs, those RFPs are generally done by the state Medicaid agency. And so there's just a lot more familiarity with the Medicaid players. They're used to submitting RFP responses things like that.

That said, you could make an argument that it's really the Medicare plans that are better equipped to actually care for that population and so that's been sort of interesting as some of these things have rolled out I would say, by and large none of the plans are all that equipped to do long-term support services. It's something that they've never really done, at least to any significant extent previously.

So, too early with most of these roll outs to have a real definitive answer, but I think probably the most pressing policy question right now is that the opt out rates for many of these dual demonstrations have been extremely high. So, Los Angeles, as of last month, was a 50 percent opt out rate. It did come down to 40 percent for the November data, but if that opt out rate continues to run at that level, then I think it's going to raise a lot of policy questions about, how effective this really was if you have 40 or 50 percent of the people choosing not to participate.

Paul Ginsburg: What would you say the critical managed care skills that are most potentially brought to bear on this population? Wouldn't those skills would likely be more possessed by the Medicare plans?

Carl McDonald: Yeah, so just from the perspective of the Medicare plans are used to dealing with a sicker population that has a lot of health needs, where as that's generally not the business of a traditional Medicaid managed care vender. But what they can bring to bear is just all the things managed care is supposed to do, care coordination, so as a couple of examples, there's all kinds of rules about if you get discharged from an inpatient facility where you go, into what setting, for post-acute care and the various reimbursement schemes, that you get. A lot of times those decisions aren't made on what's best for the patient, they're made on revenue maximization so you can smooth some of that out.

I think there's lots of situations where people end up in settings that they don't need to be in but there's no way to fix it in the current system. So, specific example, may be

exaggerated, but somebody moves into a nursing home, not because they need to be in the nursing home but because they've got stairs in their house and they just can't get up the stairs anymore. So, managed care company can make the decision that putting in one of those chair lifts might cost \$10,000 -- to make a number up -- versus annual expenses in a nursing home might be \$25 or 35,000. So, clear financial benefit to put that in as opposed to moving somebody to a nursing home. In the current system it's not like you could submit a code for a chair lift.

Paul Ginsburg: Okay. And let me change topic again to hospital construction plans and how is the current market environment affecting hospital construction? And are you more concerned with over capacity or shortage of capacity over the next few years?

James LeBuhn: Well, I think in the not-for-profit space we've seen capital spending come down in terms of inpatient capacity I think a lot of organizations, again, from an efficiency standpoint, they're looking at how can we best use and operate more efficiently within our inpatient walls right now. I think as you look at the technology more and more is going into the outpatient space. It's lower cost in terms of development and construction. I think the other thing is as health systems are building out their systems, I think they want to improve their access points. And so, whether it's putting physician offices out into the community, putting outpatient capacity out into the community, making that ease of access greater and really looking to drive more high acuity stuff into their inpatient facilities right now is what we hear a lot of.

And so, I guess what I would say is over the near term I think that the inpatient capacity is sufficient. In fact, I think depending on which markets you're looking in, there's probably an over capacity of inpatient space right now.

Carl McDonald: I would agree on that front. I would also say that it's interesting to note, as we see a lot of the consolidation in the industry, there's been acquisitions at fairly low multiples, but with fairly high aggressive Cap Ex plans, so a lot of the smaller not-for-profits don't like to see the for-profits coming into town, they think they're these big, bad guys and in reality one of the ways in which they're breaking that barrier down and saying, hey, look it, we get that you're one of the largest employers in the county and what not, we'll not only purchase the facility but we'll upgrade, whether it be the front of the house or whether it be in the emergency room, whether it be in the ORs, et cetera.

So, we're seeing that. We're also seeing a lot of the Cap Ex, as in dollars spent, on the outpatient side these days.

Paul Ginsburg: Does that apply lower Cap Ex overall, at least on the construction side when there's movement from inpatient to outpatient, is the next less investments?

James LeBuhn: I would say we've seen probably -- so, we look at sort of capital spending as a percentage of depreciate -- we've seen that come down, but it's been in other areas. I mean, IT has been a huge area of capital expenditure and it's probably going to continue to be that way for a while going on, but in terms of bricks and mortar, we're seeing -- inpatient bricks and mortar seeing that, I think, has trended down pretty significantly.

Nick Leventis: I agree on the bricks and mortar part. It'll also be interesting to see what happens in the next year or so in terms of hospital Cap Ex spending because margins

have gotten a boost from coming off the trough levels of utilization and the benefit from a reduction in the uninsured and now that there is some extra money there and they're not spending it on getting certified for meaningful use, that there could be more spending in terms of beds, pumps, all your other ancillary products that go along with caring for the patients.

So, that will be something very interesting to watch in the next year.

Paul Ginsburg: Good. I've got some questions about primary care physician supply. And, there were a lot of expectations that shortages, in light of expanded insurance coverage and the expanded roles for primary care practitioners, that, some of the evolved delivery systems envisioned. What's your sense of how this is sorting out? Is this -- is primary care physician shortages a real barrier to access or to actually implementing some of the delivery reforms?

Ralph Giacobbe: I mean, going in to reform I thought we would hear more. It's been kind of quiet on that front in terms of complaints from individuals not being able to access, doctors and physicians. So, either it's happening and it's not being brought to the forefront or maybe it's been either overstated or we haven't hit that sort of breaking point of physicians. Maybe the other side of it, as well, is that we did have a payment -- Medicare/Medicaid payment parity where your Medicaid rate got boosted up to Medicare. That's expiring at the end of this year, so, I just -- you wonder if that doesn't get extended whether or not we hear more noise from physicians maybe unwilling to see, Medicaid in terms of keeping their offices open for more the commercial and Medicare side of things.

Nick Leventis: I think on that front, parity is very important because a lot of these primary care docs, if they're not -- the money's not there, they're not going to be there. I mean, there's a profit motive there as well other than just ethics of taking care of people. So, that's point number one.

I would also say, point number two, just as a longer term, bigger picture item, a lot of physicians are generally entrepreneurial, competitive people and with employment of physicians, with somebody presenting in the emergency room and they have to follow a cookie cutter menu of procedures rather than getting to practice medicine the way in which they want, those are all hinder -- kids coming in out of college deciding whether or not they want to go into medicine, so that's also something to think about.

But, one of the issues with primary care is it's not really a sexy industry to be in. I mean, okay, I'm going to -- don't get me wrong, some people love it and they do very well at it, but it's not -- people are more attracted towards the specialists fields and until you can kind of get people more excited about primary care, you're going to have somewhat of a shortage over there.

James LeBuhn: I think the other thing that we hear a lot is that it's the -- making sure the incentives in primary care meet what the goals are. So, right now, as we were talking about with physicians, they're still volume base and RVU based and, we hear a lot about getting primary care physicians to work at the top of their license, and so how can you expand that panel size, whether it's through nurse practitioners and PAs and case managers so you can essentially leverage that primary care physician's ability to touch

more patients, and what things are they doing that really they don't need to be doing on their license?

Paul Ginsburg: That's a good transition into my next question, which is, have you seen much activity, as far as states or private insurers, Medicaid plans, to actually ease policies concerning nurse practitioners and other mid-levels in order to increase primary care supply? Is this going to be a big response to the lack of attractiveness of primary care, of pulling more lesser-trained people into it?

Nick Leventis: Personally, I think that you've seen a lot of this already with the Minute Clinics of the world and the express doctor clinics where a lot of times you don't even have a primary care doctor in there, it's a nurse practitioner, and consumers seem to be liking those facilities for care just given how they're -- there's now a line at them, actually, close to where I live, so I don't see -- I don't see them -- insurers, public or private -- really working to hinder those access points to care.

Paul Ginsburg: Maybe that's the reason that Ralph hasn't seen much -- any complaints about primary care shortages because there are so many other places to go today.

Good. I think we're getting to time for your questions and, yeah, if you want to just get the microphone, that would be great to start. Others can write on their cards.

MS. CANTOR-WEINBERG: I'm Julie Weinberg with the --

Paul Ginsburg: Actually, where's the microphone? I'd like to get this recorded on the webcast.

MS. CANTOR-WEINBERG: Two questions. I'm Julie Cantor Weinberg with the College of American Pathologists, so part of this question won't surprise you. You haven't talked at all this morning about the changing diagnostics markets, both from the perspective of the legislation last year that dramatically cut reimbursement as well as the growth of genomics and companion diagnostics. And then two, you talked a little bit about HIT, but there's been a lot written in town on the term of the meaningful use program. We haven't talked about the impact on vendors and assuming there's a stage three, people will have to upgrade their systems.

Nick Leventis: I'll tackle the second question first. In terms of what we're seeing with the health IT companies right now, a few years ago the whole push was meaningful use and that was the buzzword and it was a land grab to who could get the most facilities using their product.

In terms of going forward, the two big buzz words and themes there these days are primarily population health, and they're essentially trying to put a stake in the ground with the ACO models and accountable care to essentially say that in order for you to operate this ACO, you really need our products because we have the analytics that you need and -- versus having to go to a health insurance company where they'll give you everything.

So, you're seeing that on that front and then it's hey, ICD-10 is coming. Well, you have to upgrade to the next version of our software because if you don't, it's not compatible. So, I think you'll continue to see them priced that way and they're going to try to take advantage of any type of -- whether it be ICD-10, whether it be pop health, so that they can price to those themes in the market because meaningful use is basically gone at this point.

James LeBuhn: But I think the investment in IT is going to continue -- what we hear a lot is organizations, probably 20, 25 percent of their capital budget has been sort of carved out for IT spending and I think that's an area that they can -- hospitals, whether or not they get reimbursed from meaningful use is an area that they're going to continue -- they feel that they continue to have to invest in going forward.

Paul Ginsburg: Good. I've got a question here that provider/hospital cost reduction initiatives, have you observed that a -- a difference in cost reduction between providers or systems with greater market share, i.e. Negotiating clout, versus those with lower market shares? I think I get this as are you seeing the cost reduction activities concentrated more in the providers that have less market power?

James LeBuhn: I think if you have larger market share you're generally a larger provider to begin with, right, so you have more resources. So, you look at hospital staffing levels, they're real time now. I mean, you're tapping nurses on the shoulder at lunchtime telling them to go home because there's just not enough volume in the system right now for you to justify being there.

So, versus a smaller -- two-, three-, four-hospital system in rural America. They don't have the sophisticated programs and systems in place to do that. I think where everybody is benefitting is on the supply cost side because everybody is -- everybody does contract with the GPO and the GPOs do have a lot of clout in terms of buying power and you see that with medical device companies talking about, well, price is going to be down 1 percent this year. Oh, now it's going to be down 2. And then you hear them talking about certain commodity items like knees and hips and you have mid-single digit pricing declines that you occasionally hear them talk about and it just goes to show you that the systems are really trying to control what they can and I think they're definitely doing it on the supply and labor cost side.

And I'd agree. I mean, I don't think you're seeing the smaller hospitals that may need to cut more being able to. I think, again, cost containment, whether you're a large system, whether you're a national system that is where the focus is. I do think that the larger systems, just due to their size, their scale, the depth of their management, their information systems probably are in a much better position to drive cost containment, and in the not-for-profit space, that's why you're seeing a lot of consolidation. You're seeing small, independent hospitals sort of understanding that it's -- it's just more and more difficult to compete if you don't have that size and scale, again, where you can spread some of those costs across a much larger revenue base and across a unit basis.

Paul Ginsburg: Yeah, so an interpretation of what both of you have said is that really all hospitals are looking hard to cut costs, but the larger ones are perhaps better positioned to do it.

MS. CAREY: Hi. I'm Mary Agnes Carry with Kaiser Health News and I just wanted to ask you an ACA related question. We're hearing a lot in Washington about a push for this medical device tax repeal that's in the ACA. If that were to pass and if the President were to sign it -- I know those are big "ifs," but if that were to happen, how do the rest of the sectors react who are being taxed -- the insurers, the drug makers? Would hospitals say, you can't enforce those DSH cuts until you hit certain metrics? I mean, is there sort of a

cataclysmic effect if that happens?

Paul Ginsburg: Is that political activity or market activity?

MS. CAREY: I just wonder if the markets really care about it. Some people suggest that perhaps the drug makers got concessions in the ACA negotiations, for example, nobody is negotiating Medicare drug prices, so this may not be that big of a deal for them. Is it that big of a deal for insurers if they continue to pay the taxes in the ACA because they're getting new customers? I'm looking at how the segments of the markets might react or not.

Carl McDonald: Well, I mean, from the insurer perspective, I mean, they would certainly use that in the public relations campaign to restart some of the things they'd done previously to try to get rid of the tax. The issue that you constantly run into is that, okay, you want to get rid of the tax. Where is the funding?

I think given the size of what the insurer tax amounts to, I think that's the biggest stumbling block is coming up with a reasonable plan for how you would offset that lost revenue. So, I don't think they'd end up getting a ton of traction from that.

Ralph Giacobbe: But, yeah, to your question, I think there would be a lot of "me too's" if that were to come through. I mean, it's just hard to think that other trade industries and lobby groups wouldn't be all over, you know, why them and why not us, essentially, in terms of having to take something away that others have to continue to sort of pay for.

Paul Ginsburg: I've got a question about Medicare Advantage. When I saw it I realized, oh, I didn't put any questions in Medicare Advantage. And if I'm understanding it right, I think the question is about, just given the Medicare cuts made so far and scheduled to continue, what's your sense about how that's going to affect growth of the sector over time? Should we expect continued growth in, say, the market share percentage of Medicare beneficiaries in Medicare Advantage or not?

Ralph Giacobbe: I would expect enrollment to continue. I mean, MA penetration, I think, still in the 27 -- under 30 percent range and I think even though there may not be public acknowledgment by the government, I think there's a greater acceptance that, fee-for-service isn't working and the fee-for-service model isn't working and I think there is a push and a want to move more lives onto private plans.

So I would expect enrollment to go up. Do I expect there to be funding cuts going forward? Yes. I mean, so there may be some level a breaking point where the enrollment potentially starts to slow, but I think as of right now, I think, we've gone through some pretty hefty cuts, enrollment's been pretty healthy and, now that things are getting somewhat more benign, I don't know why that would derail the penetration rates within MA.

Carl McDonald: And I would just say, for 2014, at least from a growth perspective, there has been no perceptible impact on growth from the rate cuts. So, 2014 was the single biggest year for Medicare rate cuts. Enrollment growth in 2014 actually accelerated for the industry. So, there's been really no noticeable impact there.

As you think through sort of how that happens, a couple factors to think about. So, one is that although the base rates were down 5 percent in 2014, there's very few plans out there actually reporting a 5 percent reduction in reimbursement. The reason is they've been

able to continue to significantly improve their risk scores and the risk adjustment payments that they get. So, the actual rate cut that the plans are seeing is more low-single digit as opposed to 5 percent.

The second factor is the employers are increasingly shifting more of their retirees into Medicare Advantage plans, so we have been getting 200,000 lives a year into plans. This year it was over 400,000. And then the third point is that you have actually seen some companies sort of actually believe in the fact that they're saving money. So, as an example, Humana, this year, despite seeing the 5 percent rate cut, did not do very much in terms of changing their benefits.

So, typically, Medicare rates come down, plans adjust their benefits, they keep their margins stable. This year Humana said, we think we can do a good enough job medically managing people and keeping them out of the hospital that despite the rate cut we're not going to adjust our benefits. And the result is, they have grown significantly this year and picked up share.

James LeBuhn: And it seems like from a provider standpoint, we've seen where providers and some of the large national insurers have been able to come together on MA plans because they -- and work together from a savings standpoint, so on the provider side there seems to be a lot of interest in expanding MA and working with some of the insurers in developing an MA plan.

Paul Ginsburg: Both of those responses really were part of what I was going to ask about as a follow up question, which is your sense of whether the actual trends in spending, which is a function of external things, but also how care is being levered, whether managed care -- whether Medicare Advantage is now at the point where it's actually having a lower trend than fee-for-service Medicare, because if that's the case then that's a way of withstanding the cuts.

James LeBuhn: I think the answer is, unquestionably, yes in the sense that if you go back a few years ago, Medicare Advantage plans were paid 15 percent more than fee-for-service and it's now down to about 6 percent. So, been some meaningful cuts to reimbursement. The extra benefits that the managed care companies offer to seniors is still relatively equivalent, so most plans will tell you that their benefits are 10 percent better than what you can get through fee-for-service on average at the margins, in some cases have come down, but for the industry as a whole, are essentially the same. So, I think the answer is, yes, they have done a better job with it from a management perspective.

Paul Ginsburg: And we're almost out of time and rather than going to another question, let me just ask -- or invite the panelists if there's anything else they would like to say. Are there thoughts they've had from our conversation, an issue that didn't come up, before I close the meeting?

Carl McDonald: I guess one thing that we touched on a little bit was just around small group dumping and sort of what the trends will look like there. So, what we've seen this year is -- Well Point is an example has talked about their small group business falling about 15 percent, which they attribute to lots of small employers dropping coverage. I think that's a trend that we will see continue into 2015. I would expect it actually probably will accelerate given that there were probably a number of small employers hesitant to drop

coverage last year with all the technology issues on healthcare.gov.

Nick Leventis: I would just say that if we -- from a very high level, if you look at last year, a lot of the worry was about how is this thing going to play out, is the system going to be able to handle it, how is the -- on the provider and the payer side, is it going to work? And there was a lot of worry about that.

So far, this year, it's kind of a, let's sit back and just watch how this plays out. I think what we've seen thus far, and we're only three-quarters of the way through the year here, well, a little bit further, but in terms of reporting statistics we're only three-quarters of the way through the year. We don't really have that many data points still, so there's still -- just because 2014 has looked pretty good so far, there's a lot more to come and it's -- time is going to tell how the rest of health reform actually impacts the delivery system.

James LeBuhn: I guess the thing I would add, Paul, and I agree with you, we go to a lot of conferences and you hear the consultants and I think it's just human nature, if it's sort of black or white, and I think the change is going to be much more incremental than maybe a lot of what you read in the headlines, whether it's private exchanges, whether it's providers, moving in and disintermediating insurance companies. I think it's going to be much more incremental maybe than sort of what you expect and what you read in the consultancy reports.

Ralph Giacobbe: Yeah, I mean, I guess we're obviously in dynamic times in the history of healthcare right now and I think -- I made a couple of references earlier, I think there is some level of learning curve and so headlines can be distracting, I think, to the general sort of public, but when you sit back and you think about it, I mean, we wrote a (inaudible) report last year where we estimated 6.5 million individuals had access to a zero premium plan -- now, obviously, there were deductibles tied to it, but those are big numbers and I think that's yet to be recognized by the broad based uninsured and I think as outreach efforts continue to improve, it's one of the reasons why I continue to believe that the exchange enrollment will continue to grow, because if you just sit there and you go on and you look at sort of the ability to sort of capture sort of achievable or affordable, I should say, healthcare, I think the outlook is pretty positive for more uninsured gaining coverage.

Paul Ginsburg: I want to thank you -- all of you. I think each of you four has been terrific today and I think you've done a really good job. I can -- I think a lot of the audience is very engaged in this. I want to thank you for your participation.

(Applause)

Paul Ginsburg: I want to thank the JKTG Foundation for supporting this conference. I want to thank Alwyn Cassil and Tad Lee, my former colleagues from HSC who are working with me as contractors to USC, for this conference, the Alliance for Health Reform provided the people downstairs and also please fill out your yellow evaluation form and drop it off. So, we're adjourned.

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