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Key Market Dive

M&A Strategy

Exclusive Q&A with KP on the Kaiser-Risant-Geisinger Deal

Many LHS strategy leaders were surprised last week when **Kaiser Permanente** (through Kaiser Foundation Hospitals) announced plans to form a new multi-system, multi-payer value-based care organization called **Risant Health**. In tandem, it announced that Risant will acquire the 10-hospital system **Geisinger** as the first step towards assembling a portfolio of five or more like-minded community-based systems.

Kaiser will invest at least an additional $5B over the next five years in the venture. Ultimately, the new nonprofit will aim to reach a total revenue of $30B to $35B over five years. It was also announced that Geisinger's president and CEO Dr. Jaewon Ryu will become Risant's new CEO as he steps down from his current role (Dr. Ryu spent almost seven years at KP earlier in his career).

Notably, Geisinger will also keep its name, branding and payer relationships even after the deal closes (which is expected early next year). Other organizations that join Risant will do the same.

Financial terms of the deal were not disclosed (however the deal was not structured as a traditional purchase according to a spokesperson). Last year, Kaiser reported $95B in revenue and a net loss of $4.5B (compared to an $8.1B net gain in 2021). Geisinger reported $6.9B in revenue in 2022 and a total $842M loss.

While the move has attracted intense interest, very little beyond these details has been reported. To give our readers an exclusive look into the thinking behind this bold new venture, *The Strategist* spoke with Kaiser Permanente SVP of Strategy Debby Cunningham. We thank her and the KP team for their willingness to share more.

A lightly edited transcript of the conversation is below:

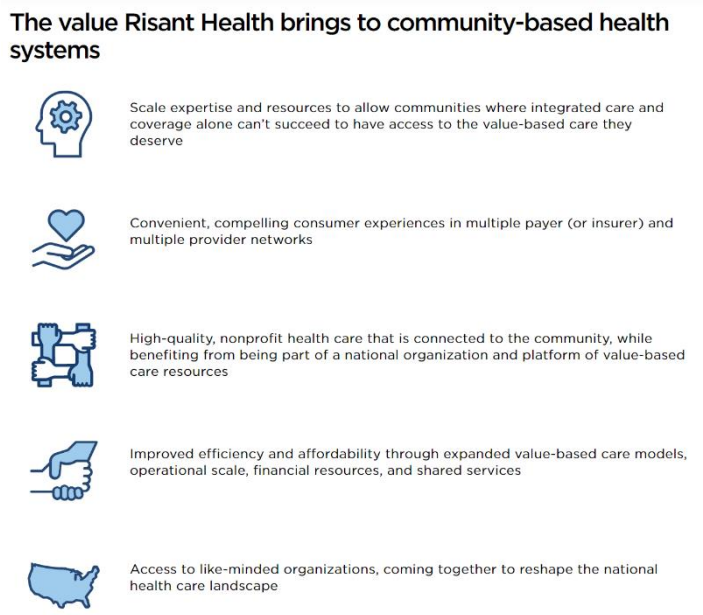
So, I want to start with the obvious question, how do you pronounce Risant?

It's rise-ant. It's a combination of rise and constant—that's the way to think about it.

Why did you decide to form Risant? With the side question: what's the advantage of forming Risant, as opposed to just acquiring Geisinger and acquiring future hospitals?

When we look at what we need to do in order to continue to really lead in healthcare, we know we need to create some new and innovative partnerships and think about different ways of helping KP succeed in the market.

And we're seeing a market now that's driven by economic and industry challenges. There's evolving consumer needs and a new competitive environment. As we think about that, we know our mission is calling on us to find different or new ways to provide the high quality, affordable health care that we provide to our members and to the communities we serve.



*A promotional slide from Kaiser's announcement of **Risant Health***

And so as we looked at how do we do that and thought about growth for KP, we developed the idea of Risant Health, a new non-for-profit organization created by Kaiser Foundation hospitals with we what we think is a transformative vision to improve the health of millions of people by increasing access to value-based care and coverage and raising the bar for value-based approaches in more communities across the country.

So that's the nugget: Risant Health is a separate nonprofit and it's really designed to extend the mission of Kaiser Foundation Hospitals and health plan. And what I would say is, while it's affiliated with Kaiser Foundation hospitals, it will operate with autonomy from our core enterprise.

To be clear, we are going to continue to invest and pursue growth in our core integrated care and coverage model, and Risant is another way for us to think about how to grow through an additional part of our organization.

To answer your question about why it's a different organization, Risant Health will have the freedom, the ability, the need to operate differently from core KP and specifically in environments with multiple payers and multiple providers while drawing on the best of what we do in our traditional integrated care and coverage model. This new entity gives us an ability to invest in the future of value-based care, really in support of our mission, but outside of that core integrated care and coverage business model. We think that gives KP an ability to learn from the health systems that are coming into Risant in ways that will help us compete and be more affordable and better for our members and consumers. But we also think this new organization, since it is separate, will give the market and prospective systems, payers, providers confidence that we are committed to operating differently with multiple payers and multiple providers. Risant is that vehicle to do that.

That makes me curious: Will you sit on the board of Risant, or is it completely separate?

There is a governance overlap with Kaiser Foundation Hospital board members and that's how we think about the influence. It's affiliated and that affiliation is through our board overlap.

I would love to learn a little bit more about what the strategic goals of Risant are. I know you started to touch on some of those but I would love to hear more specifically.

Going back to the vision for Risant, it's to improve the health of millions of people by increasing access to value-based care and coverage and raising the bar for what value-based approaches really

mean, and those that really prioritize patient quality outcomes. So it's that focus on value-based care. We want to expand and accelerate the adoption of value-based care in these different ways.

In different environments, multi-payer, multi-provider, community-based health system environments, Risant will develop a new platform that offers best practices, tools, technology, and services that help those community-based health systems advance value-based care where they are. And then it will grow its impact by acquiring and connecting a portfolio of what we're calling like-minded, not-for-profit, value-oriented community health systems so that they're growing in their communities.

The thinking is that that the systems that join Risant will be able to expand and accelerate the adoption of value-based care in their environments. So, we're helping to improve those systems, do better from a patient outcome and from a performance perspective in their markets.

Do you expect that all of those local systems will be like Geisinger and be able to maintain their local branding and market control?

That's one of the design features of Risant. The intent is that the systems that are joining will maintain their brand, their mission, their connection to their communities. It's a key piece of it.

Will these systems contract together with payers? Will they all work together across the markets that they serve?

Some of that is still being figured out, but part of the concept is yes, there is a way that Risant has of helping those systems present themselves as the value-based alternative and option in their communities.

Do you have a focus area you'd like to start with in terms of moving towards value, whether, say, an MA population or a Medicaid managed care or is it going to be payer-agnostic?

Our approach is really to advance and think about value-based care at a population level. So it's not a contract-based approach only. Obviously, that's important, but that's not the core behind it. It's really about how we're improving care and care outcomes for everyone.

What we think is that it will create a growing demand amongst purchasers, consumers, and policymakers for improved outcomes and affordability through value-based care. It's really about promoting that type of care delivery.

Are you going to be pulling from what you all have done historically at Kaiser— like with data analytics, a virtual platform, population health tools, all of those types of capabilities – into Risant?

Part of the design of Risant Health is so that we can bring in the tools and capabilities from KP, but also those from the systems that are joining. So, think about what Geisinger has and how they're so well recognized and have a great history as well, we can bring the power of those two things together into this platform.

We also know much of what we have is designed for integrated care and coverage that won't work perfectly in a multi-payer, multi-provider environment.

Why are you doing this now? I know you talked about all of the ways the market is changing, but why now?

A lot of it is that the healthcare industry is being disrupted. You know there's for-profit plans, private equity firms, new entrants and they all see the opportunity to change healthcare and they are focusing on new experiences and segments where maybe margins are high. Maybe some of them are figuring out how to increase margins for their own return's sake as opposed to really thinking about what's better for patients and populations. And we know that nonprofit community-based health systems are facing new competitors, changing demographics and affordability challenges, and they're looking for options.

One of the most effective ways we think to address those challenges and focus on better, more equitable health outcomes for those community systems is to continue that shift that providers are on to value-based care, while they continue to operate in their markets with diverse payers and providers. Risant Health is another option for those systems. Our belief is that by lifting up those high-performing systems that are already committed to high quality, affordable care that we can help set a standard for every system, improving outcomes and improving the sustainability of not-for-profit health care overall.

Which is a wonderful goal. Do you have a sense of the percentage of value-based revenue as opposed to fee-for-service revenue that you would like these systems to be at in the future? Are you thinking that these would be primarily value-based systems five years down the line?

We think value-based is the right way to deliver care. So, we'd like to see more and more of it, but certainly we recognize that we have to operate in communities and meet communities where they are. The goal is clearly more value-based care.

What systems do you think will be a good fit for Risant. I know you just mentioned you have a kind of a framework in mind for the systems you think would be good candidates.

We do have some pretty clear criteria for systems. One is that they have recognized quality outcomes, so we're starting from that base. The next is sustainable standalone financials. So, they are sustainable, strong organizations in their own right.

Next, do they have a leading reputation in their geography and, as part of that, do they have a demonstrated commitment to value-based care? Now what does that mean? We're not necessarily looking at percentages, but there are definitely ways that you can see it. Sometimes it is in those quality outcomes. And sure, you can see it in their financials perhaps. But it's really about like-minded organizations. And then trying to define that.

So do systems need to have a provider-sponsored plan? Or could they also have been part of an ACO, MSSP, or other types of value-based entities?

We know that everyone's not going to have a provider-based health plan, so it's not a requirement. But we want organizations that have experience with an ACO or who are thinking about what value looks like.

Have you started to have conversations with the systems that you're interested in having join Risant or are those still early on?

What I would say is that we have a goal to bring five or six health systems in over the next five years, which I think is an ambitious goal. And we know those partnerships are going to come in different forms and business models. We're going to need to look at specific opportunities as they present themselves.

What made Geisinger a good fit for the first member of Risant?

Geisinger is, and has been, a national leader on quality and delivering leading care and coverage and research. And they've got an education pipeline in their Pennsylvania communities. They bring nationally recognized leadership and capabilities in areas like Medicare, Medicaid, rural health and how to approach all of those populations. And they have a proven commitment to value-based care. And so in talking with them we are very like-minded and we really share that vision for what healthcare could be. Through Risant we can bring together what I was talking about earlier, the best of both organizations and be able to create something that will really help expand access to value-based care across the country and in so many different markets.

Geisinger also brings a degree of credibility to Risant and our commitment to operate differently and advance value-based care in that multi-payer, multi-provider model—not just our core integrated care-only model. That's the big part of it. And that's also why, for Geisinger and then for future systems that join, they're maintaining their name and their mission. They will absolutely continue to work with their payers and providers in the ways that they do now.

I've heard talk of this kind of being a type of MSO model in the sense that you're giving these capabilities to the portfolio systems that may join. Would that be the right way to characterize it or would you say it's much beyond that?

It’s beyond what I would call an MSO. Risant is acquiring Geisinger. So that's a pretty different model than a straight MSO model.

OK, so much more of an acquisition.

I want to be clear that the acquisition is Geisinger to Risant. It is to Risant not to Kaiser Permanente and that's something that's been a little bit of a confusion point. We're creating Risant and then Risant is acquiring Geisinger.

That’s actually a perfect segue for where I was hoping to end, which is what else would you clarify in terms of what you've seen so far with the coverage of Risant? Anything you want to make sure is really clear to other health system leaders?

So I think number one is that this isn’t about Geisinger being acquired by Kaiser Permanente. It is our intention for Risant to operate separately and with some autonomy. This isn’t about hospital consolidation, it’s actually the opposite of that.

This is another option for leading health systems to consider as they're looking at their future and how to really have an impact and expand value-based care in a meaningful way across the country.

We're also hoping to get Geisinger's perspective on health systems joining Risant in a future piece in the Strategist. Stay tuned for more and other possible ways to discuss the implications.

Market Scans

1. AmerisourceBergen and TPG acquire OneOncology for $2.1B

Drug wholesaler **AmerisourceBergen** and private equity firm **TPG** are teaming up to purchase specialty cancer practice network **OneOncology** from fellow private equity giant **General Atlantic** in a deal valued at approximately $2.1B.

Under the deal's terms, TPG is buying a majority interest while AmerisourceBergen will purchase a roughly 35% ownership stake for $685M in cash. The two companies and OneOncology's affiliated practices will form a new JV to acquire the firm from its existing shareholders. However, the "put/call" structure will allow AmerisourceBergen to eventually own OneOncology in three to five years. TPG has a one-year put option to require AmerisourceBergen to purchase all of the JV stakes at 19x EBITDA.

The acquisition gives AmerisourceBergen a network of cancer specialists, building up its practice management services and supercharging its specialty pharmacy business. It also follows another recent massive purchase by AmerisourceBergen—its $1.3B acquisition of the Germany-based pharma and bio-tech services firm **PharmaLex** in January as part of its global expansion ambitions.

OneOncology, an MSO based in Nashville, has rapidly grown over the past four years to cover 15 practices in 14 states with 550 physicians and 940 providers. The company grew notably in 2022—adding 170 physicians (314 total providers) and expanding into three markets. Key to the company is OneOncology's operational platform for clinics, which helps independent practices ramp to support value-based contracts. AmerisourceBergen sees the platform as complementary to its existing strengths with inventory management, practice analytics and clinical trial support.

If all goes as expected, the transaction is expected to close in September 2023. According to a company announcement, AmerisourceBergen plans to rebrand as **Cencora** in the second half of 2023.

So what? This is a story of another drug distributor trying to gain additional influence in specialty pharmacy—a rapidly growing space. As we noted in our profit pools analysis, specialty pharmacy and infusion services are expected to generate $33B in EBITDA by 2026 according to **McKinsey** (with one of the fastest growth rates across the industry).

First and foremost, the purchase gives Amerisource an opportunity to diversify into the oncology provision space and a deeper foothold into controlling specialty distribution patterns. It's a big move towards competing with rival distributor **McKesson's** subsidiary **US Oncology Network**, which currently covers over 1,400 physicians, 500 treatment centers and 1.2M patients treated annually, according to company materials. McKesson acquired the network all the way back in 2010—so it's been a long time coming for Amerisource to make a similar move. And as the latter streamlines operations with layoffs, it's clearly trying to cut into tap into the growth McKesson has found in the space. Notably, despite similar overall market shares, McKesson has seen double the net profit margin (1.21% vs. .63%, according to Pitchbook) as Amerisource the past 12 months.

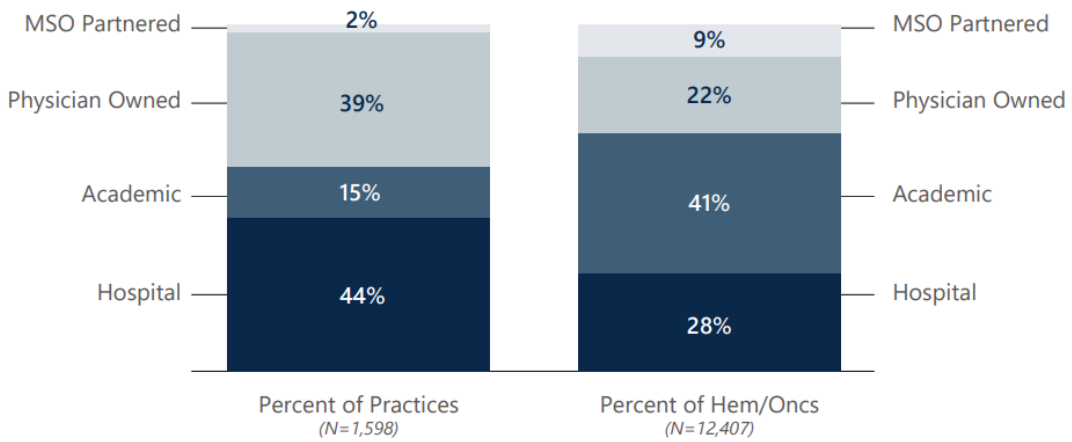
A larger piece of this story is one of the largest healthcare public companies betting on the transition to value-based care among independent oncology practices. Trying to operate in value-based models—particularly in the oncology space—is resource-intensive. Partnering or joining larger

organizations is a tried-and-true method to accelerate that transition and OneOncology's MSO promises practices the tools they need. Amerisource clearly believes in the growth of that offering.

This seems well-placed given CMS support. CMMI is moving beyond its initial Oncology Care Model (with participants including **Aetna**, **BCBS South Carolina**, **Cigna**, **Priority Health**, **Univ. of Arizona** with a total of 200 practices at some point), which accounted for approximately one-quarter of chemotherapy-related FFS spending and ended in 2022. The new Enhancing Oncology Care Model (an administration priority, given that it is part of President Biden's "Cancer Moonshot" initiative) is being seen as a strategic lifeline for independent practices. OneOncology, for instance, required that 100% of its practices join the model. Further, the selling point of getting into value now is that, if such models were ever made mandatory (however unlikely), there would be a huge leg up to whichever practices have value-based experience.

So what for LHS? OneOncology's entire business model (and political advocacy program) is aimed at offering community-based cancer care "at a dramatically lower cost than hospitals." It has been able to convince a growing number of independent practices to sign on. Notably, while the vast majority (65-70%) of medical oncologists are aligned with community or academic hospitals, the remainder of the market is growing highly consolidated. The 2% of practices owned by MSOs represent 10% of total oncologists due to the rapid growth of PE-backed platforms. With the growth of McKesson's US Oncology, OneOncology, **Silver Oak**-owned **Integrated Oncology Network** and **KKR**-owned **GenesisCare**, these MSO platforms have been quickly growing volumes.

Figure 1: National Hematology/Oncology Workforce Distribution



Source: Chartis analysis of Medicare Physician Compare Database for hematology/oncology

There is certainly a ceiling of how many oncology volumes they can likely capture. Notably, for patients with rarer or more complex cancers, a large system or AMC is often the most attractive (or only adequate) option given specialized needs. But for the broader market—the growth of these networks is siphoning patients away from LHS. These volumes are particularly notably given how many LHS rely on the 340B program to cross-subsidize important community care and how many LHS have turned to specialty pharmacy as a growth opportunity.

In addition, payers looking for more leverage and lower costs have been steering patients to smaller networks and independent clinics, siphoning away relatively lucrative business for LHS. **Optum** has even created its own cancer centers in Las Vegas as it seeks to move oncology services into the home. Many other payers have been expanding oncology medical home models.

All told, this is somewhat a story about Amerisource wanting more leverage with specialty pharmacy distribution. But the fact that a major drug distributor is willing to wade into value-based community cancer care also signals that they believe in the continued growth of oncology volumes into lower-cost community, home- and value-based programs. It adds to the urgency of LHS to ensure sufficient oncology offerings in ambulatory sites of care and to consider value-based oncology bundles offered direct-to-employer in partnership with companies like **Carrum**.

2. Lawsuit alleges Univ. of Iowa shared PHI with Facebook

A new lawsuit filed against the **University of Iowa Hospitals & Clinics** (UIHC) alleges that the health system shared confidential PHI with **Facebook** in an "intentional, reckless and/or negligent disclosure"—allegations that UIHC strongly rejects.

The details of the allegations, according to the filing, are that UIHC included code on its websites that collected information on website visitors for marketing purposes and shared that information with Facebook, which then allowed that information to be used for the purposes of targeted advertising purportedly tailored to their medical issues. The allegations are similar to "Meta Pixel" lawsuits that have hit dozens of the largest LHS in the country earlier this year including **Advocate Aurora Health**, Raleigh, N.C.-based **WakeMed**, Dallas-based **Steward Health Care System,** and two of the largest Louisiana-based systems, **LCMC Health** and **Willis-Knighton Health** (we also covered similar lawsuits against **Novant**, **UCSF**, and **MedStar** in an earlier edition of *The Strategist* last year). However, it also expands the complaint to include Facebook "conversion APIs," a relatively new form of internet activity tracking that thwarts many of the privacy and ad-blocking technologies commonly in use by consumers concerned about their privacy.

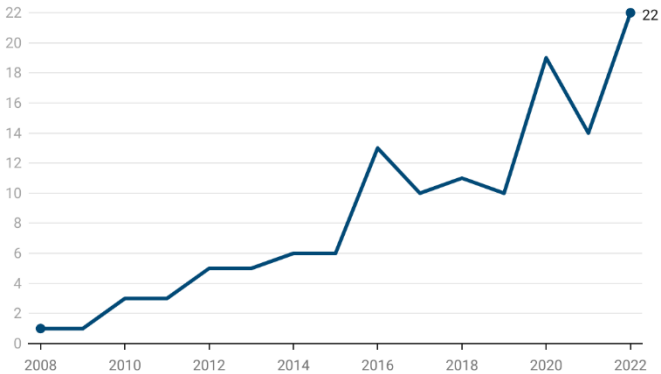
According to the complaint, the code was present on two websites that the health system operates to allow patients to book appointments, procure information on conditions and treatment, and sign up for events and classes. Denying the allegations, the health system issued a statement stating that the "University of Iowa Health Care is committed to protecting patient privacy. We do not share protected health information of our patients with Meta or Facebook. We will review the lawsuit once received."

So what? The continued growth of patient lawsuits over digital privacy practices is putting LHS on the defense as they expand to cover new complaints not previously contemplated by even seasoned healthcare IT teams. Rapid changes in digital technology (down to the exact code Facebook asks marketing partners to embed) and increasingly stringent consumer expectations are lowering the bar for what kinds of disclosures are considered negligent, an easier violation to accidentally commit than what is usually considered a privacy violation (like HIPAA violations which are relatively easier to avoid with the right processes in place).

While the lawsuit is a private matter for now, it follows recent notable cases of the FTC cracking down on digital health startups like **BetterHelp** and **GoodRx** (which we've covered in previous editions of *The Strategist*) for sharing sensitive patient data with marketing firms and lines up with our predictions that this kind of elevated scrutiny about PHI and online marketing is going to impact the industry more broadly, including many legacy incumbents that may have a false sense of

HIPAA enforcement on the rise with new funding, staff

Number of penalties issued by HHS for HIPAA violations, by year



Source: HHS Office of Civil Rights • Created with Datawrapper

security about how legally airtight their current practices are with respect to patient information.

According to a recent *Health Affairs* paper we cited in last edition's ICYMI roundup, liability-generating third-party tracking on hospital websites is an incredibly widespread, possibly present on 98.6% of all hospital websites, according to the authors' methodology. While there's some kind of herd-like safety in numbers as far as federal enforcement is concerned, the growing number patient lawsuits surrounding these kinds of practices are likely to draw more attention and possibly encourage regulators to set their targets on more traditional providers. Three makes a trend—and with growing patient lawsuits, newly punitive FTC activity, and rising HIPAA enforcement, the direction seems clear.

It's also worth noting that many of the tech-enabled competitors elbowing their way into the market are still willing to make some pretty risky moves in this area, or at least try new ways of mitigating that risk. Take, for example, **Amazon's** move to insulate its Amazon Clinic service from legal risk by asking consumers for a far broader set of permissions to use their data, authorizing Amazon to have the "complete patient file" and notes that the information "may be re-disclosed," after which it "will no longer be protected by HIPAA."

Consumers might be somewhat accustomed to blindly signing away those privacy rights to Big Tech companies, but traditional providers (with a strong culture of iron-clad PHI safety) clearly are much more cautious. These lawsuits add weight to the ever-thinning tightrope LHS are walking between wanting to personalize patients' care experiences with available data and having well-founded concerns about how such moves could expose systems to legal or reputational risks.

Other News to Know

1. Growing bipartisan momentum is making full site-neutral payments more possible

- Bipartisan congressional lawmakers on the House Energy and Commerce Committee are signaling interest in proposals to add site-neutral payment polices to Medicare, in line with MedPAC recommendations, and the new **Alliance for Site Neutral Payment Reform** is collecting a list of influential allies across the political spectrum.
    - Proponents of the policy joining forces now include experts belonging to the influential conservative think tank **Americans for Prosperity**, the liberal-leaning **Progressive Policy Institute,** the centrist **Brookings Institution**, and the libertarian-minded **American Enterprise Institute**. Hospital groups, led by the **AHA** and **FAH**, continue to push back.
    - Similarly, the **Blue Cross Blue Shield Association (BCBSA)** just commissioned a large study on the policy and financial savings that it has been sending to members of Congress.
    - The change would be truly massive in dollar terms: according to the nonpartisan Congressional Budget Office in 2020, the policy would save Medicare $140B per year over the next decade. Because the CBO is Congress' official budgeting scorekeeper, reducing that spending (and likely redirecting it elsewhere) is a juicy target for lawmakers.
- ***So what?*** If implemented, the long-debated reform would most obviously cause a large loss of revenue for hospital systems, many of which have been able to keep practices on the

HOPD fee schedule due to a grandfathered status (when policies changed in 2015) or due to construction near hospital campuses. The change would therefore reduce outpatient revenue (especially specialty revenue), especially if policies were adopted to possibly reduce HOPD surgeries to ASC rates.

- Of course, the fight over site neutrality has been raging for years, with any changes likely to continue to cause legal battles in the courts. That being said, the recent movement has led policy experts to suggest that a real change could be coming.
  - Politically, it would be a sign of declining clout for LHS and it would be noteworthy if such a fiercely contested change could make it through such a narrowly divided Congress.
- However, if actually implemented it would consequently launch a sea change in Medicare policy and the associated economic incentives around site-of-care choices and provider ownership. Further, it might provide further justification for commercial payers to adopt a similar approach.
- The change could reshape M&A activity by reducing the incentive to open facilities near hospital campuses and rather consider diffuse ambulatory sites. More importantly, it would likely speed up the transition to ASCs and require substantial strategy changes to medical group compensation and alignment.

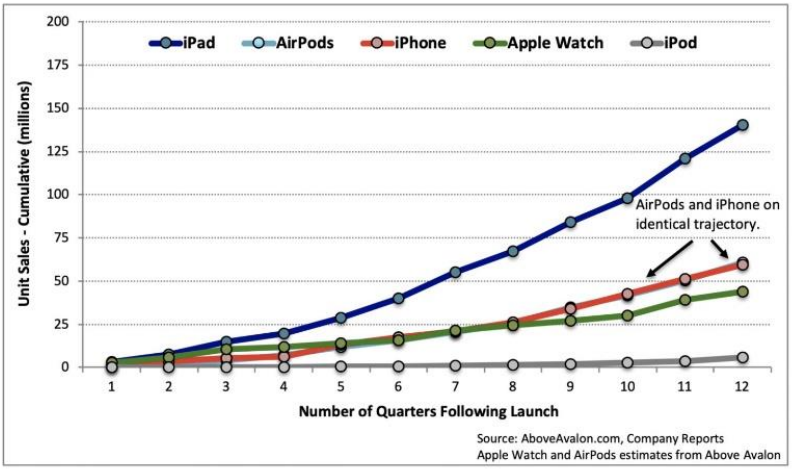
2. CVS and Catholic Health form new partnership on ACO REACH

- The retail giant **CVS** is collaborating with Long Island, NY-based **Catholic Health** to participate in CMMI's ACO REACH program, jointly assuming responsibility for nearly 40k Medicare FFS beneficiaries.
  - The deal follows a similar agreement earlier this year with Chicago-based **Rush Health**, announced last January.
  - According to CVS's corporate website, the disruptor covers more than 80k aligned beneficiaries in ACO REACH across 4,000 providers and more than 800 CVS MinuteClinic locations as of the beginning of the year.
    - This makes CVS one of the largest participations in the program.
- ***So what?*** After many partnerships between LHS and CVS to co-brand or co-offer retail sites have generally fizzled, this is an interesting 2.0 version of a partnership model. The arrangement is unusual in that the systems are network partners of CVS, rather having their own ACOs. In this way, it seems like CVS is admitting that it doesn't have sufficient resources to provide a full suite of services to patients in the program so is working with the health system as a preferred partner. We're not sure of the terms of the risk-sharing.
  - This could be a way for the health systems to get involved in taking on some risk without being left fully on the hook. Another similar structure is **Allina Health** and **Pearl Health**, which have partnered to operate in an ACO under the Allina name.
  - From CVS' view, this is a sign that the disruptor wants to scale its VBC programs beyond just Oak Street's ACOs. It's another step in CVS's goal to become a platform for providers looking to transition to VBC, as the corporate giant seeks to shift from a retail model to take on full-scale risk.

3. Apple plans AI-powered health coach as Chat-GPT outperforms doctors

- Tech giant **Apple** is quietly working on a AI-powered health coaching service codenamed "Quartz" as part of a broader push into health and wellness that includes new apps and a mood tracker.
    - It's the latest escalation in the AI-powered arms race by tech giants to move into healthcare, following the unveiling earlier this year of an AI-powered clinical documentation service by **Microsoft** and **Nuance.**
    - AI-powered apps like **Open AI's** Chat-GPT are increasingly proving their worth in the healthcare space, including a recent provocative study that found that the general purpose chatbot outperformed real doctors in a test of diagnostic accuracy and empathy judged by a panel of licensed physicians.
- ***So what?*** As judged by the actions of the tech giants, healthcare appears to be one of the most promising areas for new AI-powered writing and listening technologies, and Apple is merely the latest to take this possibility seriously.
    - This is concerning to many LHS strategists who may have skepticism about the clinical safety of their use, but also exciting to many given the potential applications within the wider healthcare system. Widespread (safe) AI-enabled health coaching, particularly for those with chronic conditions, could significantly free up clinician time.
        - As the *JAMA* study cited above shows, this future may not be as far away as expected. However, substantial questions remain about whether patients want AI to serve as their doctor or coach.
    - Apple's position in wearable healthcare devices is also looking stronger after news that **Amazon** recently shuttered its Halo health tech division. Amazon cited the increasingly crowded market as a reason to bow out, but it also comes as the company is planning layoffs and restructuring other businesses in response to recent tough economic headwinds.
    - Apple's stellar, unique reputation in consumer electronics is hard to ignore, so it might ultimately find more success than other giants wading into the wearables market. It's important to remember that the company's approach to product launches and product iteration is built around long-term success: the iPod, iPhone, iPad and Apple Watch all sold slowly during the initial quarters after launch.

Exhibit 1: Unit Sales out of the Gate



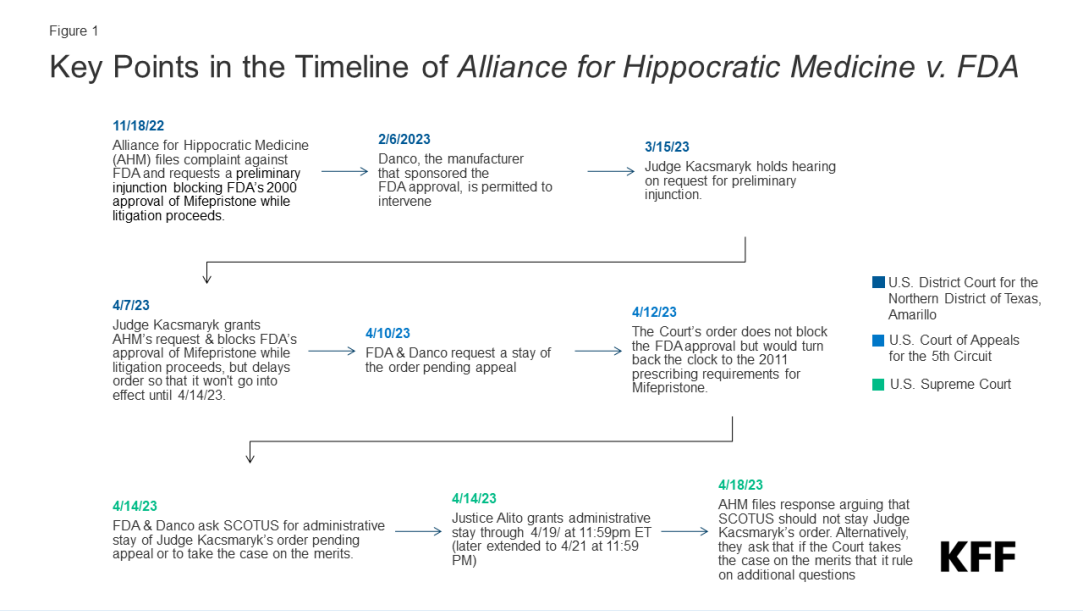
In Case You Missed It

The Milbank Quarterly — *Century-Long Trends in the Financing and Ownership of American Health Care*

- A fascinating overview of healthcare financing that uses data from the **AMA**, **AHA**, government publications and other surveys to trace the rise of government payers and for-profit ownership across a number of key service sites.

Kaiser Family Foundation — *Update on the Status of Medication Abortion and the Courts*

- A detailed overview of the conflicting rulings on the FDA's legal ability to approve and regulate abortion bills, emanating from federal district courts and quickly heading to the Supreme Court.



JAMA — *Comparing Physician and Artificial Intelligence Chatbot Responses to Patient Questions Posted to a Public Social Media Forum*

- In another test of the AI capabilities of **Open AI's** Chat-GPT, a new study suggests the chatbot can outperform human physicians in answer users' online health questions, as judged by a panel of licensed physicians who considered both the quality and the empathy of the responses.

Modern Healthcare — *Health systems in limbo as Medicaid redeterminations get underway*

- This interesting article from **Modern Healthcare** covers the early fallout in the states already removing beneficiaries from Medicaid rolls through redetermination, with vignettes describing how health systems across the country are handling the change.

GoodRx Health — *More Than 16 Million Black Americans Live in Counties With Limited or No Access to Cardiologists*

- More than 16.8M Black Americans live in counties with limited or no access to cardiology specialists, according to this new report by the telemedicine provider, highlighting gaps in care delivery that potentially contribute racial disparities.

IQVIA — *The Use of Medicines in the U.S. 2023*

- The pharma and clinical research service company's annual report gives one of the most comprehensive overviews of the state of drug distribution, finding that utilization has finally equaled pre-pandemic levels for the first time.

In the Numbers

80% of Medicare payments for personal care, homemaker and home health aide services would need to go towards wages (at the minimum) under a new proposed rule released last week by CMS.

65 new hospitals have been planned in Florida between 2020 and 2022 after the state changed its Certificate of Need (CON) process in 2019. From 2016-2018, the state had approved just 20 hospitals.

15% smaller average payments are paid to providers by market-leading insurers in less competitive markets compared to the same insurers in the most competitive markets, according to a new study in *Health Affairs*.

50% of all eligible Medicare beneficiaries were enrolled in MA plans as of January 2023, surpassing traditional enrollment for the first time, according to a new **KFF** analysis.

43% of physicians say they regret their career choice, according to a new survey published in a collaboration between the **AMA**, the **Stanford University School of Medicine** and the **University of Colorado School of Medicine**.

1 in 3 female high school students said they had considered suicide in 2021, according to the latest edition of the CDC's national Youth Risk Behavior Survey.

Idea of the Week

"ChatGPT cannot be an author. Only humans take responsibility for what they publish. Only humans can talk about their conflicts of interest, can say, 'Yes, I've looked through all of these citations.' So our position is only humans can be authors."

- Dr. Kirsten Bibbins-Domingo, MD, PhD, MAS, editor-in-chief of JAMA and JAMA Network™