Wharton ALUMNI CLUB
UNIVERSITY of PENNSYLVANIA

Health Care Management Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

WINTER 2023, VOLUME 12, NUMBER 1

TABLE OF CONTENTS

IN EVERY ISSUE

FEATURED ARTICLES

IN UPCOMING ISSUES

Behavioral Economics in Consumer Purchases of Health Insurance - Part 2

QUICK LINKS

Join Our Mailing List

Upcoming Events

Wharton Healthcare Management Alumni Association

Penn Connect

GET INVOLVED

Have an article to contribute or words of wisdom for the Philosopher's Corner?
Send us an Email.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

EDITOR'S LETTER

Z. Colette Edwards, WG'84, MD'85
Managing Editor

To learn
more about Colette, click here.

Happy New Year!

With the start of 2023, I'd like to thank all who participated in the Wharton Healthcare Quarterly's 10-year anniversary. The anniversary theme was "Celebrate the Past and Embrace the Future." With a celebration which included a monthly webinar series, LinkedIn interviews, special "Anniversary Spotlight" articles, an eBook (The Philosopher's Corner), and video launch, we're looking forward to the next ten years!

Now that we've celebrated the past, there's no time like the present to embrace the future. So, let's get started!

"The best way to predict the future is to create it."
~ Abraham Lincoln

Z. Colette Edwards, WG'84, MD'85
Managing Editor
Contact Colette at: colette@accessinsightmd.com

THE PRESIDENT'S DESK

Heather Aspras, WG'08
To learn more about Heather, click here.

By the time you read this issue of the *Wharton Healthcare Quarterly*, we will already have rung in the new year. As 2023 opens, I can't help but reflect on the journey we've all collectively been on over the past 3 years. Though a lot of life has returned to somewhere near normal, one area in which we're seeing long-lasting impact is in mental health.

Prior to the pandemic, 11% of U.S. adults had symptoms of anxiety or depression. After nearly a year of the pandemic, that number shot up to 41%. Though the impact has subsided slightly, in 2022 a full third of U.S. adults were still experiencing symptoms. That means a large number of us reading this letter have personally experienced anxiety or depression in the past year, or if we haven't experienced them directly, our loved ones certainly have.

And it's not difficult to understand why. There have been the direct effects of the pandemic, with many people losing loved ones and experiencing the stress of trying to avoid getting ill and getting long COVID. There has also been the "meta" stress of having to constantly reevaluate a changing situation to determine what you're comfortable with, along with the stress of navigating relationships with family and friends who may evaluate the risk differently. In addition, everyone has experienced their lives being disrupted for years, missing celebrations, and missing rites of passage, as well as missing the small day-to-day interactions that make up "normal" life.

Even before the pandemic, the U.S. had too few mental health providers to meet the needs of people with anxiety and depression. According to data from the Kaiser Family Foundation, more than 25% of the population in the U.S. lives in an area with a shortage of mental health professionals.

The causes are many. The U.S. population has grown faster than the number of residency slots required to train enough doctors in psychiatry. In addition, providers are retiring, given that about two-thirds of psychiatrists are 55 and older.

But there are signs of hope. The number of available psychiatric residency spots has been increasing, as have the number of applicants. Telehealth has also made mental health services more accessible. Virtual visits eliminate the need to take as much time to travel to the therapist's office physically, making it much easier for people to integrate appointments into their lives. In addition, people who live in underserved communities have access to more providers when untethered from physical location. Unsurprisingly, as telemedicine has declined to a much lower portion of overall healthcare, about 40% of mental health services are still being delivered virtually.

There is still more work to be done and more progress to be made. But the growing recognition of mental health as something that impacts everyone and something that is important to care for, is an important first step.

Kind regards,

Heather Aspras, WG'08
President, Wharton Health Care Management Alumni Association

Contact Heather at: haspras@gmail.com
LinkedIn Profile

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

ALUMNI NEWS

Michael Brodie, W'78, WG'84
I have entered semi-retirement. That does not mean I have stopped working, but I now have a partner for Michael Brodie Senior Placement, which finds suitable senior living environments for my clients. I continue to work as an expert witness in the long-term care field and am developing a small business speaking on current events in independent living communities. Last month's subject was: "The U.S. National Cultural Characteristics and Why They Failed Us Utterly in Confronting the Pandemic."

Semi-retirement means I play golf 3 times a week and do lots of other healthy activities in our community, and work gets to fill the remaining hours. I have less spare time than ever and am loving it. My wife, Abby, is fully retired since August this year, leaving us more time for visiting our three grandchildren and other travel.

Learn more.

Contact Michael at:
Mbseniorplacement@gmail.com

ALUMNI NEWS

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

THIS MONTH'S PHILOSOPHER:
Katie Ellias, WG'06

To learn more about Katie, click here.

THE PHILOSOPHER'S CORNER

Katie Ellias, WG'06

LIFE LESSONS
If I knew then what I know now, I would have...

relaxed about the idea that you need a specific and detailed career plan to be successful. From early on, I felt self-conscious when others would describe their five, ten, or twenty year "plans." I could imagine certain scenarios playing out over time, but I struggled with the idea of what I wanted to do or be far (or not so far) into the future. Over time, I've embraced a new philosophy that feels more authentic for me and hasn't let me down – follow the interesting work and the inspiring people, and it will bring you great learning, leaving you continually energized about what you do. I never would have predicted I'd end up in venture capital for over a decade and counting, or live in Europe 12 years, but following the thread of being opportunistic and being a student of others has taken me on an unforgettable and rewarding journey. Be open to life's adventures, even if they don't fit your "plan."

If I knew then what I know now, I would NOT have...

focused as much on my weaknesses as on my strengths. We spend a lot of time in our academic (and sometimes work) lives overemphasizing the areas where we are struggling or less apt. Playing to your strengths and identifying what you can uniquely do best or how you can add differentiated value, will bring rewards. The same discipline applies to a venture portfolio: the "problem children" aren't usually the ones with the big returns, so prioritize your energy and capital on the winners, even if that is a painful exercise in the moment. I continue to fight the ingrained urge that we all are supposed to be perfectly well-rounded, or every project deserves equal attention, but we deliver our best to our teams and organizations when we figure out how to leverage our superpowers in ways that others can't and figure out who can take care of the rest. It can take a while to get comfortable thinking of yourself as having unique talents, but recognizing how to put yourself in situations where you can bring your best self, and allow others to do the same, is critical.

FAVORITE QUOTES

1. "Hope is not a strategy." ~ Unknown
   Spending time to break down how you can achieve your goals into discrete steps is critical to understanding risks and developing balanced and targeted plans. It is important to go through the exercise of understanding what information, or motivations and beliefs, will lead you to your desired outcomes, and what incentives or elements you might have overlooked.
2. "In God we trust; the rest must bring data." ~ W. Edwards Deming
   Early in my venture career, another Wharton alum, partner, and mentor of mine, Antoine Papiernik, President of Sofinnova Partners, said this frequently

THIS MONTH'S PHILOSPHER:
Katie Ellias, WG'06

To learn more about Katie, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

THE PHILOSOPHER'S CORNER

during our diligence process. For me, it speaks both to the key of challenging your assumptions and keeping yourself grounded in the facts when you analyze an opportunity. People talk about investors using their "gut." I believe your gut begins to emerge after years of detailed analysis of companies and industries, and it is more pattern recognition than instinct.

3. "What's the magic word?" ~ All parents everywhere
   There can never be enough kindness and compassion in the world. Relationships and human interactions have a huge impact on what we can all achieve. There are people behind every action and decision, and we all deserve respect and understanding for our efforts.

RECOMMENDED READING

1. *Complications* by Atul Gawande (or really anything by Atul…)
2. *Genome: The Autobiography of a Species in 23 Chapters* by Matt Ridley from 2006 (lay-friendly explanation of our genes and how and why they work; even if slightly outdated, still a great read)
3. *Third Culture Kids 3rd Edition: Growing up among worlds* by Ruth Van Reken, Michael Pollock, and David Pollock (handy for bringing up or working with people with mixed cultural backgrounds)

Contact Katie at:
katie.ellias@gmail.com

THIS MONTH'S PHILOSPHER:
Katie Ellias, WG'06

To learn more about Katie, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

AFFIDAVIT: HEALTHCARE AND THE LAW - BEWARE OF HEIGHTENED HEALTHCARE M&A ANTITRUST SCRUTINY

Source: Bigstock

Mergers and acquisitions ("M&A") are obviously important strategic tools for businesses in the healthcare space, and there are good policy reasons why such combinations benefit society. For example, M&A transactions often result in substantially improved quality and access to healthcare in many small and rural communities that would otherwise have minimal options. However, healthcare organizations need to pay particularly close attention to the views of regulators on this subject. Recently, the federal government has applied increased scrutiny to healthcare M&A transactions, and state attorneys general are following. This focus certainly applies to hospitals and health systems, but also other healthcare businesses, including, for example, pharmaceutical companies, pharmacy benefits managers, and other players in the healthcare supply chain. The entire healthcare industry should thus be mindful of these changes even at the very earliest phases of transaction planning.

ANTITRUST M&A REGULATION GENERALLY

For more than a hundred years, federal antitrust laws have prohibited M&A transactions that increase prices, lower the quality of goods and services, and stall innovation by unreasonably impeding healthy competition among competitor firms.[1] According to the Federal Trade Commission ("FTC"), the "greatest antitrust concern arises with proposed mergers between direct competitors (horizontal mergers)," which may be especially "likely to create or enhance market power or facilitate its exercise."[2] Combinations that may unlawfully impede competition can be stopped, or even reversed, by the government, including the FTC, Department of Justice ("DOJ") Antitrust Division, and state attorneys general.[3]

RECENT TRENDS IN GOVERNMENT ENFORCEMENT

Increased scrutiny under President Biden. The Biden administration is specifically prioritizing antitrust scrutiny of healthcare mergers. In June 2021, the FTC, led by new FTC Chair Lina Khan, passed a resolution that made procedural changes to the FTC's investigative priorities, calling for investigations into "healthcare businesses such as pharmaceutical companies, pharmacy benefits managers, and hospitals."[4]

In July 2021, President Biden issued the "Executive Order on Promoting Competition in the American Economy" that initiated a broader federal crackdown on healthcare and other M&A activity. The Executive Order argued that consolidation in the healthcare sector had led to increased prices and lower quality of care:

> "Americans are paying too much for prescription drugs and healthcare services — far more than the prices paid in other countries. Hospital consolidation has left many areas, particularly rural communities, with inadequate or more expensive healthcare options. And too often, patent and other laws have been misused to inhibit or delay — for years and even decades — competition from generic drugs and biosimilars, denying Americans access to lower-cost drugs."[5]

The Executive Order instructed federal agencies, including the FTC and DOJ, to more strictly enforce the antitrust laws in healthcare.

Implementation by federal regulators. The agencies have listened. The past year has brought more lawsuits challenging proposed M&A transactions and other, more abstract and long-term policy changes from the government.

Most concretely, federal regulators have increased legal scrutiny of mergers and sued to block them, including the FTC's recent success in blocking two hospital mergers in New Jersey and Utah. In June 2022, RWJBarnabas Health — a 12-hospital system in New Jersey — halted its acquisition of the smaller St. Peter's Healthcare System after the FTC sued to block the deal.[6] The FTC there alleged the transaction would raise prices and hurt patient care because the parties to the merger were competitors, and their merger would over-concentrate market power.[7]

The FTC also sued to block HCA Healthcare, a large health system in Utah, from acquiring five hospitals from the Steward Health Care System hospitals in the Wasatch Front region of Utah, and HCA then determined not to proceed.[8] There, the FTC alleged that "[a]s the second and fourth largest healthcare systems in the Wasatch Front region of Utah," "HCA Healthcare and Steward Health Care System help to keep costs down for consumers by competing vigorously with each other," and the "result is lower prices and more innovative services for patients and their families."[9] The FTC then claimed that if "these companies merge, this competition will be lost, and Steward will no longer be available to patients as a low-cost provider in this region."[10]

Most recently, the *Wall Street Journal* reported that the FTC is investigating U.S. Anesthesia Partners, one of the country's largest anesthesia providers, in order to examine the company's rapid growth in the context of alleged market power in the Southwest.[11]

The FTC has also recently issued broadly applicable policy guidance that would make the antitrust enforcement in healthcare mergers stricter. For instance, in August 2022, the FTC released a policy paper entitled "FTC Policy Perspectives on Certificates of Public Advantage."[12] Certificate of Public Advantage ("COPA") laws "attempt to immunize hospital mergers from antitrust laws by replacing competition with state oversight" and generally "facilitate hospital consolidation."[13] The FTC's policy paper sought to discourage these agreements with state regulators and shows the extent to which the FTC is taking a broad-based, long-term approach to changing healthcare M&A antitrust enforcement.

State-level scrutiny. State regulators have followed suit. In late 2021, a group of 26 state attorneys general supported the FTC's lawsuit in *Federal Trade Commission v. Hackensack Memorial Hospital*, arguing that the hospital merger would have reduced competition and led to higher prices and lower quality healthcare.[14] The state attorneys general joined the FTC, alleging that the merged system would result in control of three out of the six inpatient general acute care hospitals in Bergen County, New Jersey, and that the "proposed acquisition would eliminate close competition between major New Jersey hospitals that would leave insurers with few alternatives for inpatient general acute care services.[15] State attorneys general have also appeared particularly focused on smaller healthcare mergers that may not have been on the federal radar.

CONTRIBUTORS:
Sean S. Zabaneh and Pat Gavin

To learn more about Sean and Pat, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

AFFIDAVIT: HEALTHCARE AND THE LAW - BEWARE OF HEIGHTENED HEALTHCARE M&A ANTITRUST SCRUTINY

KEY TAKEAWAYS FOR HEALTHCARE BUSINESSES

Although the torrid pace of M&A activity that defined the COVID era may be cooling down in light of higher interest rates, such activity in healthcare markets will undoubtedly continue. Here are some key takeaways for healthcare businesses to consider:

- **Early planning and consultation with subject matter experts.** From the earliest phases of M&A planning, organizations should work closely with their legal teams early and often to get in front of potentially perceived antitrust risks, including even the theoretical ways in which the merger might increase prices. Front-end planning will often involve the input of subject matter experts, such as economists, if the transaction poses particularly difficult questions. Early planning will reduce or eliminate significant delays and setbacks later in the process.

- **No merger is too small for antitrust scrutiny.** Do not assume your transaction is not significant enough to draw scrutiny. The federal government has demonstrated through its scrutiny of the attempted St. Peters acquisition, that it will pursue even acquisitions of local providers. State regulators may focus even more on smaller mergers in order to fill gaps in federal enforcement.

- **Past mergers are not out of the woods.** Even though the federal government's efforts have focused on new M&A activity, past combinations that have been consummated are also at risk of potential divestiture or reversal.

CONCLUSION

M&A is a crucial tool for businesses in the healthcare sector. With good planning from the early phases of the process, healthcare businesses can avoid or mitigate some of the risks and headaches that might come along with scrutiny from regulators down the line.

Contact Sean at: sszabaneh@duanemorris.com

Contact Pat at: pjgavin@duanemorris.com

Disclaimer: This article has been prepared and published for informational purposes only and is not offered, nor should be construed, as legal advice.

REFERENCES

1. 15 U.S.C. § 18 (prohibiting mergers and acquisitions whose effect "may be substantially to lessen competition, or to tend to create a monopoly").

2. Federal Trade Commission, Guide to Antitrust Laws: Mergers https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/mergers (last accessed October 3, 2022).

3. See, e.g., United States Department of Justice, Merger Remedies Manual (September 2020), https://www.justice.gov/atr/page/file/1312416/download (last accessed October 3, 2022).

4. Federal Trade Commission, FTC Authorizes Investigations in Key Enforcement Priorities (July 1, 2021), https://www.ftc.gov/news-events/news/press-releases/2021/07/ftc-authorizes-investigations-key-enforcement-priorities (last accessed October 3, 2022).

5. Executive Order on Promoting Competition the American Economy (July 9, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/ (last accessed October 3, 2022).

6. Spencer Kent, 2 N.J. health systems call of merger after federal lawsuit, NJ.com (June 15, 2022), https://www.nj.com/healthfit/2022/06/2-nj-health-systems-call-off-merger-after-federal-lawsuit.html (last accessed October 3, 2022); see also Harris Meyer, Biden's FTC Has Blocked 4 Hospital Mergers and Is Posied to Thwart More Consolidation Attempts (July 18, 2022), https://khn.org/news/article/biden-ftc-block-hospital-mergers-antitrust/ (last accessed October 2, 2022).

7. Federal Trade Commission, FTC Sues to Block Merger Between New Jersey Healthcare Rivals RWJBarnabas Health and saint Peter's Healthcare System (June 2, 2022) https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-sues-block-merger-between-new-jersey-healthcare-rivals-rwjbarnabas-health-saint-peters (last accessed October 3, 2022).

8. Federal Trade Commission, FTC Sues to Block Merger Between Utah Healthcare Rivals HCA Healthcare and Steward Health Care System (June 2, 2022), https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-sues-block-merger-between-utah-healthcare-rivals-hca-healthcare-steward-health-care-system (last access October 3, 2022).

9. Id.

10. Id.

11. Dave Michaels, FTC Probes Market Power of One of Country's Biggest Anesthesia Providers, Wall Street Journal (October 1, 2022), https://www.wsj.com/articles/ftc-probes-market-power-of-one-of-countrys-biggest-anesthesia-providers-11664644401 (last access October 3, 2022).

12. Federal Trade Commission, FTC Policy Paper Warns About Pitfalls of COPA Agreements for Patien Care and Healthcare Workers (August 15, 2022), https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-policy-paper-warns-about-pitfalls-copa-agreements-patient-care-healthcare-workers (last access October 3, 2022).

13. Federal Trade Commission, Key COPA Facts, https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf (last access October 3, 2022).

14. See https://www.ftc.gov/system/files/documents/cases/de_91_-_amicus_states_brief.pdf (last accessed October 3, 2022).

15. Federal Trade Commission, In the Matter of Hackensack Meridian Health, Inc. and Englewood Healthcare Foundation (updated July 6, 2022), https://www.ftc.gov/legal-library/browse/cases-proceedings/2010044-hackensack-meridian-health-inc-englewood-healthcare-foundation-matter (last accessed October 3, 2022).

CONTRIBUTORS:
Sean S. Zabaneh and Pat Gavin

To learn more about Sean and Pat, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

DOWNLOADING SUCCESS: MAKING A CAREER MOVE - IS IT RIGHT FOR YOU AND YOUR FAMILY?

Changing jobs is both exciting and nerve-wracking. Candidates often ask for advice about how to assess whether or not an opportunity is right for them. After nearly two decades in and around healthcare recruiting and executive search, I typically offer the following guidance.

DEFINE YOUR MOTIVATION

When assessing your fit for a particular job, there are personal as well as professional considerations. First, you should deeply understand your motivation for considering the role. Does it represent a logical career progression that is aligned with your overall career objectives? Consider if your professional timeline, energy, and passion truly align with the needs of the organization and the community.

EXAMINE THE CULTURE

Do you genuinely like and enjoy the interactions you've had with your potential new colleagues? Think about this: at the end of a grueling week, will you be around people you enjoy? Would you mind being in the trenches with them — or would you be running for the closest exit? I'm not suggesting you have to be best friends with everyone, but you should trust your gut about the team dynamics and decide if they're simpatico with how you operate.

IDENTIFY MEASURES OF SUCCESS

I believe it is a good idea to ask your potential new boss about what types of people have experienced success in the organization. Why were they successful? Was it skill or style? Listen closely to the responses and be honest with yourself about your skills, style, and personality as it relates to how they define success. While new ideas are important to bring to the table, it is important to look historically at what types of folks have experienced success, made an impact, and enjoyed longevity in the organization.

EXPLORE THE COMMUNITY

Now, step outside of the work setting and explore the community where you will presumably be asked to live. Does it offer most of what you and your family enjoy? If the answer is no, you should carefully consider your quality of life. For example, if going to Broadway style shows is important and you are hundreds of miles from the nearest theater, I suspect this will create a bit of unhealthy tension.

If you have children, does the community offer schools, childcare, and support programs that are personally important to you? Does it offer a place of worship for you to connect, engage, and honor your faith? These are often major issues, if not total deal breakers. For example, if your child or spouse/partner have particular wants and needs and the resources to support those needs are limited in the community, this will inevitably create resentment, and usually a very short tenure. Most organizations are happy to align you with colleagues in similar situations or connect you with a member of the community to offer guidance in these areas, so don't hesitate to ask for introductions.

Being honest with yourself about these elements will undoubtedly ensure a smoother transition and longer tenure with an organization, as well as deeper connections with the community.

NAME YOUR NON-NEGOTIABLES

I recommend making it clear to the hiring leader and others throughout the interview process what elements of professional development, personal connection, and community fit are important to you so there is ample time for reflection, guidance, and response on these topics.

Changing jobs and moving to a new community have a profound impact on so many people that it is well worth spending a little extra time in evaluating the fit from every angle. When assessed correctly, it often results in a fulfilling career move as well as a joy-filled connection in the community, ultimately leading to deeper dedication and longer tenure.

TAKE CALCULATED RISKS

I certainly recognize that for great reward there is often associated risk. My appeal: trust your instincts, do your research, ask questions, and ultimately take as calculated a risk as possible to ensure the least disruption and highest satisfaction for all involved.

Over the years, I have asked dozens of CEOs and Board members about "fit" and consistently hear their priority is to ensure a candidate and their family are fully satisfied with the opportunity and would rather have an opt-out in the interview process rather than accepting a job only to find dissatisfaction resulting in a short and disruptive tenure.

Contact Dan at: dyoung@wittkieffer.com

CONTRIBUTOR:
Dan Young

To learn more about Dan, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

CYBERVITALS: CYBERSECURITY INSURANCE - PLACEBO OR PAINKILLER?

With the healthcare sector remaining a top target for cybercriminal activities, one of the emerging trends over the last few years has been around cybersecurity insurance. **To be clear,** I'm not a lawyer or an insurance specialist, but as an executive of a small business focused on medical device cybersecurity, I've certainly encountered this strategy and observed a few things.

Risk management experts agree that cybersecurity insurance can help, but the evolving landscape for both attackers and defenders, in conjunction with a lack of historical data for modeling, means both insurers and consumers are facing unpredictable risks.

WHAT IS CYBERSECURITY INSURANCE?

A relatively new product in the insurance market, cybersecurity insurance '...enables business to mitigate the risk of cybercrime activity…'. Similar to other insurance practices, the idea is to shield enterprises when an exploit or incident occurs with a root cause in cybersecurity.

WHAT MAKES THIS DIFFERENT IN HEALTHCARE?

A recent study from Ponemon noted that 57% of attacks experienced by healthcare provider organizations resulted in adverse impacts on patient care. This speaks directly to what the FDA has been citing for years - cybersecurity is patient safety.

Most healthcare systems were not initially designed to be connected. Devices started out as analog, then as software 'became a thing,' the potential for improved clinical experiences emerged. Suddenly a modicum of data standardization meant patient health information could be more easily shared across the value chain. Rapidly adopting the USB, then the Internet, to Bluetooth, and now mobile/app-based care, the adoption of connectivity has been quick.

The focus at every step, and justifiably so, was on enhancing the patient care experience. But this means we have built an ecosystem of connectivity without clear ownership of the increased burden of connectivity and the potential cybersecurity vulnerabilities they introduced.

One such case is if a cybersecurity incident causes care delivery to be compromised, which means patients are rerouted to other institutions during emergencies or procedures are canceled/delayed. The attacks can also leverage data: as of September 2022, a hospital in France has been battling hackers holding data and releasing sensitive information on the dark web.

IS INSURANCE A SILVER BULLET?

No industry is immune from cybersecurity-related vulnerabilities; but given the lack of historical data, it can mean that cybersecurity insurance in healthcare is more expensive because there is more uncertainty (not to mention the threat

landscape is constantly evolving, making it difficult to assess risk by insurers). This means pursuing cybersecurity insurance can become a cost-benefit analysis.

As the United States Government Accountability Office (GAO) notes in a report issued in May 2021, rates have significantly increased with diminishing coverage. The report further points out we haven't normed on the same lexicon - terminology and definition variability has resulted in presumed coverage being misaligned with actuality.

This hasn't necessarily deterred companies from pursuing cybersecurity insurance, but there has also been a change in requirements to obtain coverage. In particular, the diligence for meeting coverage requirements has increased and is constantly evolving. Which isn't a bad thing – insurance can certainly play a role as part of a multi-layered security strategy. However, it would be naïve to assume that insurance, and the related criteria required, is sufficient in building a defensive strategy that will persist with an evolving threat landscape.

HOW TO BUILD A STRATEGY AROUND CYBERSECURITY INSURANCE?

Starting with the basics, every organization should have an executive who owns the decision on mitigating cybersecurity risk, and, with that, accountability for the decision on pursuing insurance coverage or not. While the CEO is ultimately accountable, there will be a variety of inputs to that decision - requiring cross-functional coordination and collaboration.

When determining level of coverage, or even pursing coverage or not, cybersecurity frequently falls victim to the "show me what ***could*** have happened" narrative, i.e., $x has been spent in building security, but there have been no incidents to prove it worked. There are moments when cybersecurity spend will directly correlate to top-line revenue. But proving the defenses are the reason the incidents never occurred is a difficult task and can muddy the business case for cybersecurity.

In determining pursuit of coverage, it's important to assess whether the provider understands your niche of healthcare and the related risks. Between HIPAA, GDPR, and FDA expectations, the variability of impact on your specific business can be massive. But if it can be clearly defined because of existing regulatory environment constraints, perhaps the scope of exposure can be sufficiently defined.

Ultimately, healthcare has been suffering through a global pandemic, and cybersecurity is likely the next pandemic. Comprehensive and sustainable security strategies include prevention and mitigation spanning technology, people, and processes.

Contact Vidya at: vidya@medcrypt.com

CONTRIBUTOR:
Vidya Murthy, WEMBA'42

To learn more about Vidya, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

BEHAVIORAL ECONOMICS IN CONSUMER PURCHASES OF HEALTH INSURANCE - PART 1

When designing and pricing a healthcare product, it is not only important to know how to model frequency and severity, but it is essential to understand human behavior. Of course, the issue of anti-selection in medical insurance is well known, as individuals know more about their health and prior expenditures than an insurer does. Anti-selection on behalf of the consumer is rational and to be expected, but one must also anticipate non-rational behavior.

Source: Bigstock

Most individuals do not make rational economic decisions due to cultural, societal, psychological, and emotional reasons. There are many examples that show how individuals choose to avoid possible, but very unlikely, large losses over more likely but smaller gains.[1] Even among those who are highly educated, there is innumeracy when it comes to understanding statistical thinking, especially problems involving conditional probabilities.[2] As a result, people tend to choose financially inefficient or suboptimal products.

During my career as a health insurance actuary, I've come across various situations that illuminate the importance of understanding both rational and irrational behavior when designing and pricing health insurance products.

RELUCTANCE TO SWITCH CARRIERS

In October 1980, The Prudential Insurance Company of America [the Pru] was awarded the endorsement by the American Association of Retired Persons [now called AARP] to offer the Association's medical insurance products to its members as well as to members of NRTA, the National Association of Retired Teachers. Their portfolio consisted of more than 20 different indemnity products (e.g., paying $10 or $15 a day while hospitalized or $5 for an office visit and $3 for a lab test) and three reimbursement plans loosely tied to Medicare. The plans generated over $300 million in premium.

The award was considered quite newsworthy for two reasons. First, one of the largest and best-known life insurers was going to team up with one of the largest, most influential, national associations. Second, Pru was replacing Colonial Penn Insurance Company, which had been the sole provider of insurance products to AARP and NRTA members for over 20 years. Indeed, Colonial Penn was founded by a broker, Leonard Davis,[3] and others in 1958 specifically to sell medical insurance to NRTA members when no other company thought senior citizens were insurable. Recall that Medicare didn't start until 1965.

After a few years Colonial Penn thought, "Why limit ourselves to retired teachers?" and founded The American Association of Retired Persons, open to those over 60. The company not only sold insurance to this larger group, but it was deeply

involved in recruiting members and managing this new association, which, by 1980, was a force in the American political scene.

While Pru was, arguably, the largest group health carrier in 1980, Pru did not sell individual indemnity coverage, nor did it market to seniors nor by direct mail, which was the only way insurance was sold to AARP members. A new division within the Pru was created to service this new customer, and I, a newly minted Fellow, was asked to transfer there in January, 1981 as the division's actuary.[4] Typically in group insurance, the winning carrier takes over the group's insured members from the previous carrier. But in this instance, the Pru only won the right to compete with the prior carrier. Between May and July 1981 each policyholder had three opportunities to select either insurer for their current plans. Prudential touted the synergistic union of two large, well known organizations, while Colonial Penn, with their long history with AARP, urged members to stay the course with them.

So, what do you think happened?

The result was that 2/3 of the members chose the Prudential, generating over $200 million in annual premium, but claims were very slow in coming. It turned out Colonial Penn's 1/3 share generated 2/3 of the claims that year. Individuals who had been getting their claims paid by Colonial Penn in the past were more reluctant to change carriers. Many of the claims Pru received turned out to be for members who enrolled with both carriers. Since there was no coordination of benefits between the two carriers, these members realized they could receive double payments if they were hospitalized.

Prudential, however, did not make a windfall profit, as our winning bid guaranteed AARP at least a 75% loss ratio and an expense ratio below 25%.[5] Refunds to AARP based on these guarantees reduced premium rates in future years.

PRODUCT SELECTION IN MEDICARE SUPPLEMENT

Literally the day I began work at Pru's AARP office, we were faced with the need to design a new suite of Medicare Supplement plans to meet the new minimum standard as defined by the Baucus Amendment (adopted by Congress in June 1980). From my actuarial studies, I was aware that an insurer can experience anti-selection when offering consumers medical products that differ in obvious ways that permit individuals to take advantage of their known medical conditions. In general, consumers in better health choose a less expensive plan that requires higher copayments or meeting a higher deductible. The claims experience in these plans tend to be better than expected, while the experience in the more expensive plan tends to be worse than expected. As a result, when the plan premiums are re-rated in future years based on experience, the premium differentials get out of whack quickly.

After conducting focus groups, we designed four plans with increasing benefits, but not all plans had the same benefits, thus making it harder to compare plans (e.g., private duty nursing or vision benefits may have been covered in one but not another). Those plans remained pretty much intact until new legislation in 1992 created ten standard plans. But those standard plans built on one another in obvious ways. For example, Plan B differed from Plan A only by adding coverage for the inpatient hospital deductible [IHD]. Of course, Plan B would cost more than Plan A, as some members would incur a hospital stay, but as a result of consumer selection,

CONTRIBUTOR:
Roy Goldman, PhD, FSA, MAAA, CERA

To learn more about Roy, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

BEHAVIORAL ECONOMICS IN CONSUMER PURCHASES OF HEALTH INSURANCE - PART 1

it is not unusual to find the difference in the annual premium for these two plans to be greater than the current IHD [$1,556 in 2022]. That is, the member is paying more in premium than the deductible he/she would have to pay if hospitalized. Of course, a beneficiary could have more than one benefit period and, thus, be responsible for more than one IHD in a calendar year under Plan A.

Perhaps a clearer example is Plan F vs. Plan F* [High Deductible Plan F]. F* pays all the same benefits as F but only after the insured pays an annual deductible of $2,490 [in 2022] for covered Medicare expenses. But, for the privilege of not having a deductible, a computer search for my zip code reveals the monthly cost of Plan F to be at least $264 greater than for F*. This amounts to $3,168 a year, which is greater than the deductible the insured is trying to avoid.

Why the difference in premium rates? The main reason is that Medicare members who choose F feel it is likely they will incur significant medical expenses, while those in F* believe they are healthy and would rather save on the monthly premium and pay out-of-pocket as needed whatever Medicare doesn't cover. As a result, relatively few F* insureds reach the deductible. The majority incur zero claims for the insurer, while under Plan F the insurer will be paying some claims for almost everyone.

It could be argued that those who choose F over F* are not only those who know they have health issues, but also include people without sufficient savings to cover an unplanned expense. However, (1) such individuals must still be able to afford at least $264 more in premium a month, and (2) I would argue that given their scanty savings, they are more likely to have put off getting medical advice or annual tests in the past and, therefore, when problems arise now, they are more severe.

PRODUCT SELECTION IN OPEN ENROLLMENT WITH MULTIPLE CARRIERS

Selection can drive huge differences in premium even when the benefit differences are relatively small. A great illustration is in the design of the Missouri Consolidated Health Care Plan [MCHCP] circa 2003, which was offered to state and public employees. Healthcare companies were asked to submit premium rates for two plans, call them Low and High. Members could choose either plan from any of the approved carriers. There were only two small differences between the plans: (1) the Low plan had $15 physician co-pay vs. $10 for the High and (2) $5 - 10 higher copay for prescription drugs.

My actuarial team at Mercy Health Plans calculated that if there were only one plan with everyone enrolled in that one plan, the difference in expected monthly benefits would be about $8. But we anticipated consumer selection and knew that a greater premium differential was required. We strived to be the lowest bidder on the Low plan, and the highest bidder on the High plan, and that's what happened. We ended up with a majority of the Low-plan members, who had fewer claims than expected, while the carriers with more attractive High-plan premiums incurred much greater than the expected number of claims. Within two years, members faced a $100 difference in premium rates between the Low and High plans since High-plan members not only had more physician visits and prescriptions, but also used more inpatient and outpatient services. Eventually, MCHCP had to limit the choice to one plan.

Although this story began in the 1980s, in so many ways the challenges and behaviors are the same in 2023. In Part 2 of this series, I will discuss product selection in employer group plans, non-cost-related product selection, Medicare prescription drug plans, and incentives that ***can*** change behavior and make it easier to achieve better health outcomes and lower costs of care, or at least mitigate the typically upward trend in costs.

Contact Roy at: roygo@earthlink.net

REFERENCES

1. For example, see *Thinking Fast and Slow* by Daniel Kahneman or *The Undoing Project* by Michael Lewis

2. A classic example is the Monty Hall problem, based on the TV game show, which fooled many readers of Marilyn vos Savant's column in *Parade Magazine* https://en.wikipedia.org/wiki/Monty_Hall_problem

3. This is the namesake of the Leonard Davis Institute of Health Economics at the University of Pennsylvania.

4. I became a Fellow in May, but I was older than most new Fellows, as I went to graduate school for five years, attained a Ph.D. in mathematics, and taught at the university level for 2 ½ years before beginning an actuarial career. This was my first test as an actuary, as I was joining the team that put together the winning bid without an actuary and saw no need for "an intruder."

5. The VP of the division was extremely expense conscious. Indeed, when he purchased a new car that year, he bought it without a radio thinking he could more cheaply install one himself. He never did!

CONTRIBUTOR:
Roy Goldman, PhD, FSA, MAAA, CERA

To learn more about Roy, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

GOVERNANCE REFRESH FOR THE FUTURE

It might be an understatement to say that the healthcare field is navigating tremendous change — seismic might be a better descriptor. On the provider side in particular the fallout from the COVID-19 pandemic continues to strain an already stressed health system. Stories of workforce shortages, employee burnout, inflation, and mounting financial losses are featured in daily headlines. Many organizations are scrambling to rethink their strategies to meet the needs of an uncertain future — but what are the implications for governance?

Source: Bigstock

Given the turbulence in the market, boards should challenge themselves to test whether they have the optimal membership, diversity, skills set, structures, and practices to make good decisions and effectively fulfill their fiduciary obligations. One long-tenured health system board chair put a fine point on it, asking "Is our board designed for the past or for the future?" It is time for boards to rethink and refresh their governance.

GETTING STARTED

We do not view governance as one-size-fits-all. Different boards will have different challenges, depending on their unique context. For example, we worked with one post-merger health system whose primary aspiration was to adjust the decision rights between the system board and the subsidiary boards. This is in stark contrast to another board that was rethinking its practices due to a significant shift in its strategy and the need for stronger academic and community partnerships. Consider these principles in shaping the context for effective reform.

- **Lead with business needs**. Good governance starts with being clear about strategy and purpose. It should be shaped (and reshaped) based on the dynamically changing needs of your business. What are the challenges and opportunities facing your organization in its next stage of development? What are the implications for reshaping governance to support that agenda?

- **Consider the connection between leadership transition, strategy, and governance development.** A recent article from the search firm Spencer Stuart reports that more than 80 percent of hospital CEOs will turn over or retire within the next five years, if current trends continue.[1] CEO succession is a natural part of the organizational lifecycle. It is the board's top priority and can be all-consuming. Don't underestimate the impact of a new chief executive on governance, whether that be changes to the strategic direction or testing long-standing expectations about how to engage with the board.

- **Use the refresh process to test and prepare future leaders.** Those who participate in thinking through the dilemmas associated with changing governance will be better prepared to take up the work of implementation and to serve as future leaders themselves.

UNDERSTAND THE CURRENT STATE, IDENTIFY ASPIRATIONS, AND DESIGN FOR THE FUTURE

We find that opportunities to strengthen board effectiveness are generally found in four areas:

1. Membership and composition
2. Individual members' behavior
3. Scope of deliberation
4. Structure and processes

An assessment of each area provides a shared understanding of your baseline, a starting point which is critical as you begin to explore your future aspirations and how to translate them into action. When a board knows what it is trying to achieve, it will inform the board practices, structures, and processes to best position them to do so.

1. **Membership and Composition: Does the board have the right people at the table?** Many organizations maintain a matrix (whether explicit or implicit) to describe and track the skills, positions, and/or backgrounds they want to include among their board membership. The ideal mix of skills and backgrounds will vary over time, as the focus and challenges of the business change. Boards should occasionally review their ideal membership to determine whether there is an important skill, experience, or capability that is missing. Many boards have identified the need to bring greater diversity to its membership, including racial and ethnic, gender, and non-traditional experiences. Boards must also examine term limits and size. Considering the value of different skills and backgrounds must be weighed against the potential impact of increasing numbers on group dynamics.

2. **Individual Members' Behavior: Do board members know what they are expected to do? Is the distinction between board and executive roles clear?** We regularly hear concerns that board members do not understand their role and responsibilities. Likewise, many board members worry they are not as effective as they could be because they don't know what is expected of them. Boards can get far off-track when the behavior of individual board members is not consistent with expectations—and/or the expectations themselves are not consistent with the organization's needs. A common consequence is that board members begin to take up management instead of stewardship. Occasional review of both the expectations and the behavior of individual board members is essential. This starts with effective onboarding and can be fostered through annual self-assessment processes.

3. **Scope of Deliberation: Is the Board talking about the right things?** With so much change, perhaps the most critical question for healthcare boards is whether they are deliberating over the right issues. Should every item that is on the board's agenda ought to have been there? Did the board miss any important topics? Is the chief executive overly managing the discussion and the data that supports it? It is useful to consider how the board chooses to allocate its time within and across board meetings, including the scope and authority represented in the committee structure.

4. **Structure and Processes: Do discussions result in good decisions? Is the board structured in the best way to leverage its collective expertise?** Most boards bring a formidable level of experience, skill, and intelligence to bear on the issues they debate—and yet, their ability to efficiently make good decisions can be greatly helped (or hindered) by the processes they use for their debate. Before jumping to a review of specific processes (e.g., "Do we have the right committee structure?" "Are the decision rights clear enough?"), boards may find it helpful to reflect on whether their decision-making processes lead to good debates with good outcomes, if they have the knowledge and information they need, and if they are efficient in their use of time.

Taking the time to explore these areas, in the context of strategy and purpose, will help boards make the adjustments they need to successfully face the future.

Contact Jennifer at: jtomasik@cfar.com

For more information on this topic or related materials, contact CFAR at info@cfar.com or 215.320.3200 or visit our website at www.cfar.com.

REFERENCE

1. https://www.spencerstuart.com/research-and-insight/ceo-succession-in-healthcare

CONTRIBUTOR:
Jennifer L. Tomasik, SM, FACHE

To learn more about Jennifer, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

RECOVERING AND THRIVING POST-PANDEMIC - PART 6B: BEHAVIORAL HEALTH

In Part B of the sixth article in our series, we continue our focus on behavioral health (BH) services. Healthcare providers have many considerations in this period of recovery as the most disastrous waves of the pandemic start to recede.

In Part A, we recapped the current behavioral health landscape, including the rapidly changing framework for behavioral health services: from broader screening and improvements in diagnosis to payment and delivery transformations. We also touched on the impact of the COVID-19 pandemic on the decline of emotional well-being, specifically, the increased prevalence of depression and anxiety. In this article, we are focusing on a handful of considerations for integrated health systems which offer any level of behavioral health services. These organizations are often the center of care delivery in the communities they serve, along with affiliated providers such as Federally Qualified Health Centers (FQHCs) and community-based or faith-based groups. The tactics below are most impactful when a variety of stakeholders find common ground, align, and work together.

Generally, we have organized these tactics in a "waterfall" of descending order. We start with tactics that generate more revenue – working collaboratively with payers – and transition into tactics that expand capacity, improve workforce, and tap into opportunities available through smart partnerships.

- **Build and execute payer strategies that include behavioral health.** Providers are increasingly finding that commercial payers are more willing to negotiate behavioral health reimbursement alongside payment for other physical health services. This is partly because payers are increasingly realizing that carving out behavioral health doesn't align with the overall objectives of integrated payment and care delivery to achieve optimal clinical outcomes. Despite mental health reimbursement parity laws, we still observe effective differentials between the average reimbursement level for non-BH medical services in the physical health arena and behavioral health services. Payers have complex systems to administer reimbursement arrangements, and sometimes it takes dialogue between payers and providers to arrive at a correction. We see these lagging "legacy" rates most often when BH benefits were outsourced to third parties. Insourcing opens the door for amicable discussions about reaching parity. Additionally, increases in payment for BH services usually don't regularly adjust (e.g., annually) using the same mechanisms as other service categories. For providers looking to ensure a behavioral health service line (BHSL) covers its operational costs, adjustments that increase average reimbursement on a periodic basis should be included in every contracting discussion.

- **When coupled with the above, acute care facilities may have an increased opportunity for expanding capacity.** For example, bringing reimbursement to a level where a BHSL line is at least covering its own costs, serving more BH patients becomes a logical next step. Increasing inpatient licensed beds designated for psychiatric services can be complex (and potentially costly), but an extreme lack of access in some markets can make the undertaking

worthwhile. This can be evaluated with a bed need study that assesses the demand trend for inpatient psychiatric services, along with workforce requirements and availability and associated estimated direct and indirect costs. Additionally, many markets would benefit from adding or expanding outpatient services to include partial hospitalization and intensive outpatient programs. BH service line leaders can often provide insight on specific clinical needs in the community. Where increasing beds for inpatient residential capacity is untenable, exploring outpatient program capacity expansion might offer an opportunity to serve more patients. These approaches often require less capital investment (they can sometimes be co-located in the same physical space as other outpatient services) and can generate sufficient revenue to cover direct costs. Health systems and other providers with multiple locations should ensure they consider all service locations to understand if office-based services should also be enhanced, perhaps with partnerships from previously unaffiliated therapy and counseling providers.

- **Understand and augment the provider complement for behavioral health clinicians.** Many organizations offering BH services find themselves chronically understaffed, dealing with high turnover, and spending precious resources to maintain staffing for existing physical capacity (expanding to serve more patients is a near impossibility.) Root causes for workforce challenges include historically low reimbursement levels (including steep rate differentials for advanced practice providers [APPs]), limited workforce availability, high burnout (even more than in the broader healthcare profession[1]), and high baseline stress. Behavioral health services are difficult to render, and day-to-day job requirements can take a toll. Sometimes, these challenges can be solved with additional funding from either health plan payers, large employer groups, or even philanthropic organizations; a case can be built for an increase in reimbursement, or for a one-time payment, to build and/or enhance workforce development/wellness programs. Enhancement or transformation programs focused on workforce are an excellent starting point to explore partnerships with BH-focused startups (regardless of funding source). The culture of these organizations often attracts talent away from traditional health systems and office- or clinic-based delivery settings. These established organizations can look to their start-up siblings to explore opportunities to improve access to the BH care delivery workforce, rather than fostering more competition among employers. Beyond development programs, simply recruiting more providers can result in shorter shifts and better balance for over-burdened clinicians, while adding non-clinical staff can also provide relief for the clinical segment.

- **Engage meaningfully with safety-net payers or build partnerships to enhance or augment BH services at the community level.** Depending on the regional provider makeup, there may be opportunities for health systems and other provider organizations to work together to meet the behavioral health needs of the wider community. In most states, there are significant investments underway to invest in strengthening BH services offered. Additionally, funding streams are directed to or though safety-net providers, often public entities such as county or municipal organizations.

Many of these priorities center around Medicaid and uninsured populations, and programs include delivery system reforms, alternative and value-based payment models, and other transformative initiatives such as a data exchange. In addition, many states are investing to reduce health inequities, which can have an additive positive impact when coupled with other programs/funding streams (we covered some of these considerations and tactics in a prior article.)

CONTRIBUTORS:
Wren Keber, Lisa Soroka and Z. Colette Edwards, WG'84, MD'85

To learn more about Wren, Lisa and Colette, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

RECOVERING AND THRIVING POST-PANDEMIC - PART 6B: BEHAVIORAL HEALTH

In New York, a proposed 1115 waiver program will, if approved by CMS, invest billions of dollars in the Medicaid system, with a material allocation earmarked for behavioral health providers. Among the proposed programs is a framework for Medicaid managed care organizations (MCOs) to partner with value-based provider networks comprised of behavioral health organizations (known as behavioral health care collaboratives). Health systems (and other providers with a predominantly primary care service complement) can partner with the BHCCs (and vice versa) to expand service capacity and meet the needs of regional communities over time, while simplifying contracting with MCOs and improving the patient experience for Medicaid members struggling with behavioral health conditions.

In conclusion, we believe there are significant opportunities to improve all aspects of behavioral health, from payment and delivery to improved clinical outcomes and management. An unanticipated, perhaps positive, "side effect" of the COVID-19 pandemic is the unprecedented attention paid to the importance of diagnosing and treating BH conditions at the same level as physical health. We believe organizations that move proactively to integrate these tactics alongside more traditional avenues will make the most of financial and clinical opportunities available in this unique post-pandemic period.

Source: Bigstock

Contact Wren at:
wkeber@cardinalcg.com

Contact Lisa at:
lisasoroka@themarbleheadgroup.com

Contact Colette at:
colette@accessinsightmd.com

REFERENCE

1. How behavioral health integration helps beat physician burnout | American Medical Association (ama-assn.org)

CONTRIBUTORS:
Wren Keber, Lisa Soroka and Z. Colette Edwards, WG'84, MD'85

To learn more about Wren, Lisa and Colette, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

THERE'S MORE TO PRACTICING GRATITUDE THAN JOURNALING

Kicking off a new year brings a sense of renewal and prompts us to look ahead with the hope of being more present and meaningful in our daily activities and interactions with others. One way to further cultivate and sustain renewal and hopefulness is practicing gratitude and creating new mental habits to "hardwire" these new year intentions and benefits.

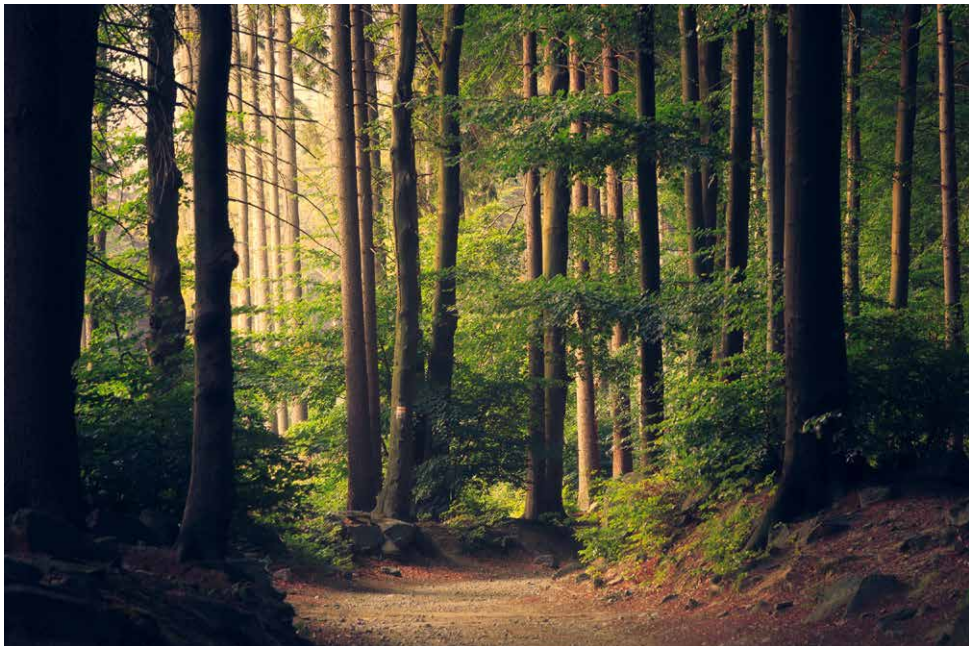

Photo by Lukasz Szmigiel on Unsplash

Keeping a gratitude journal is one of the most cited practice techniques for experiencing the benefits of gratitude. And yet, we often hear from those who dislike journaling – for various reasons – lack of time or failure to journal (practice) regularly.

For millennia, journaling (keeping a diary) has been used to record experiences, reflections, and observations. More highly recognized journalers include Roman emperor Marcus Aurelius in *Meditations*, Marie Curie, Leonardo Da Vinci, and many others. Journaling continues to be a core element in cultivating and sustaining a grateful disposition. Handwriting your journal entries creates a meditative benefit and allows you to access both the analytical left hemisphere of the brain and the creative and feeling right hemisphere.

For those interested in a variety of practice techniques, below are a few applications that offer individual benefits, support leadership development, and align with a positive workplace environment and workplace wellness initiatives.

Take an "awe" walk. Take a walk out in nature and use all five senses (if possible) to notice, observe, and experience everything nature offers. This activity heightens our awareness of being part of something bigger than ourselves and enhances positive emotions and prosocial behaviors. Albert Einstein (also a journaler) connected awe as a source of all true art and all science. Studies show a 15-minute awe walk – experiencing the awe of what you experience during the walk - once a week for eight weeks can provide health and healing benefits, increase positive emotions, and decrease stress over time. A college wellness expert gave her students an awe walk assignment. Students returned amazed over what they had observed on campus that they had never noticed before. Some were motivated to draw their experience as a visual journaling practice.

Write a letter of gratitude. Write a letter to someone in your life for whom you are grateful. This is one of the earliest researched and most meaningful practice techniques. Some scholars recommend this letter be between 250-300 words. We recommend you cover these five criteria and be as specific as you can in your writing:

1. What were the true actions of this individual that you're grateful for?
2. Why were these actions so meaningful to you?
3. How have you benefited?
4. What were their intentions and possible sacrifices?

5. After writing the letter - call them or plan a visit and READ it to them.

A colleague wrote a letter of gratitude to her mom for her 90th birthday. As she said, "I didn't know what I could give her as a gift that she doesn't already have. This letter was the best gift I ever gave her."

Use grateful processing. Consider an open memory that you have - an intrusive emotional memory that continues to surface and is still an "open book" years after the event occurred. This activity should **not** be linked to memories associated with shame, guilt, or regret. Instead, recall an open memory associated with sadness, loss, anger, anxiety, or frustration. Grateful processing diminishes the unpleasantness of the open memory, perhaps a loss of promotion, and helps to reappraise these events.

The "process" is one of curiosity, seeking out several responses to several questions. Questions such as: "What personal strengths grew out of this experience?; how did this experience help build resilience to meet future challenges?; what bigger perspective do I have in life?; and how has it helped me appreciate the truly important people and things in my life?" Overall, this Grateful Processing of Unpleasant Memories has improved the processing of these events and brought emotional closure. It can be viewed as a coping mechanism contributing to our well-being.

Team Gratitude Practice. From our coaching experience, some of the most inclusive, prosocial, and trust-building activities are associated with gratitude team-building activities. Practices can be designed to complement team building methodologies such as Lencioni's Five Behaviors of a Cohesive Team, TeamSTEPPS, or Just Culture. Additionally, if a new strategic planning process is part of the new year activities, ensure the success of your strategic plan by building gratitude practices to recognize how and who will support the milestones of strategic priorities. Also, consider what upcoming activities you have planned where you can introduce the research on the impact gratitude has in organizations.

These activities require the utmost attention by leaders to create a safe environment for team building, using best practices from relevant gratitude interventions. In addition, bringing multidisciplinary partners together will require an environment where they can participate without fear of judgment and be acknowledged for their vulnerability and humility.

WHERE TO START

Consider starting with one of the individual practice techniques, such as the awe walk or writing a letter of gratitude, before building and broadening to the other applications. By sustaining your new mental habits, you'll begin to show up differently, leading to a more successful implementation of other practices while creating a more positive work environment.

Want to learn more?

- Weaponizing Gratitude
- Gratitude - An Essential Element for Greater Inclusion
- The Reciprocity of Gratitude
- A Culture of Gratitude - Imperative in the Post-Pandemic Era
- The Healing Benefits of Gratitude Post-Pandemic - Start Now
- Emotional Intelligence and Gratitude
- The Neuroscience of Gratitude
- Discovering the Health and Wellness Benefits of Gratitude

Contact Linda at:
lburton@drwcoaching.com or 410.707.3118

CONTRIBUTOR:
Linda Roszak Burton, ACC, BBC, BS

To learn more about Linda, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

WHARTON AROUND THE GLOBE: WHARTON GLOBAL HEALTH VOLUNTEERS (WGHV) PARTNERS WITH PRAAVA TO DEVELOP AND EXPAND ITS TECH-ENABLED SERVICES ACROSS BANGLADESH

Earlier this year, a team of Wharton students, including Harold Agblonon (WG'23), Ava Chang (WG'23), Natasha Ramanujam (WG'23), Blair Seiler (WG'23), Lindsey Sheppard (WG'23), and Billy Thomas (WG'23), had the opportunity to be involved in a pro bono consulting project with Praava Health, a "brick and click" (both physical and digital) health clinic in Bangladesh, to build out the product strategy for its newly developed virtual care, e-pharma, remote monitoring, and chronic disease management solutions.

Launched in Dhaka, Bangladesh in 2018, Praava delivers high-quality, in-clinic primary and specialty care, and also offers its own diagnostic lab, imaging services, and a pharmacy. Praava is founder Sylvana Sinha's response to what she saw as a broken healthcare system in one of the world's most populous countries. In addition to these services, Praava also provides solutions via digital channels.

Praava is the country's fastest growing healthcare brand – today it has 50+ doctors, has served 250K+ patients since inception, 600+ corporate clients, and also became one of the first private labs recognized by the government to provide COVID-19 tests. Praava is currently fundraising for its Series B round.

With the increasing adoption of technology and the Internet across Bangladesh, especially during COVID-19, and its mission to expand access to critical health services, Praava saw a big opportunity to further develop its tech-enabled services. The WGHV team was engaged to help conduct market landscape analyses to identify potential users and understand market size, define use cases, estimate the investment required, and project future growth for each product. The WGHV team also provided recommendations on ways Praava could reduce churn and increase retention for its e-pharma product, especially for less tech-savvy patients.

The team sought to answer these questions through interviews with internal Praava stakeholders and external industry experts, secondary research on similar solutions in other emerging and developed countries, and the review of academic articles. The team also had the opportunity to travel to Bangladesh to meet with the Praava team, visit the hospital, test out

its products to gain a better understanding of current operations, and work closely with the team to refine our recommendations.

In our final deliverable, we presented our recommendations across virtual care, e-pharma, and Praanno, Praava's newly developed remote chronic disease management tool. For each, we provided an overview of industry trends and our view on the market opportunity in Bangladesh for these products. For virtual care, we identified a large opportunity in both chronic disease management and mental health services and recommended that Praava expand its offerings in these areas. For e-pharma, in addition to identifying use cases, we provided detailed recommendations on marketing opportunities and retention initiatives to improve the business' customer base. And for Praanno, we identified important use cases that could be leveraged, in addition to its use today as a COVID-19 disease management tool. For all three products, we also defined the monetization strategy and investments required to scale each product and ensure they deliver maximum impact and cover patients across all income levels in Bangladesh.

The Praava team was complimentary of the WGHV team's work and recommendations and expressed the importance of our work in informing their roadmap, necessary investments, and growth trajectory, especially as they ramp up for Series B fundraising. For the WGHV team, we gained both industry and functional expertise through this project, learning about the healthcare landscape across Bangladesh and opportunities to scale technology, and gaining real-life consulting experience.

WGHV is grateful for the generous, ongoing support of the Wharton Health Care Management Alumni Association that allows our teams to continue to make an impact on the global stage supporting international health organizations and to contribute to improving access and outcomes for underserved populations around the world. We are always looking for interesting and impactful organizations to partner with in the semesters ahead. If you have any leads for potential projects, please reach out to the WGHV Executive Board.

Contact Jasmine at: jzhang1@wharton.upenn.edu
Contact Meghna at: meghna15@wharton.upenn.edu
Contact Ava at: avachang@wharton.upenn.edu

The Wharton team

Jasmine Zhang

Genentech

Oliver Wyman

University of Waterloo, Bachelor's Degree

WG'23

Meghna Dasgupta

McKinsey & Co.

University of California - Berkeley, Bachelor's Degree

WG'23

Deva Saxena

Allen & Co.

Kearney

University of New South Wales, Bachelor's Degree

WG'23

Dolapo Salawu

Brookfield Asset Management

African Capital Alliance

University of Ibadan, Bachelor's Degree

WG'23

Moshe Emilio Lavi

Kearney

Meidata

Israeli Ministry of Defense

Carleton College, Bachelor's Degree

WG'23

Shubha Jain

Amazon

Deloitte

Delhi College of Engineering, Bachelor's Degree

WG'23

CONTRIBUTORS:
Meghna Dasgupta, WG'23, Jasmine Zhang, WG'23, and Ava Chang, WG'23

To learn more about Meghna, Jasmine, Ava, and the WGHV Team, click here.

WINTER 2023
Volume 12, Number 1

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org