Rivka Friedman, Managing Director, Innovation, Morgan Health

About half of the U.S. population—including more than 70% of working adults—gets healthcare through employer-sponsored insurance (ESI). This has remained constant, even after the introduction of the Affordable Care Act of 2010, and even as healthcare costs continue to rise. Can addressing affordability for employers and employees help address healthcare cost, quality, and accessibility issues that drive health disparities in the United States? Rivka Friedman, managing director at Morgan Health, is betting that it can.

During her career, Ms. Friedman has looked at the U.S. healthcare system from many perspectives. She spent a decade at Advisory Board, working with healthcare providers and health systems to research interventions and innovations for healthcare delivery. From there she moved to the Centers for Medicare & Medicaid Services (CMS), where she oversaw population health and state-based Medicare and Medicaid payment models at the CMS Innovation Center. In 2021, she joined JPMorgan Chase's Morgan Health, where she now leads the organization's Innovation team, working to improve quality and reduce the cost of healthcare for people who get healthcare through ESI.

In a recent interview with the *Journal of Healthcare Management*, Ms. Friedman talked about ESI and how employers and healthcare systems can work together to improve the quality, accessibility, and affordability of healthcare. The interview is edited for length, clarity, and format.

JHM: *What is Morgan Health's origin story and mission?*

Ms. Friedman: In 2018, JPMorgan Chase, Amazon, and Berkshire Hathaway formed a joint venture called Haven to focus on the costs businesses incur for employees' healthcare. That effort wound down in 2021 with each company deciding to address and improve healthcare through their own corporate governance. JPMorgan Chase wanted to stay focused on this set of issues and launched Morgan Health as a solo venture. But where Haven targeted employer costs, Morgan targets *employee* costs. The mission of Morgan Health is to improve the quality, equity, and affordability of healthcare for JPMorgan Chase's 285,000 insured employees while driving change across the entire healthcare system.

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JHM: *Why do you focus on employee costs, rather than employer costs?*

Ms. Friedman: Affordability of healthcare is a core issue that often drives poor outcomes. If people can't afford their care or they're paying a lot of money to get subpar care, we see the impact in poor outcomes and racial, income, gender, and geographic disparities in care. We take a consumer-first approach where we think about every JPMorgan Chase employee—and every employee in the *country* who gets their healthcare through their job. We ask: What is their experience of care? How can we make that care better, easier to get, and more affordable?

JHM: *What approach does Morgan Health take to making healthcare more affordable?*

Ms. Friedman: Morgan Health has both an innovation arm and a venture arm to identify, evaluate, and make the best ideas and innovations scalable and replicable. We deploy capital to support innovative companies and do research and data analysis to inform our strategic guidance about where those companies can make the biggest difference.

I lead the Innovation team, and we concentrate our attention on three main things: The first is research and data analysis to understand the status quo, including where outcomes are poor, where disparities lie, and what innovations work to improve outcomes and quality and reduce disparities. The second area is working with innovative companies to pilot evidence-based clinical and payment interventions and evaluates what works. The third thing we do is scale successful innovations to make them available to more people.

JHM: *How does health equity fit into the work of Morgan Health?*

Ms. Friedman: Addressing health equity in a meaningful way is a part of everything we do. It is a core area of research and data analysis for us. Over the past two years, we've looked at where healthcare disparities lie both in our JPMorgan Chase population, with an internal health equity analysis, and in the ESI population at large, by analyzing publicly available data. For example, we are looking at the disparities in outcomes for Black women as compared to non-Black women. Once we understand the status quo of these disparities, we will do root cause analyses to try to understand how changing a specific aspect of the delivery model would affect the disparity.

It can be difficult to measure disparities in small populations such as the employees of one company. We are working with Kaiser Permanente to understand how we can accurately measure disparities for our employees in California to develop a methodology that's suitable for small populations so that we can measure and track those gaps in outcomes.

We know that solving social needs such as housing, transportation, and utilities is a driver for closing disparities in healthcare. If people don't have basic needs met, they're not going to get their health needs met, either. We are working directly with Vera Whole Health to measure and then address employees' health-related social needs for our employees in Columbus, Ohio.

JHM: *What role does ESI play in the cost, quality, and access to healthcare in the United States?*

Ms. Friedman: Roughly 180 million people in the United States get their healthcare through ESI, so it plays a big role in the cost, quality, and access to healthcare. But the ESI system shines the biggest spotlight on how healthcare is fragmented.

Every employer is, in essence, running their own healthcare business, in addition to their business. Every employer makes their own decisions about the insurance they offer their employees. That creates fragmentation, so employers and their employees rarely have enough leverage to scale innovation and drive change. We see this in a lot of places, but especially in access to quality and outcomes data. Most healthcare data are gathered from multiple sources like medical records, insurance claims, and pharmacy prescriptions and then filtered by data warehouses, which use their own definitions for, say, what constitutes a chronic condition. You can imagine that if those definitions are inconsistent from vendor to vendor, this affects what employers understand is happening with their employees. From an individual consumer's perspective, it's hard to know where to get the best care.

Fragmentation at the health system level also hinders change and innovation. At Advisory Board, I worked mostly with hospitals and health systems, thinking from their perspective and identifying innovations to improve care. The hardest part, by far, was getting those innovations to scale—convincing hospitals and health systems that, indeed, the thing that worked in Virginia would also work in Kentucky.

JHM: *What responsibility do hospitals and health systems have for lowering ESI costs?*

Ms. Friedman: Like all costs in healthcare in the United States, ESI costs are growing at an unsustainable rate. These costs are too great for employees to sustain. Employers are taking on a greater percentage of those costs to shield their employees from massive increases.

I imagine that hospitals and health systems feel pressure to agree to steeper discounts applied to their rates. In some ways, hospitals and health systems are feeling this from both sides, as healthcare providers and employers.

Hospitals and health systems are also in a unique position to develop solutions. Most are self-insured, which offers them the opportunity to pilot value-based-care protocols, processes, and approaches for their employees in a way that they will benefit from directly and that they can learn from. If a hospital has pilots and interventions that work well, we'd love to hear about it at Morgan Health and consider whether there are opportunities to scale it outside of the four walls of that hospital.

For example, in the Dallas area, Baylor Scott & White Health piloted advanced primary care for their employees. Now they're working with Centivo, one of Morgan Health's portfolio companies, to market that solution more broadly. Innovation like this is certainly easiest for large systems, but I know many small organizations feel the pressure to consolidate as the economics of being a small entity get harder and harder. At Morgan Health, we've been looking at the experiences of small- and medium-sized businesses as

purchasers of healthcare, which would include smaller hospitals that, again, don't have the benefit of scale. I hope that, over the next year, you'll start to see products custom-tailored to smaller and medium-sized businesses and their needs.

JHM: *How does the work of Morgan Health intersect with hospitals and health systems?*

Ms. Friedman: In many ways, hospitals, health systems, and employers want the same thing: They want Americans who get their healthcare through ESI to have access to high-quality, affordable, patient-centered care. They are thinking about the journey through the healthcare system and where that journey sets up an employee or patient for success or failure.

Both health systems and employers have an opportunity to concentrate on better outcomes, which can drive lower costs and mitigate healthcare inflation. This is going to sound like the simplest thing, but if you make high-quality healthcare easier to get, you're more likely to see people accessing high-quality healthcare.

Hospitals and health systems are bringing care closer to people every day and making it more accessible, whether it's through telehealth or putting urgent care centers closer to where people live and work. Morgan Health is doing this, too. For example, we've deployed Vera Whole Health to be the on-site primary care clinic solution for our Columbus employees. If we lower barriers to entry, more people will get the care they need.

One way to break through the fragmentation issues in our healthcare system would be for providers to take on the challenge of publishing cost and quality data—not just publishing the data that they're required to publish, but leading the charge to make available data on patient outcomes for a particular condition or for a particular episode or procedure in a way that patients can use.

Employers and health systems have an opportunity to work together on things like contract terms, but also on letting employees, payers, and patients know who the high-quality providers are in the area. I understand the real-world implications and significant challenges of publishing those data. I think we would probably hear from hospitals and health systems that this would put them at a negotiating disadvantage. But for hospitals and health systems who believe that they have the lowest cost and the highest quality in a market, I say, lead the charge. Make those data available on your website. I think that type of leadership will be rewarded.