REPEALING "OBAMACARE"

A few months have passed since Donald Trump's inauguration as the 45th President of the United States, and what an eventful time it has been. From his first day in office, President Trump, Congress and key departments wasted no time acting on many hot button issues. The healthcare industry is on edge and many leaders are scrambling to figure out how to react.

These developments prompted SPM to take a hard look at the future of the Affordable Care Act (ACA), starting by interpreting the potential policy changes and concluding with important implications for strategic marketing and communications leaders. We've also applied our expertise in healthcare consumer behavior and insights to uncover key 'no-regrets' next steps for healthcare marketers. So, let's get started.

BACKGROUND ON HEALTHCARE REFORM IN A TRUMP PRESIDENCY

Democrats and Republicans alike believe the U.S. health care system needs reform. At issue is their fundamental disagreement about how to do it and what reform should look like.

On the campaign trail, nominee Trump provided few concrete clues about how he would go about "repeal and replace." But, in his first 100 days, four key events occurred:

1. President Trump signed an executive order, directing departments to delay implementation of ACA "burdens" and advancing campaign promises of tort reform and selling insurance across state lines
2. Congress began the process of budget reconciliation to dismantle specific components of the ACA through spending cuts impacting Medicaid expansion, individual subsidies and delivery system reforms
3. The Senate confirmed heads of Health and Human Services (HHS) and the Center for Medicare and Medicaid Services (CMS)
4. Speaker Ryan introduced the American Health Care Act (AHCA) as an ACA replacement—with the initial vote on the bill postponed due to intra-party disagreements

While a new health care bill is not yet law, we can postulate the impact of these moves' intent and offer smart responses for health care provider strategists, marketers, and business development leaders.

REPEALING & **REPLACING/AMENDING/REPAIRING** THE ACA

A full repeal of the Affordable Care Act, logistically, practically, and politically, is nearly impossible—which may explain, in part, the emergence of words like "amending" and "repairing." Despite Republican majorities in both Houses of Congress and control of the Presidency, the GOP does not hold a filibuster-proof majority in the Senate. This means passing sweeping new legislation will be rather difficult without incorporating ideas that can win some Democrats' support. In the meantime, expect to see Congress use budgetary and other parliamentary tools to pick away at sections of the ACA. Some portions of the ACA can't be altered through budget reconciliation and may be de facto "un-repealable," while others are just too broadly popular to undo.

This means passing sweeping new legislation will be rather difficult without incorporating ideas that can win some Democrats' support.

IMAGINING **REFORM**

To predict how the President and Congress might go about reshaping the ACA, it's helpful to consider what, philosophically, troubles them about it. For simplicity sake, it's sufficient to consider three planks that generally form the opposition's platform:

1. Anger at the government forcing/requiring citizens and businesses to do (just about) anything.
2. Fervor to reduce the size of government (in terms of departments, staff, regulations, budget, and its presence in people's lives) in favor of individual citizen decision-making and market forces.
3. Frustration when seemingly well-meaning policies/programs have negative consequences on the broader society and economy.

With these three planks in mind, it's next important to break down the inner workings of the ACA.

While there are many detailed components across its thousands of pages, for our purposes, the ACA can be thought of as consisting of three key categorical thrusts:

1. COVERAGE EXPANSION AND INSURANCE MARKET REFORMS

This category contains some of the ACA's most beloved and inflammatory elements. On the "beloved" side are the provisions that allow young people to stay on their parents' insurance until age 26 and the prohibition on pre-existing conditions exclusions.

On the "inflammatory" side fall elements such as the individual and employer mandates, the health insurance exchanges created to facilitate compliance with the mandates, and Medicaid expansion.

2. FINANCING PROVISIONS

Implementing the ACA is costly. Federal subsidies for individual purchasers in the exchanges. Additional federal staff and departments to implement the ACA. Supplementing the cost of Medicaid expansion. It all adds up. So, the ACA contains a range of "taxes" on individuals, providers, pharmaceutical and device manufacturers, health insurance companies, and high-price health insurance plans to help cover these costs.

3. DELIVERY SYSTEM REFORMS

These sections of the ACA are intended to help catalyze the system's shift from volume to value. It contains the guidelines for initiating Pay For Performance, Value Based Purchasing, Accountable Care Organizations, Bundled Purchasing, and a myriad of other programs that have begun to take hold.

With these two frameworks in place, one can begin to project what might come under scrutiny in a "repeal and replace/amend" effort.

IMPACT ON **COVERAGE EXPANSION** AND INSURANCE MARKET REFORMS

MANDATES

Individual and employer mandates violate the "government intrusion" plank of those who oppose the ACA. Benefit requirements for plans offered on the Exchanges and the regulatory superstructure necessary to support them increase the size (and cost) of government and violate the "big/expanding role of government" plank. Abolishing mandates has been the first thrust of reshaping the ACA.

MEDICAID

To reduce the federal financial burden of the ACA, and, again, address the "big/expanding role of government" concerns, states that have not yet expanded their Medicaid programs will probably be allowed not to. For the states that have, they will likely have the freedom to choose to sustain that expansion or roll it back. However, states should not expect federal financial support for the cost of maintaining expansion.

Previously, both candidate Trump and some House Republican bills advanced the idea of providing Medicaid block-grant funding to the states. The AHCA did this through per capita caps, a tool that achieves the same end a different way. Either move would limit the Federal government's financial exposure and involvement in state affairs, allowing the states to set and manage their own eligibility, participation, and payment systems. At the same time, a block grant or per capita cap puts the burden on the state to cover costs beyond the federal government's allotment. While it has been proposed that this would help manage costs and budgets, it could also result in loss of coverage for the poor, sick, an old. A "Catch-22" for sure.

INSURANCE MARKETS

Regarding insurance market provisions, they tend to fall into two camps: Those that are "Liked and Popular" and those that are not. On the "Liked and Popular" side of the ledger sit the notions of health plan portability and young adults remaining on their parent's insurance until age 26.

On the "Liked and Popular" side of the ledger sit the notions of health plan portability and young adults remaining on their parent's insurance until age 26.

The "no pre-existing condition exclusions," while very popular, are trickier. People generally like this notion, but it is seen as a huge financial risk for insurers—sick people only buying insurance when they need it—that drives up costs for everyone else (a "well-meaning program that has broad-reaching negative consequences" like we discussed earlier). As we saw with the ACHA, amending this provision requires a two-pronged approach. First, requiring applicants to prove they have carried insurance for a period of time immediately prior to applying for coverage or face a higher premium. And second, creating state-administered and underwritten high-risk pools to subsidize insurers costs and stabilize insurance markets. Yes, state high-risk pools have been tried before with a varied history of success. Yes, funding and administering such pools would require additional government resources.

UNIVERSAL COVERAGE

As a side note, with the mandates stripped away, it is reasonable to wonder about the ACA's goal of Universal Coverage (e.g., no one in America being without health insurance). On this point, it is important to understand another difference between the parties. The ACA is based, in part, on a belief that *everyone should have health insurance*. Alternate proposals offered by House Republicans have been more nuanced: That everyone without access to employer-sponsored health insurance, Medicare, or Medicaid, who wants health insurance, should have access to it. The difference is significant. The latter position provides citizens the free choice to not have health insurance if they would prefer not to buy it, placing the responsibility for any consequences of that choice on the citizen.

WHERE DOES THAT LEAVE PRIVATE INSURANCE?

As mentioned above, the private health insurance market will likely be thrust into the center of the amended health care program. There are three possible and likely outcomes that will be the heart of the health insurance market going forward.

1. Expanded emphasis on high-deductible/catastrophic health plans. People are getting used to and comfortable with approaching health insurance like they do vehicle insurance—low premiums and high deductibles, using insurance only for major issues or complications.
2. Relaxing "essential health benefits" requirements to provide health insurers flexibility designing less comprehensive, lower cost products
3. Use of tax deductions for purchasing insurance on private markets to expand coverage and motivate people to buy health insurance
4. Loosening of the rules regarding how Health Savings Accounts (HSAs) can be used and higher limits on what consumers can bank in those accounts.

These tools are seen as providing greater consumer control over their health care decisions, more flexibility to employers and insurers in plan and network design, more conventional approaches to cooling premium growth, and more effective incentives to motivate coverage. All of it adds up to more engaged, activated, value-conscious consumers.

IMPACT ON THE ACA'S FINANCING PROVISIONS

Based on Trump's executive order, the initial push through budget reconciliation, and the stalled AHCA, there is a lot of enthusiasm for rolling back the taxes and other levies contained in the ACA and changing how subsidies work. The net effect of these changes is uncertain, but nothing is free (like state-administered high-risk pools) and revenue will need to come from somewhere (e.g., reduced support for Medicaid expansion). This is a very murky space for sure.

IMPACT ON DELIVERY SYSTEM REFORMS

Here lies another mixed bag. There is evidence to suggest Medicare's volume-to-value reforms have saved the Federal government north of $1.2 billion. More significantly, health systems across the US have aggressively retooled their organizations, their ways of doing business, accelerated clinical integration efforts with physicians, and improved quality, information technology and documentation processes, to name a few. Provider leaders, generally, don't want to change direction now—because it's both working and the right thing to do—and some elected officials have expressed an interest in staying the course.

That said, new HHS Chief Dr. Tom Price has a "go slow" temperament on Medicare change and wants to reduce Medicare's administrative burden on physicians. Also, the Center for Medicare and Medicaid Innovation is a perennial budgetary target of House and Senate leaders. De-funding this department, and/or the Independent Payment Advisory Board, could hobble CMS's ability to move these programs forward. Ultimately, there is little political advantage to undoing this work because it is invisible to voters. It is another case where we'll all be taking a "wait and see" approach.

OTHER POSSIBILITIES

Beyond what the ACA currently does and how it might change, important are ideas not contained in the ACA that have been central to Republican and Candidate Trump's health care policy statements and might be part of replace/amend/repair legislation. Some things to keep your eye on:

MEDICARE REFORM

There is a faction within the House Republican membership interested in transitioning Medicare away from a defined benefit program as it is today to a "premium support" program. In a premium support model, the Federal government provides Medicare-eligible citizens credits with which to buy private health insurance in the open market. While not part of the AHCA, such a move would help the Federal government limit its financial exposure for health care costs and make the program more budgetable. In some scenarios, this approach is presented as another choice to consumers, alongside Medicare Advantage and traditional Medicare.

PRESCRIPTION DRUG COST

While there is agreement that government should do something about the rising cost of prescription drugs, sides, and factions within sides, disagree on what. On the campaign trail, Candidate Trump lobbied for Medicare to use its considerable negotiating power to broker lower drug prices for all seniors. Some in his party are not keen on this idea. He has also suggested loosening FDA clamps on the approval of new drugs and devices to release cheaper options into the market. This too is fraught with disagreement and apprehension. And, while the President at one point asked for these provisions, they were not addressed in the AHCA bill. Some have proposed easing restrictions on the import of drugs available overseas into the US to increase competition and drive down prices, also an approach with fans and opponents.

There is little political advantage to undoing delivery system reforms.

SELLING INSURANCE ACROSS STATE LINES

The theory goes that a health insurer that offers affordable plans in one state should be able to compete in another state using their apparent proficiency to make local markets more competitive and, in some markets, less monopolistic. While this concept made an appearance in Trump's January 20th executive order, health insurance experts disagree on how effective such an approach might actually be. Issues of network assembly and provider contracting, benefit design, sales, administration, and profitability targets make this a very complicated conversation. This could turn out to be "good on the campaign trail", but marginally effective in reality.

TORT REFORM

Some believe health care costs are high, in part, because of punitive legal damages paid in malpractice cases and the defensive medicine they allegedly motivate. This is another one of those questions that has been hotly debated for decades to no consensus. It can be argued that the volume-to-value movement, clinical standardization, increased use of health information technology, and other developments have been influential steps to reducing malpractice and defensive medicine's impact on health care costs. This issue has already re-entered the reform conversation (through the initial executive order), though it may, ultimately, have a negligible impact on cost reduction.

IMPLICATIONS FOR HEALTH SYSTEM STRATEGISTS AND MARKETERS

So, while there are few definitive "knowns" about how the coming debate on repeal and replace/amend/repair will go, there are four areas of strategic emphasis that appear to be 'no regrets' smart bets.

1. BRAND

Brand strategy, positioning, and communications matter, now and tomorrow, more than ever. Certain trends begun over the last four-plus years have shown that a strong provider/health system brand is extremely valuable to winning volume and growth—both to consumers as individual buyers of services and larger "wholesale health care buyers," such as employers, health insurers and risk-bearing ACOs who make healthcare decisions for large groups of beneficiaries. Regardless of the details of repeal and replace/amend/repair, expect these trends to continue. In particular:

For consumers, it's the rising prevalence of high deductible health plans and the growth of consumers-as-individual-shoppers of health insurance. In the former case, consumers are pressing health systems to demonstrate value for the price of their services, be they shoppable services such as outpatient testing and routine care (e.g., urgent, emergent, or on-demand virtual visits), convenient access, and a responsive understanding of consumer needs. Through the growth of narrow network insurance plans, consumers have put provider brands to the test. Is the provider/health system brand attractive enough to connect with enrollees willing to trade breadth of network for lower premiums?

Consumers are pressing health systems to demonstrate value for the price of their services.

Further, for commercial PPO enrollees and seniors in traditional Medicare, freedom of choice reigns. Even in the Alternative Payment Programs (e.g., ACOs, bundled payments), Medicare recipients can see whomever they choose. In addition, Medicare Advantage enrollment, now just over 30% of all beneficiaries, will very likely continue its upward trajectory, and with it more and more seniors will make price-value decisions about the products and networks available to them. A strong brand ensures that you dominate the consideration set when Medicare enrollees decide who to see, or which plan to choose based on who's in the network.

For "wholesale health care buyers," provider and health system brands must understand these value-conscious partners' needs. Demonstrating a willingness to accept and manage risk will power business arrangements, such as carve-out specialty contracts and designation as a preferred provider to receive advantaged member/employee steerage.

A strong brand ensures that you dominate the consideration set when Medicare enrollees decide who to see, or which plan to choose based on who's in the network.

As providers and health systems have also learned over recent years, careful brand planning and strategic brand positioning is necessary to confront a painful truth. For individuals, employers, payers and ACOs, health systems must demonstrate they are not only desirable but also desirable at an often-premium price—the ultimate test of brand power.

Brand is and will continue to be central to earning customers and revenue.

2. GROWTH

The increasing margin pressure currently faced by health systems will most likely grow as the Affordable Care Act is transformed. While the causes of margin pressure are wide ranging—including increased competition, a shrinking pool of commercially insured patients and downward price pressure—expect Medicaid expansion disruption and potential increases in the numbers of uninsured to add fuel to this fire. Health systems have seen a decline in no pay/bad debt through the implementation of the ACA. Those figures will likely move upward in the future.

Strategic growth must counteract this new factor in margin pressure. Employers and Payers seek high-value providers to treat the unavoidable demand in their populations that account for approximately 70% of their costs. To capture growth in this segment, health systems must effectively communicate high quality, low episode costs, an expansive, integrated specialist and post-acute network, and a willingness to collaborate and communicate with the buyer as a partner.

To attract growing numbers of individual buyers, health systems must convey excellent price, convenience, access, an exceptional experience, provide tools that enable a range of means of engagement, transparency and, last but not least, quality.

Health systems must simultaneously explore new growth corridors. These corridors provide access to the large portion of health care spending that is historically made outside of the provider system and are typically much

more present factors in consumers' everyday lives. These include wellness, prevention, health promotion, lifestyle management, nutrition, complementary therapies, retail products and services, health status tracking and monitoring, and fitness, to name a few. Business Development leaders must busily work to tap into these new growth streams with strategic marketing, communications and branding enabling their success. Simply, the health system must be part of somebody's life before they get sick or injured or that is all it will ever be good for.

Health systems must simultaneously explore new growth corridors.

3. ENGAGEMENT

Customer engagement is the critical first step to success in strategic brand connection and growth. Over the past few years, health systems have become more willing to shift their mindset from "sit back and react to what comes our way" to "reach out and prompt customer interaction." However, the ACA is reformed, this work must accelerate. It will take the form of online, mobile and social tools/programs, new platforms for face-to-face connection (e.g., retail wellness "stores," fitness centers, classes, or health coaching), or other technology or program-driven interactions. The point is the "first touch" will increasingly be the new competitive front-line.

Customer engagement doesn't stop at the first touch. Healthcare reform, among many other factors, is changing how health systems/providers must interact with consumers across their journey. Ethnographic patient journey research conducted by SPM found consumers pass through as many as nine "need states" as they navigate a healthcare situation—from before the healthcare need through exploration, selection, and recovery. Each need state has its own information demands, appropriate media mix, and content requirements to meet the levels of anxiety that wax and wane across the journey. Designing programs that engage patients and prospective patients by meeting their different needs along the entire consumer journey through a wide range of engagement mechanisms will better position your organization for future success.

4. LOYALTY

Developing and cultivating loyalty, or, said another way, share of wallet, must be on every health system's To-Do list. Recent analysis by the Advisory Board found that the average consumer—even the most satisfied—received services from nearly 3 different health systems over a period of five years, indicating healthcare organizations struggle to retain patients and keep them within their system. This amounts to tens of millions of dollars in revenue leakage.

Consumer products companies have known for years, "The best customer to have is the one you've already got." Many of the growth metrics in the value-based healthcare economy represent a deeper level of utilization and connection between the consumer and the health system. Small changes in behaviors for the consumers that you have already captured (e.g. those who choose your urgent care center rather than a Walgreen's or CVS clinic), achieved across the entire patient base of thousands of households, add up to a considerable boost in sales and success in sales and health status management.

Cultivating health system loyalty or share of wallet is a deliberate process comprised of demonstrating an appreciation of the commitment a consumer has already made to the health system, a sincere interest in their feedback and other needs, a responsiveness to their feedback and needs, a clear benefit to spending a greater share of their healthcare wallet with you, and an imagination to present them with new offerings that will surprise, delight and further re-engage them. If you cannot commit across these five dimensions, retention will suffer. Give patients a compelling reason to stick with you, and they will.

The average consumer—even the most satisfied—received services from nearly 3 different health systems over a period of five years.

The course ahead, one that may have up until November 8th seemed clear though wrought with its own particular challenges, is unquestionably altered. And altered in ways that by and large defy confident prediction. At this point, the best we can do is find clues that might mark the new path and identify steps that are strategically sound regardless of how the final map is drawn. Fortunately for health system strategists, marketers, and business development leaders, there are a few 'no-regrets' strategies on which to anchor our efforts in this uncertain period to emerge well positioned for success as the view becomes clearer.

If you find yourself wondering what an "Repeal and Replace" world might demand of your hospital or health system brand and communications, we can help—our integrated team of experts in healthcare policy and strategy, consumer insights, and powerful, unique marketing solutions have the tools and experience necessary to catapult your brand into the future. **Get in touch with our team by contacting Bill Tourlas at tourlas@spmmarketing.com. We can't wait to work with you!**

Thanks.

For more thought-leading content, contact us to receive a full list of other topics.

Bill Tourlas, SVP, Innovation & Engagement
15 W. Harris Ave, Suite 300 • La Grange, IL 60525
708.246.7700 • spmmarketing.com • @spm_marketing
tourlas@spmmarketing.com