OLIVER WYMAN HEALTH

The business of transforming healthcare

SPECIAL ELECTION COVERAGE

What Does a Trump Presidency Mean for Healthcare Organizations?

CONTENTS

WHAT NOW?
THE IMPACT OF A TRUMP PRESIDENCY

by Sam Glick, Partner, Health & Life Sciences, Oliver Wyman

After what was surely the most acrimonious – and what felt like the longest and most bizarre – presidential campaign in history, we are finally ready to put November 8 behind us and get to work.

Sort of.

The country remains deeply, bitterly divided on many issues – and many are still shocked at the unexpected outcome of the election. President-elect Trump has a healthcare agenda that – with the support of allies in the Republican-led Congress – will undoubtedly shift the industry.

Now is the time for all healthcare stakeholders to ready themselves for the impact and 'what now?' of a Trump presidency.

Through this series of articles and infographics, learn how various industry stakeholders will be impacted by our 45th president. First, we offer a refresher on the Trump health plan, followed by how his plan will affect payers, providers and, life sciences companies.

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Key Components of President-Elect

TRUMP'S HEALTHCARE PLAN

REPEAL ACA

- "Completely" repealing the ACA was a tenet of his campaign, but within 72 hours of his victory he indicated he was reconsidering his stance

FREE MARKET REFORMS

- Aims to use free enterprise to decrease barriers to competition, and increase transparency and consumer choice

REFORM MEDICARE

- Though the President-elect did not discuss Medicare much on the campaign trial, the GOP platform supports a transition to a premium-support model
- In such a model, the government would make fixed per-capita contributions and beneficiaries would use those payments to shop for care from traditional Medicare or private plans

RESHAPE MEDICAID FUNDING

- Proposes to convert to state block-grant program

REMOVE INTERSTATE RESTRICTIONS

- Would allow insurance to be sold across state lines

ALLOW PREMIUM DEDUCTIONS

- Would allow individuals to fully deduct health insurance premium payments from their tax returns

EXPAND TAX-FREE HSAs

- Would encourage contributions into tax-free HSAs and enhance tax-free accumulation

REQUIRE PRICE TRANSPARENCY

- Would "require price transparency from all healthcare providers" so that consumers could shop to find best prices for procedures, exams, and medical-related procedures

PRESCRIPTION DRUG REFORMS

- Would lower barriers for import of safe, reliable, cheaper products

NOW THE WHAT, WHEN, HOW OF HIS PLAN

"Repeal? I meant amend!" – President-elect Trump indicated he may not ditch the ACA completely and is inclined to retain the provision that allows people in their 20s to stay on their parents' plan and another that prevents insurers from denying coverage to people with pre-existing health conditions; the individual mandate and federal subsidies are still on death watch

Medicare – Doesn't seem likely to see changes before 2018 mid-term elections

Medicaid – Block grants are priority in the Republican agenda, but it is not clear whether it will make it through legislation

How fast? Not fast! – Just like implementation of ACA was staged over many years, the undoing, even if not a complete repeal, is almost certainly going to be staged; Republicans aren't going to strip voters of coverage on day one

Sources: donaldjtrump.com, gop.com, Oliver Wyman analysis

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TRUMP'S HEALTHCARE PLAN

The Impact and What Now:

PAYERS

ACA

- Even without a wholesale repeal, the market is still set to enter a period of disruption and uncertainty
- Removing the individual mandate (which is expected) will likely lead to the collapse of the ACA market, the Exchange will have to be removed entirely, and Individual underwriting will emerge again
- In the event of ACA market collapse, we anticipate some states will pass their own individual-mandate legislation
- State high-risk pools are likely to re-emerge as a solution for individuals with significant health conditions who don't qualify for underwritten individual health insurance
- We may see a resurgence of limited-benefit plans that cover either basic primary care or hospital indemnity style
- While ACA business was not profitable for many payers, major investments were made in the capabilities needed to compete in the ACA environment and those investments will now need to be reevaluated
- Payers that *are* profitable on the exchanges should and prepare to scale back operations accordingly
- Payers should dust-off pre-ACA levers to increase profitability and put renewed focus on commercial business lines
- Even with rollback of ACA, the push to value focus won't stop – MACRA will still charge ahead and the trend is in full force with employers jumping on the bandwagon of tiered, narrow, and value-oriented networks to drive cost savings

MEDICARE

- If the GOP position to transition Medicare to a premium-support model goes forward, payers will face increased financial uncertainty, as plans are paid based on average vs submitted bids
- Will force MA plans to be acutely aware of costs and require renewed focus on efficiency

MEDICAID

- Block grants could create 50 distinct experiments in Medicaid, each requiring different strategies for those in the managed Medicaid market
- Medicaid changes will play out more slowly, as states have largely outsourced their programs to managed care and are expected to continue to do so
  - In time, though, this could lead to slow reduction of benefits in several states as budget concerns and reduction of minimum benefit and coverage thresholds causes states to "raid" Medicaid in the face of revenue shortfalls

INSURANCE ACROSS STATE LINES

- Increased cross-state competition could increase the power of consumer choice
- However, it is unclear how many insurers would be willing to participate; Georgia, Maine, and Wyoming already allow cross-state licensing and no payer has yet taken advantage
- Payers that pursue the opportunity should prepare for challenge of entering new markets, building provider networks, and attracting enough customers to create a large-enough risk pool
- Expect participating insurance companies to move to states with the most favorable (least stringent) regulations
  - This could result in a “race to the bottom,” with payers offering cheaper and less-comprehensive policies in new markets
  - Those plans would attract healthy individuals from some states, leaving the sicker people behind and causing insurance premiums there to increase

Sources: National Conference of State Legislators, news sources, Oliver Wyman analysis

"TRUMPCARE" AND HEALTH INSURANCE MARKETS: A TALE OF TWO TIMELINES FOR REPEAL AND REPLACE

by Marcia Macphearson, Partner, Health & Life Sciences, Oliver Wyman
Parie Garg, PhD, Partner, Health & Life Sciences, Oliver Wyman

President-elect Trump and the GOP-controlled Congress have the opportunity – and fully intend – to reshape the healthcare landscape by unraveling certain aspects of the ACA. For insurers, the critical question is how quickly some of these changes will be enacted and how changes to individual mandates, underwriting requirements, and government funding will impact products, membership, and profit levers.

Key provisions of the law (federal subsidies, individual and employer mandates) have long been in the sights of the GOP and were campaign targets for President-elect Trump. The campaign rhetoric focused on the repeal of Obamacare and that continues to be the mantra for the GOP in the days post-election, with some GOP leadership indicating that they will move as quickly as inauguration day to pass a bill to repeal.

However, the timing for a replacement and how the changes will be staged remain far from certain; and that is driving significant trepidation across the healthcare market. Here, we consider two scenarios for how these changes might unfold: an accelerated timeline, in which the GOP moves swiftly and broadly in their actions, and a more moderate timeline, where key elements of the law are amended over time.

Fast path to Trumpcare

Operating on the belief that they have been given a mandate by the American people, with a finite window for sweeping changes (the 2018 mid-term elections are right around the corner), the GOP could attempt to drive swift action across the individual markets, as well as Medicare and Medicaid.

An accelerated repeal and replace approach might play out along these lines:

- Obamacare is "repealed" in early 2017
    - Medicaid expansion is rolled back by cutting off federal government funding for the additional members and benefits covered within ACA Funding
    - Support for subsidies are withdrawn in 2017 via the Trump Administration simply dropping the Obama Administration's opposition to a GOP-backed lawsuit alleging that ACA subsidies were not appropriated correctly by Congress when the legislation originally passed
    - The individual mandate is removed and the administration signals that it will not apply tax penalties starting as early as 2017
        - Presumably, this would need to be partnered with a relaxation of the restrictions on health plan underwriting rules, such as pre-existing conditions and product coverage mandates
    - If the repeal doesn't address both of these issues (subsidies and individual mandate) together, it could collapse the individual market entirely
- A Medicare overhaul is attempted.
    - This would potentially drive toward a premium-support model, as laid out in Speaker Paul Ryan's "A Better Way" plan

In our accelerated scenario, key issues for insurers to consider include:

Responding to worried consumers. Plans may need to prepare for high customer-service call volumes, as customers who bought ACA insurance will likely be questioning what a repeal means for their near-term coverage.

ACA population shifts and subsequent impact on revenue. A repeal of the individual mandate and the possibility of no subsidies could cause ACA enrollees to drop coverage at a rate even higher than previously seen (member attrition rates for ACA products over the course of a year are already high at about 30 percent). In this case, insurers will need to find ways to flex their operations over the course of 2017 in order to cut administration costs in response to reduced membership volumes.

Strategic planning for the Individual book of business. The first 2018 ACA exchange market price and product-filing deadlines are in April, less than 90 days after President-elect Trump takes office.

The decision to participate in the exchanges (or not) could occur amidst continued uncertainty about the future of public exchanges – particularly if the administration announces a repeal plan in January without simultaneously clarifying and defining a replacement plan.

If this is the case, plans may need to consider how to maintain their Individual book of business, potentially via off-exchange products that (presumably) would look very different than the current ACA product and underwriting guidelines require. In order to retain profitability, plans may need to consider pivoting back to product structures that were common in the pre-ACA market (limited-benefit plans, for example) and target a different block of Individual consumers than they did under the ACA.

Medicare moves and opportunities. If passed, a premium-support system could lead to lower Medicare payments for insurers and higher out-of-pocket costs for beneficiaries. Generally, the discussed changes to Medicare could mean a material difference in how health plans will go-to-market in the future, and they may face greater price competition among MA plans. Organizations will face even greater pressure to be efficient in managing the Medicare population.

Medicaid MCO impact. Managed Medicaid organizations that have experienced substantial growth will likely experience significant loss of membership if Medicaid expansion is stopped or repealed. Coupled with disruption of the individual exchanges (where some Medicaid plans are doing very well), Medicaid MCOs should be considering how to prepare for a decrease in membership revenues, as well as a potentially sicker population, as healthier members who were part of the expansion population may no longer have coverage.

Slow-and-steady shift to Trumpcare

While the "fast" scenario is a possibility, many believe it is more likely that the administration will take a measured approach and establish a timeframe of staged changes over the next several years.

The ACA is a broad and complex law that links together all of the key health markets of Medicare, Medicaid, employer-sponsored coverage (small group market), and Individual exchange markets in a deadly embrace, of sorts. It will likely be difficult to fully pick apart singular elements of the law that the GOP finds less favorable without having a ripple effect on other more favorable aspects. (For example, the individual mandate and its implicit link to the prohibition to deny people insurance for pre-existing conditions). As such, the administration may take a more staged approach to change that allows them to account for all of the various moving parts of the law that need to work in concert.

In that case, the administration's approach may include:

- Signaling that the foundational elements of the public exchanges will persist through 2019 and focusing on more targeted changes that will encourage payer participation and competition in the meantime – adjusting the special enrollment periods that have been a real challenge for many payers, for example

- Cancellation of the planned 2020 Cadillac tax deployment
- Repeal of the SHOP marketplace for small groups, which has had lower-than-expected adoption rates to date, and remove the requirement for small businesses to comply with ACA minimum essential benefit plans by the end of 2017
- Shift Medicaid to block grants
- No disruption of Medicare given the political sensitivities of changing a program that is popular with voters

In this scenario, key issues for insurers to consider include:

Retain and prepare to reframe in the individual market. Even with a slower progression, the high level of uncertainly and disruption may cause some payers to exit. However, it seems likely that 2018 and 2019 will not see major individual market shifts and payers will have the opportunity plan for the pivot.

In the short term, retaining existing membership volumes will be important to meet 2017 revenue expectations. During this time of disruption, plans that can provide a supportive and transparent consumer experience should win loyalty that could carry through to higher retention rates when the ACA changes eventually go into effect and members need to consider a different set of plan offerings.

Shore the core commercial book of business. Given the disruption across all of the government programs lines of business, renewed focus on commercial lines of business to create an anchor of margin stability will be important, especially with small businesses.

Prepare for block-grant impact. At present, the federal government provides 60 percent of Medicaid funding and requires coverage of select groups (such as children and lower-income pregnant women) as a quid pro quo. Under the block-grant program, states would be allotted annual funds for use at their discretion and these provisions would be lost. Thus, movement to block grants may result in states altering their eligibility criteria, which would result in loss of coverage, which would (in turn) lead to membership losses for Medicaid MCOs.

In addition, because states will be responsible for overages above the block grant funds, insurers should prepare for the possibility of ratcheted-back reimbursement rates.

These changes will force a focus on operational efficiencies, as well as reconsideration of health management programs for select segments, depending on how eligibility is impacted by block-grant rollouts.

No matter the pace

Regardless of the timing or the extent of the changes, there are a few no-regrets moves that we believe health insurers should make now:

- Continue the drive toward value and invest in plan capabilities to control underlying medical costs, which continues to be the primary challenge within healthcare

- Prepare for the financially empowered consumer, who will drive more transparency and increase in consumer-directed spend
- Build big-data digital expertise as benefits and rating flexibility could be vastly expanding
- Assess financial and scale flexibility to weather enrollment shifts
- Carefully evaluate how/where to participate in the individual market

The last few years have been turbulent for the healthcare industry, especially for payers participating in the ACA individual markets. The next several years will likely see a new wave of disruption, and that will put even more pressure on health plans to efficiently and effectively pivot business models and operational capabilities. That said, the complexity of the law could lead to more gradual phase-in of changes, hopefully giving insurers leeway to chart a path for an uncertain future.

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TRUMP'S HEALTHCARE PLAN

The Impact and What Now:

PROVIDERS

ACA

- Though the ACA is now in the sights of the GOP and President-elect Trump, there appears to be alignment behind the need for value-based initiatives; and, in fact, the core emphasis of being efficient and able to deliver value will become even more paramount in a world where providers face reimbursement uncertainty within key funding segments
- If the individual mandate is repealed and federal subsidies are eliminated, enrollment on the exchanges stands to decline
  - Those who remain will likely have greater needs and higher utilization
  - Those who drop will be left to find providers who will see them and that they can afford; access to preventative care and early disease management will suffer
- Providers should plan for higher uninsured rates and prepare for uncompensated care to retreat toward pre-ACA levels
- If ACA and Medicaid populations shrink, reimbursement pressure will shift to Commercial payers; to win share and returns, providers will need to stand-out on efficiency and ability to deliver value to those populations
- Providers should embrace the need to move toward a value-based model; Commercial payers and employers stand to reward those delivery systems that distinguish themselves on cost, quality, outcomes, experience

MEDICARE

- Hospitals taking in higher Medicare populations and those that are subsidized by Medicare may face funding uncertainty if the GOP pushes a shift to premium-support model
- Providers should pay close attention to traditional Medicare enrollment to inform decisions regarding involvement in future reform efforts and pilot programs

MEDICAID

- If Medicaid eligibility returns to pre-ACA levels, providers will face significant profitability challenges and major increases in uncompensated care
- Providers should monitor block grants closely and assess risk of under-funding
- Depending on block grants, providers could experience decrease in government spending and should develop strategy for securing more revenue from private payers and individuals

INSURANCE ACROSS STATE LINES

- Impact of cross-state licensing is uncertain at best, and may have little impact

PRICE TRANSPARENCY

- Although the plan does not say how the administration would implement a federal mandate for price transparency, it suggests a potentially forceful tailwind for value
  - To be sure, the Commercial insurance and employer marketplace will embrace any advance on transparency
  - For that reason, providers who embrace and excel in the shift to value stand to win in a market where pricing and utilization transparency are at the core of the conversation
  - Gaining clarity around financially viable, core services becomes paramount – as transparency would seemingly expose offerings that are sub-scale and/or not delivering value on the cost and quality equation

Sources: National Conference of State Legislators, news sources, Oliver Wyman analysis

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VALUE-BASED CARE UNDER PRESIDENT-ELECT TRUMP? HERE TO STAY

by Dr. Bruce Hamory, Partner and Chief Medical Officer, Health & Life Sciences, Oliver Wyman
Dan Shellenbarger, Global Head, Provider, Health & Life Sciences, Oliver Wyman

Since the election, there has been no shortage of speculation as to what the incoming administration will keep, scrap, and propose as replacement for the ACA. Here, Oliver Wyman's Dr. Bruce Hamory and Dan Shellenbarger make the case that as we consider what comes next, it is important to revisit the root-cause issues that led to healthcare reform. And there are lessons to be gained, they say, by studying the value-based reform solutions that are beginning to take root. Bottom line: No matter what happens with the ACA, now is not the time for providers to ease off their transformation efforts.

Whether you are red or blue or none of the above, there is unanimous agreement that our healthcare system is subpar on quality, frustrating to experience, and far too expensive. These are the underlying pressures that fueled the passage of the ACA, and they absolutely still exist today. While the access and insurance provisions of the ACA (coverage mandates, subsidies, rating rules) have direct and profound impact on consumers and, therefore, are hotly contested, they distract from the critical need for our healthcare system to reconfigure care delivery, integrate information flows, and realign payment.

Without question, solutions for access and insurance coverage are essential; however, without fundamental delivery system reform, access provisions will not be sustainable. Reining in health spending, empowering consumers with information and tools to make informed decisions, and driving outcomes and quality must remain THE priority. For this reason, it is essential that the shift to value-based payment models continues.

Value-based pilots not going anywhere

Providers must not interpret a rollback of some ACA insurance provisions as a signal to ease off their preparations for value-based payment. In fact, value-based initiatives appear to be the least likely elements of the ACA to be repealed. Studies over the past two years demonstrated that value-based pilot projects such as Patient Centered Medical Homes and the Medicare Shared Savings Program have reduced costs, and either maintained or improved quality. HR Bill 3762 – the bill passed repeatedly by the US House of Representatives to repeal the ACA, and the likely roadmap for an ACA rollback – does not include any mention of repealing these initiatives.

MACRA will roll on

Further, it would appear that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the broadest push to value to date, is not going anywhere. The Act, which establishes new provider payment rules, is budget neutral, and rewards quality and reduced costs. It was enacted to repeal and replace the Sustainable Growth Rate Formula (SGR) for the Medicare Physician Fee Schedule – a perennial thorn in the side of Congress since its enactment. Notably, MACRA was passed by the Republican-controlled majorities in both the House and Senate, and a principle element is heightened payments for providers taking on risk-based reimbursement across a majority of funding segments. For these reasons, it appears unlikely that MACRA would warrant opposition from the next Republican-controlled Congress.

In time of tightened budgets, value will be differentiator

In the near term, pressure to control healthcare costs will only increase as healthcare budgets continue to tighten across federal, state, and private employer funding segments. Cost shifting will continue to drive expansion, and use of tax-free Health Savings Accounts will likely increase consumers' awareness of cost and fuel their expectations for service and experience.

The path to value remains necessary to offset the high-cost/low-quality formula – no matter who is sitting in the White House.

As these factors play forward, delivery systems that distinguish themselves on cost, quality, outcomes, and experience stand to separate themselves from those that operate in the legacy model – regardless of what happens with an ACA rollback.

Providers should stay the course

Bottom line: The path to value remains necessary to offset the high-cost/low-quality formula – no matter who is sitting in the White House. Providers should continue to chart their course to value and rapidly implement the changes needed to improve the quality and safety of the care rendered.

While the tactics will vary by market, the following key principles should be resident in all systems' plans for the coming year:

- Position the organization to win by delivering care more efficiently in lower cost settings
- Develop and advance the organization's strategy to implement the provisions of MACRA
- Anticipate that changes to the ACA and MACRA (if any) will be relatively slow and that there will be no changes to the financial penalties for poor performance
- Focus on improving the consumer experience – before, during, and after care – to meet and surpass rising expectations for ease of access, predictability of costs, and levels of service
- Quantify and communicate your organization's differentiated value – to patients, families and purchasers of care – especially given an increased energy around price transparency

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TRUMP'S HEALTHCARE PLAN

The Impact and What Now:
LIFE SCIENCES COMPANIES

ACA

- Expect President-elect Trump and the GOP to kill the 2.3 percent medical device tax that was created – but delayed and never enacted – to help pay for program
- A repeal of the individual mandate and a rise in uninsured could result in a drop in revenue, as people may forgo care for chronic or non-life-threatening conditions
- Even with an ACA rollback, consumer cost-exposure will remain an issue for life sciences companies; companies will need to factor out-of-pocket costs into launch and lifecycle pricing strategies

MEDICAID

- Block-granting Medicaid could result in more people losing coverage and more people forgoing drug care (or seeking it from charities or pharma patient assistance programs), and this could result in revenue drop
  - Biggest impact would be on those drug categories that have disproportionate usage in Medicaid populations, such as Hepatitis C
  - Because Medicaid pays significantly discounted prices for drugs, the revenue impact won't be as significant as if a similarly sized commercial population lost coverage, but it could still be consequential

- With state Medicaid budgets more limited, state Medicaid agencies will be looking to save money on drug cost and may decide to cover fewer drugs, or push for regulation that increases mandatory Medicaid price discounts, and/or negotiate much harder for higher discounts to get onto state Medicaid drug lists

PRICE TRANSPARENCY

- The impact of provider price transparency is indirect, but worth consideration:
  - If the push for transparency is extended to pharma and results in regulation requiring companies to post their average actual received price, there could be significant change in how the industry handles discounts – likely reducing the amount of complexity, increasing the discounts being provided, and potentially lowering pharma revenue

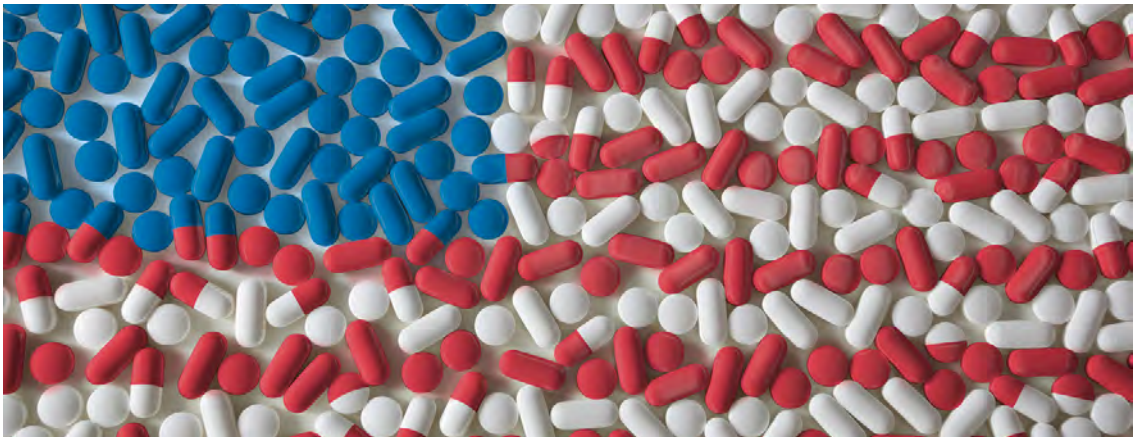
PRESCRIPTION DRUG REFORMS

- Secretary Clinton's platform took a much stronger stance on regulating drug prices and drug stocks surged in the wake of the Trump victory
- The proposal to remove barriers to entry and allow more parallel imports will impact companies' international drug pricing strategies
- The plan to allow Medicare to negotiate drug prices received much press coverage, but will likely have little impact
  - Medicare already outsources most of its Rx to PBMs, which are already negotiating aggressively
  - CBO determined that allowing Medicare to negotiate drug prices would have little impact on federal spending

Sources: National Conference of State Legislators, news sources, Oliver Wyman analysis

WHAT PRESIDENT-ELECT TRUMP'S UNEXPECTED WIN MEANS FOR BIOPHARMA

by J. David Campbell, Partner, Health & Life Sciences, Oliver Wyman
Anne Griffin, Engagement Manager, Health & Life Sciences, Oliver Wyman



Since President-elect Trump's unexpected win, there has been much discussion about how he and his Republican-led Congress might "repeal and replace" the Affordable Care Act (ACA). There is also ample speculation about how changes to the ACA will impact health insurers and people who obtained coverage via the Act.

Much less has been said, however, about how the Trump administration may impact life sciences companies. Yet one look at life science stocks reveals that the market is expecting big things for biopharma. How will President-elect Trump's changes – or lack thereof – impact the industry?

What he has said, and what he hasn't

The healthcare section of President-elect Trump's transition website mentions pharma (albeit very briefly) in its goals to "advance research and development in healthcare" and reform the FDA. Creating an environment more hospitable to R&D and approvals would certainly be a positive for biopharma.

However, the president-elect has also indicated he may make moves that would create a less-positive climate for biopharma – at least initially. On the campaign trail, President-elect Trump stated he would remove barriers to importation of cheaper products, which could have severe biopharma impact. More specifics about the level and any limitations on imports (generics only?) are needed to truly understand the impact of this plan. For now, market expectations appear to be muted.

Candidate Trump also discussed allowing the Centers for Medicare & Medicaid Services (CMS) to negotiate drug prices, which could be viewed as negative for industry; however, the idea has not yet appeared on his transition website. PBMs are already aggressively negotiating lower prices. Without the ability to remove drugs from the formulary, CMS' negotiating leverage is lessened. The net effect, as the Congressional Budget Office's prior investigations have concluded, is that allowing CMS to negotiate drug prices would only have a "negligible effect" on drug spend.

Finally, the President-elect's proposal to move to a 15 percent corporate tax rate does not impact healthcare directly, but would have a significant financial impact on life sciences companies. Flush with cash and a (likely) less-restrictive regulatory environment, an era of re-investment in development, co-development with other firms leading in their R&D areas, and even pharma mega-mergers could be re-ignited.

The biggest driver of pharma's post-election stock upswing likely has less to do with President-elect Trump's plans moving forward, and more to do with Hillary Clinton's plans not moving forward. Clinton's proposals included review of price increases; capping direct-to-consumer advertising and limiting marketing spend; prohibiting "pay-for-delay"; and allowing Medicare to negotiate drug costs. Not having to take on those fights has lifted both pharma's spirits and stock prices.

The elephant in the room… ACA repeal

While a repeal of the ACA will have great impact on insurers, there are clear implications for pharma.

The Medical Device Tax, a 2.3 percent excise tax that went into effect in 2013 but on moratorium in 2016 and 2017, was called out for elimination in previous House replacement plans and is likely to be eliminated.

Another candidate for elimination, albeit a less significant one, is the Branded Prescription Drug (BPD) Fee. Under this ACA provision, a flat-fee excise tax was imposed on the branded-drug market, as a whole. Manufacturers with sales over $5 million must contribute to the flat fee, with each manufacturer's contribution based on their share of the branded-drug market. For major biopharma companies, the fees could total in the low hundreds of millions. The flat fee started at $2.5 billion and is set to spike to $4 billion in 2017. Eliminating it would be a small but welcome win for biopharma's coffers.

President-elect Trump has indicated that areas of the law highly popular with the public, such as guaranteed issue and allowing children to stay on parents' coverage until age 26, are likely to be maintained. Closing of the Medicare "donut hole" and the increase in Medicaid discounts likely fall into this category, meaning that manufacturers would continue to pay these rebates.

Other aspects of a repeal would have less direct impact. The unwinding of public exchanges and the individual markets, along with the possible conversion of Medicaid to a block-grants program would likely increase the number of uninsured; this could mean fewer patients able to receive the medicine they require, and/or more patients using pharma-sponsored assistance and indigent programs, both impacting biopharma's bottom

line. That said, any loss of revenue from a shrinking patient pool is unlikely to outweigh the impact from the removal of the Medical Device Tax and BPD fees.

Should pharma still pay attention to the ACA-driven trends of value and increasing consumerism?

While most of the ACA's provisions did not target pharma specifically, it had a profound impact on the entire health landscape. High deductibles, increased cost sharing, and an increased role of the patient as "consumer" have all contributed to the heightened scrutiny of drug value. Repealing parts of the ACA won't change that; in fact, it will likely become exacerbated as consumers switch to using their own savings in the form of HSAs.

The genie won't be headed back into the bottle – regardless of what happens with the ACA. Now, more than ever before, understanding patient cost-sharing is a critical element of drug strategy.

So how should biopharma prepare for the next four years?

As tempting as it may be to kick back and enjoy the rising stock prices, the most successful pharma companies will be the ones that prepare for the future:

- **Revisit investment strategies in light of the new tax and regulation policies:** Companies should ensure they know the cash impact of new tax rates and repeal of the aforementioned ACA taxes; and they should develop plans for the increase. Smart companies will look at their competitors as well, and have an answer for how to best use any new-found cash.
- **War-game your portfolio to assess risk**: Various aspects of the Trump health plan will affect portfolios differently; impact could be dramatic for some products and irrelevant for others based on the relevant patient population and payer mix. Companies should ensure they understand how the population for each of their key products plays out, and then develop plans for those products that will be most affected by the changes.
- **Continue moving toward value**: Price pressure on drugs is unlikely to go away just because Clinton isn't taking office. Lawmakers on both sides of the aisle have indicated they are willing to take up the issue. Employers also have indicated that their number one priority for a new administration is to take on prescription drug price transparency. The need to incorporate perceived value into drug pricing strategies may have been set to a lower temperature, but it is likely to continue to increase.

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WHAT A REPUBLICAN CONGRESS MEANS FOR PRESIDENT-ELECT TRUMP'S HEALTH PLAN

REPEAL ACA

- Two days after his victory, the president-elect indicated he would not repeal ACA completely
- Republican leadership and the president will likely focus on implementing proposals outlined in the GOP party platform
- The individual and employer mandates are likely to be repealed; the "Cadillac tax," which was delayed to 2020, is likely to be killed
- Efforts to decrease spending will likely focus on:
  - Eliminating ACA insurance reforms such as minimum essential benefits
  - Restructuring premium subsidies
  - Eliminating the CMS Innovation Center and Medicare Independent Payment Advisory Board

MEDICARE REFORM

- Leadership may push the GOP position of moving toward a premium-support program

RESHAPE MEDICAID FUNDING

- Expect a strong push to provide block grants to states

PRESCRIPTION DRUG REFORMS

- Focus will be on speeding-up FDA approval process, but leadership will face public pressure to lower drug costs

Sources: *Modern Healthcare, Kaiser Health News*, Oliver Wyman analysis, additional news sources

PREVIOUS EFFORTS TO REPEAL ACA SHED LIGHT ON HOW PROVIDERS MAY BE AFFECTED

by Dr. Bruce Hamory, Partner and Chief Medical Officer, Health & Life Sciences, Oliver Wyman

Although candidate Trump vowed to completely repeal "Obamacare", just two days after winning the election President-elect Trump said he would consider keeping parts of it.

While we don't yet know what aspects of the ACA will be preserved and which might be scrapped, we can gain some insights based on campaign-trail statements and a review of the previous legislative activity to repeal the law.

Further, we also can project both the short-term and long-term impact of a rollback on the provider community. In brief: The near-term impacts for providers appear likely to be minimal. Rather, it is the longer-term impact of shifts in insurance and payment reform that are likely to have the greater impact.

Short-term impact

HR Bill 3762 is the bill passed repeatedly by the US House of Representatives to repeal the ACA. It cancels many of the insurance sections of the ACA, including the individual and employer mandates, and many of the taxes (including those on devices, drugs, HSAs, increased Medicare tax) required to support expanded Medicaid coverage.

Given the President-elect's campaign focus on the individual and employer mandates, it is likely that these insurance-related provisions from HR 3762 will either be eliminated or greatly reduced. If this were to happen, this direction would bring about dramatic increases in insurance premiums, perhaps even worse than those announced during the latter stages of the campaign.

While the Republican Congress and president-elect have made their views on the insurance-related provisions quite clear, there has been almost no mention of provider-related sections. In fact, only four areas in the repeal bill impact providers and only one directly impacts hospitals. Provider-focused provisions include:

- Restrictions on funding for Planned Parenthood and similar organizations
- Increased support for Community Health Centers
- Establishment of a two-year allocation fund to support states in responding to "Substance Abuse Public Health Crisis and Urgent Mental Health Needs"
- Repeal of the Disproportionate Share Hospital (DSH) allotment reductions

During the initial discussions around the passage of the ACA, the Congressional Budget Office scored the provider changes as the only section of the Act that would reduce costs. This analysis included the Center for Medicare and Medicaid Innovation and the implementation of the sections on value-based purchasing, reductions in readmissions, and reductions in hospital-acquired conditions.

Studies over the past two years have demonstrated that the hospital-related and numerous pilot projects in the provider sections (such as Patient Centered Medical Homes and the Medicare Shared Savings Program) have, in fact, reduced costs, and either maintained or improved quality.

HR Bill 3762 actually ends by recognizing the cost savings obtained from the provider-oriented programs, and suggesting that the $379 billion in savings ("which recognizes the full amount of on-budget savings during the fiscal years 2016 through 2025") be transferred to the Federal Hospital Insurance Trust Fund to extend Medicare solvency.

Longer-term impact

While immediate impact may be minimal, the longer-term impact of changes to the insurance provisions could be dramatic. Unraveling the ACA insurance provisions would almost certainly lead to an increase in uninsured patients and a reversion to ER utilization for non-traumatic care. This, in turn, would undoubtedly stress already thin operating margins for safety net hospitals and many others.

At the same time, a block-grant approach to federal funding of Medicaid without a requirement for state matching funds could reduce total funding, and the elimination of federally mandated thresholds for Medicaid enrollment could potentially further increase the number of uninsured.

If both the individual mandate for insurance and the state exchanges are eliminated, it's reasonable to believe that virtually all commercial insurers would exit this line of business.

It would also be expected, then, that the insurance industry will argue for elimination of the restrictions on underwriting parameters, and at least some change in the "pre-existing condition exclusion." For example, insurers could seek a waiting period for coverage of high-cost conditions after enrollment to reduce the number of high-cost individuals waiting to enroll until they become ill.

For those states in which Medicaid has been completely transitioned to managed care, the impact of block grants may alleviate the impact for insurers while maintaining cost pressures on providers.

Provider action items

- Prepare for the possibility of higher uninsured rates and uncompensated care; these could potentially retreat toward pre-ACA levels
- Consider carefully the impacts of decreased funding for Medicaid expansion and the potential for Medicaid to once again become a solely state-based issue
- Take into account the current financial condition of your state and its commitment to Medicaid

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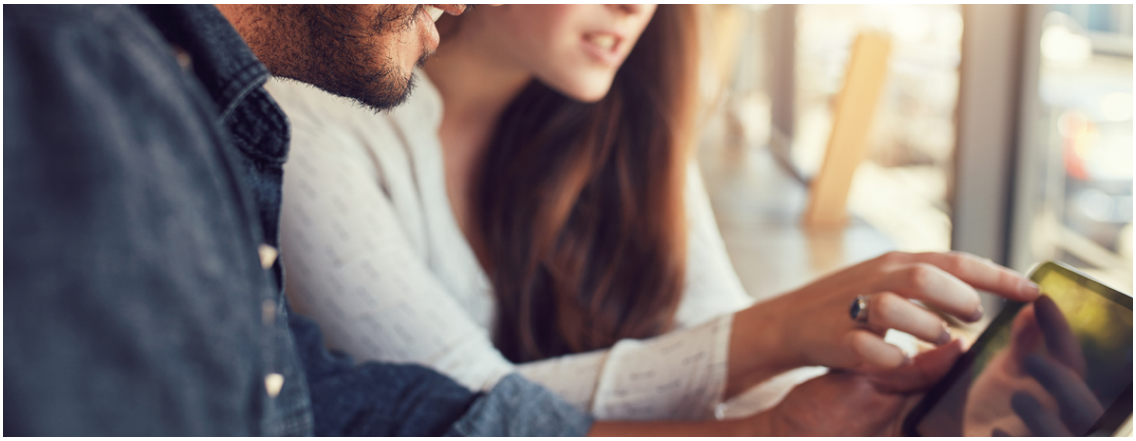
5 REASONS WHY PRIVATE EXCHANGES ARE SET TO FLOURISH IN THE AGE OF TRUMP

by Howard Lapsley, Partner, Health & Life Sciences, Oliver Wyman



Under a Trump administration, public exchanges are "dead men walking," while private exchanges are poised for significant expansion, says Oliver Wyman's Howard Lapsley. Below he explains why.

Even before Americans awoke on November 9 to President-elect Trump's stunning election upset, the ACA and its public exchanges were in trouble. The average marketplace plan saw a rate hike of 22 percent (before subsidies); and due to mass insurer exits, more than one-third of US counties faced enrollment with only one carrier option.

President-elect Trump and the Republican Congress are now set to "repeal and replace" the ACA. While we don't yet know the details or timeline of their plan, the uncertainty surrounding the individual marketplace will likely lead to further exits and rate hikes, with the sicker signing up and the healthy "young invincibles" staying clear.

Given these realities, the public exchanges from here on out may be "dead men walking." On the flip side, private exchanges for the individual and small group marketplace are set to flourish. Here are five reasons why:

1. Individual market void

With potential loosening of essential health benefits rules, private exchanges will fill the void and provide a platform for insurers to offer new, innovative products. These products will likely be skinnier versions of what is offered today, with sculpted local networks.

2. Value-conscious consumers

Under the Republicans' repeal-and-replace plan, federal subsidies are expected to be decreased or eliminated. In addition, people are facing ever-higher premiums and out-of-pocket expenses. Going forward, consumers will be even more focused on value. Private exchanges, which allow consumers to see the true cost of benefits, provide a transparent marketplace and could fill consumers' increasing interest in shopping for value.

3. Interest in total-risk protection

The expected loosening of regulations will make it easier for insurers to bundle core and ancillary benefits customized to each consumer's life-stage needs. The private exchange platform – with its consumer-centric choice algorithms – will make it easier for value-conscious consumers to consider their total risk, and then spend their dollars with greater understanding of their total-risk protection needs.

4. Employer needs

Expect large group and self-insured employers to accelerate adoption of private exchanges, as those employers will be seeking new product offerings to both keep costs down and allow their employees more flexibility of choice.

5. Provider acceptance

Providers and integrated delivery networks will likely embrace private exchange platforms, as they (and Wall Street) are concerned about the potential for increased bad debt if more individuals choose to go without health insurance.

For payers, the results of the 2016 election have created numerous product and legislative scenarios to consider, and much remains unclear. One thing is certain, however, and that is the ever-increasing importance of consumer-centric distribution approaches, chief among them private exchanges. Now that open enrollment is ending for 2017, it's time to reset distribution strategies that will thrive in 2018 and beyond.

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Based in Boston, Howard focuses on retail health strategy development, health policy and reform, seniors/government programs, individual/small group markets, distribution & marketing, and organization alignment.

TERRY STONE IN HBR: INCREMENTAL FIXES WON'T SAVE THE US HEALTHCARE SYSTEM

by Terry Stone, Managing Partner, Health & Life Sciences, Oliver Wyman

According to Oliver Wyman's Terry Stone, the risk of the current "repeal-and-replace" debate is that it shifts attention away from the real challenge facing the US healthcare system: a disjointed care delivery system that results in inefficiency, overspending, lack of consumer accountability, and a sub-par experience. Here, in an article first published in Harvard Business Review*, Terry makes the case for pushing harder and faster on initiatives that will shift the system toward one that is focused on value, outcomes, and experience.*

Tom Price, President-elect Trump's pick to be the next US secretary of health and human services, is a fierce and long-time critic of the Affordable Care Act (ACA), including initiatives that restructure how some doctors are paid.

Many are interpreting this opposition to mean that he will slow the shift from traditional fee-for-service healthcare, where doctors are paid per visit, test, or procedure, to value-based care, where doctors are rewarded for quality care and better outcomes. But I hope it means that he recognizes we need to take bold action to correct our health system's current trajectory. Incremental shifts, the approach to date, simply won't address the real challenge confronting the US healthcare system — that is, a disjointed care delivery system that results in inefficiency, overspending, lack of consumer accountability, and a sub-par experience all across healthcare.

Instead, we need to adopt policies that result in significant discomfort for the laggards and outsized rewards for the leaders. Only then might we achieve what Price has called "the principle of healthcare that Americans hold dear: accessibility, affordability, choices, innovation, quality, and responsiveness."

The ACA was touted as a remedy for our broken health system, but its overarching focus was expansion of coverage. It didn't do enough to address the system's root-cause cost and quality issues. Experts understood that to transform healthcare we needed to first shift the focus from transactional fee-for-service medicine to value-based care.

The ACA did launch several value-based initiatives. These were intended to drive change in the market. However, the way they were structured and the cautious approach to implementation has unintentionally handicapped them. There is too little penalty for staying the course in fee for service and not enough upside to take the risk of disruptive change.

Consider the Medicare Shared Savings Program (MSSP), which was created by the ACA. Under MSSP, eligible Medicare providers and hospitals can come together to form accountable care organizations (ACOs). The program provides bonuses for ACOs that reduce health spending and deliver high-quality care. It offers the possibility of even greater financial rewards for those who assume full financial risk for their Medicare patients, but few providers have been willing to take the leap. Consequently, the majority are ACOs in name only, not truly accountable for their performance and continuing down the same path as before.

In fact, the vast majority (95%) of MSSP ACOs are still operating in a largely fee-for-service payment model, working for bonuses for lowering costs, but assuming no downside risk. Few ACOs have done the hard work of changing how healthcare is delivered — moving from a physician-centric "doctor-knows-all" model to a patient-centric model that relies on a team and collaboration.

Who can blame them? Most realize that remaking their business model to succeed in a value-based care world is the right thing to do. But the push to transform their businesses occurred at exactly the same time the government was cutting reimbursement rates, putting significant pressure on hospital financials. And the reality is the pivot to value can be costly and is sure to be disruptive. By contrast, the consequence of staying in their fee-for-service world is minimal in the short term. This leaves many toe-dipping into the world of value through pilots like MSSP, while still depending on the fee-for-service model for the majority of their revenue.

The problem with this approach is it encourages players to operate completely different models with fundamentally different economic drivers under the same roof at the same time.

Accelerate value-based pilots. To achieve real change in our healthcare system, it is time now to accelerate past the pilot phase and push the industry toward value-based models. If there is any lingering doubt about the positive impact such a shift would have, note the outsized performance of organizations that are already delivering value-based care.

These players use a different kind of care model, one that provides coordinated, whole-person care, as opposed to episodic, transactional medicine.

Consider Cornerstone Health Care, a multi-specialty group practice in North Carolina that wholly redesigned the care model for its five highest-risk populations and then saw the cost-of-care drop nearly 13% and inpatient hospital costs fall 30%.

Or take CareMore, a California-based integrated health plan and provider network for frail elders and those with chronic conditions. CareMore wraps services around the sickest patients and provides a variety of non-medical services (such as transportation) to all patients. It claims 22% fewer hospitalizations, shorter hospital stays, and 32% fewer readmissions than the Medicare fee-for-service average.

Or look at Iora Health, a Boston-based network of clinics that targets services to individual patients' needs using both sophisticated analytics and a high-touch, team-based approach. It tallies a net promoter score (a measure of customer satisfaction and loyalty) of 88; the national average for primary care providers is 3. Usually only the Amazons and Nordstroms of the world see such sky-high scores.

Create discomfort and outsized rewards. These organizations offer ample evidence that the value-based approach can be successful — in terms of savings, outcomes, and improved experience. The challenge now is creating enough incentives and pressure to move the bulk of the market.

A first step is making it more painful for providers to stay stuck in their fee-for-service models. That means more aggressively reducing fee-for-service reimbursement rates relative to value-based payments. However, this isn't just about providers; we also must challenge private health insurance companies to accelerate their shift to value-based payment models. It will be impossible for providers to succeed while operating both fee-for-service and value-based models, and so health insurers should move in lockstep.

At the other end of the spectrum, we need to pour money and attention into those who are delivering better-quality, lower-cost care. Our system should be massively rewarding the likes of Cornerstone, CareMore, and Iora that have taken the risk and made the commitment. We need outsized financial incentives and more upside for taking the risk.

The government also should encourage consumers to use the best doctors; and it could use its influence to drive volume and financial benefit to those providers that transform their models and methods. How? The federal government funds 64% of healthcare costs in the United States, yet it does little to direct consumers to the best performers. Current quality and satisfaction measures (like the consumer-friendly star ratings available at the Hospital Compare website) tend to evaluate hospitals as a whole, when the reality is that it is individual practitioners where the variation on efficiency and quality tends to occur. With that many potential customers on the table, the government could make it worth every single provider's while to shift to value.

Finally, let's encourage Americans to act like consumers of healthcare — rather than just patients — and give them the information and tools they need to make smart decisions that also allow the best players to thrive.

We need the equivalent of Consumer Reports for healthcare or Morningstar ratings for clinical services. We also need to hold people accountable for the impact of lifestyle choices and where they choose to seek care. If you have a bad credit rating, you pay more for your credit; if you are a bad driver you pay more for your auto insurance. However, in healthcare, we do not have as much direct accountability.

What comes next won't be easy and we might see some players fail. It will force organizational leaders to think and act outside their comfort zones. And it will require our political leaders having the guts to push through reforms that may challenge the status quo, but could make America a world leader in providing the highest-quality healthcare and patient experience at the lowest cost.

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Terry leads the Health & Life Sciences practice group. The practice is focused on developing transformational strategies for healthcare companies in the payer, provider, life sciences, and services and technology spaces. Terry has extensive experience in the healthcare industry, including devising growth strategies, improving the cost and quality of healthcare services, establishing innovative partnerships across players in the healthcare sector, developing ACOs and other value-based solutions, and redesigning organizations to support their strategic transformations.

ABOUT OLIVER WYMAN HEALTH

Oliver Wyman Health is a virtual community of innovators convened by the Health & Life Sciences practice of global management consulting firm Oliver Wyman.

As the healthcare world changes and leaders look for direction, guidance, and new ideas, Oliver Wyman Health offers a digital platform for diffusing proven value-based solutions. Our in-house team of experts as well as a range of external thought leaders provide practical insights on the business challenges of transforming healthcare from volume to value.

We invite you to share ideas and infographics, contribute novel approaches to the financing and delivery of healthcare, subscribe to receive updates on effective strategies, and connect with other healthcare industry professionals.

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