What does the Trump Presidency Mean for Providers?

Aligning Leadership Around the Potential Changes and Impacts Ahead

As Donald Trump begins his term today as the 45th President of the United States, the healthcare industry is preparing for change once again – without knowing exactly what change is coming.

The Republican-controlled House and Senate have taken the first steps to use the Budget Reconciliation Process to dismantle the Patient Protection and Affordable Care Act (ACA) which provides some indication as to which provisions may be impacted, yet without specificity or consensus. In addition, what the corresponding set of “replace policies” will entail and the timing of such actions are still unclear. President Trump has expressed a desire to limit the disruption to the market by swiftly enacting repeal and replace “essentially simultaneously,” a sentiment echoed in his inaugural address today that “[change] starts now.” However, others in Congress are setting an expectation for late 2017.

As providers consider what the changing landscape may mean for their organizations and the communities they serve, there is considerable noise to cut through. In addition to the highly partisan, politicized debate, much is being written by policy experts, economists, consultants, industry leaders, lobbyists and others, each with various prognostications around the future of healthcare policy including value-based payment reform. Yet the reality is: no one really knows what will happen.

However, there are clear steps providers can take today to prepare for the shifts on the horizon. Assessing the implications of possible policy, economic and other market factors on the organization’s overall strategic and economic position, and aligning leadership around this perspective – inclusive of executive teams and boards – is critical. Establishing a shared understanding of the dynamics to watch, the most likely scenarios and potential impacts will
help anchor conversations and decisions in the coming year as many organizations re-evaluate their strategic priorities.

**Applying a Purchaser Segment Lens to Market Developments**

As organizations consider the myriad dynamics at play, we recommend using a purchaser lens to consider how policy, economic and other market factors may impact payors and consumers within specific segments: Medicaid/CHIP, including traditional and Medicaid Managed Care; Medicare, including traditional and Medicare Advantage; Individual Markets; and Employer-Sponsored Insurance (Self-insured and Commercial Group). This purchaser view proves a useful organizing mechanism given the expansive scope of the ACA as well as the highly-varied impact that its dismantling may have on different parts of the market.

We expect to see potentially wide-ranging and significant impacts as described in the tables below. The exact nature and timing of change will depend on numerous factors, such as:

- Which components of the ACA are repealed, defunded, replaced or otherwise impacted by executive action or intentional inaction
- Other issues of high interest or influence on the policy agendas of key Republican leadership
- Political and economic feasibility
- The state of the economy
- State leadership and policy direction

In many cases, we will see dynamics that decelerate or accelerate trends that are already underway. We also anticipate considerable variation by state and region, across payor segments and by organization.

**Anticipated Changes by Payor Segment**

**Dynamics to Watch and Implications for Providers**

<table>
<thead>
<tr>
<th>Medicaid/CHIP</th>
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<tbody>
<tr>
<td><strong>Summary:</strong></td>
<td><strong>Anticipated Changes Ahead</strong></td>
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</table>
| **Anticipated Changes Ahead** | • Shifting responsibility to states and efforts to limit federal spending and liability associated with Medicaid, resulting in state budgetary pressures
| | • Large programmatic variability between states
| | • Possible pathways some states may pursue include:
| | o Increased beneficiary cost-sharing
| | o Degradation of eligibility and coverage standards
| | o Changing role for Medicaid Managed Care
### Medicaid/CHIP

**Dynamics to Watch**

Select ACA Provisions Impacting this Segment:
- Medicaid Expansion for adults to 138% of FPL (optional)
- Essential Health Benefits
- Maintenance of Effort
- Enhanced Federal CHIP Funding; Limits to change CHIP eligibility through 2019
- Disproportionate Share Hospital (DSH) Payment Reduction
- Creation of Center for Medicare and Medicaid Innovation (CMMI)
- Various provisions related to administrative issues and services, including enrollment simplification

Other Dynamics to Watch:
- CHIP reauthorization (FY18)
- Use of waivers (e.g., Section 1115 waivers) to facilitate state flexibility
- Medicaid Managed Care penetration and support
- More fundamental restructuring of Medicaid federal funding, e.g., moving from FMAP to block grants / per capita approach to limit federal liability
- State leadership orientation and perspective on Medicaid, as well as pre-ACA state experience

<table>
<thead>
<tr>
<th>Implications for Providers</th>
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<tbody>
<tr>
<td>Increases in uncompensated care creating margin pressure</td>
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<tr>
<td>Reimbursement pressures</td>
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<tr>
<td>Utilization changes for remaining beneficiaries</td>
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<tr>
<td>Consideration of provider organizational role in setting direction for state Medicaid policy and approach</td>
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<tr>
<td>Medicaid Managed Care growth would have variable impact for providers based on their current respective positions</td>
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**Pediatric Providers:**
- May see fewer “direct” impacts from anticipated changes to Medicaid; for example, roll back of Medicaid expansion would more directly affect adult eligibility instead of pediatric
- Yet expected state budget pressures will have implications for pediatric and adult populations alike. Pediatric providers may also see "indirect” impacts of adults losing coverage given downstream implications for children’s enrollment, even if child eligibility does not change directly.
## Medicare

### Summary: Anticipated Changes Ahead
- Continued spending growth/budgetary pressure
- Anticipated continued payment and delivery reform with provider accountability for value, but likely to take different forms and points of control, and may grow at a slower rate than pace set by the Obama administration
- Continued privatization through Medicare Advantage and/or other mechanisms
- More meaningful reform is possible but politically sensitive issue is unlikely to be tackled in the near-term, if at all

### Dynamics to Watch
**Select ACA Provisions Impacting this Segment:**
- Creation of Center for Medicare and Medicaid Innovation (CMMI)
- Establishment of other value-based programs, e.g., Medicare Shared Savings Program, Hospital Readmissions Reduction Program
- Revision to MA benchmarks and rebates to bring MA spending closer to traditional Medicare
- Closing of gaps in preventive care coverage, prescription drug benefits
- Creation of Independent Payment Advisory Board (IPAB)

**Other Dynamics to Watch:**
- MA penetration/facilitation of growth through specific policy changes or administrative actions
- More fundamental changes to Medicare to address solvency issues, e.g., age of eligibility, premium support model

### Implications for Providers
- Reimbursement pressures creating margin pressure
- Evaluation of participation in voluntary, value-based payment programs (e.g., pursuit of advanced alternative payment models to qualify out of MIPS)
- Possible slow down or redirection of value-based models within CMS may impact the business case for investment in new Population Health Management (PHM) capabilities for some providers
- MA growth would have variable impact for providers based on their current respective positions
### Individual Market

**Summary: Anticipated Changes Ahead**
- Partial ACA dismantling including expected defunding of subsidies likely to destabilize individual Marketplace; could be as early as 2017 but most likely will impact 2018
- "Replace" policies will restructure market but to be determined exactly what this will include

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<tr>
<td></td>
<td>• Refundable tax credit providing premium assistance for coverage under a qualified health plan and reduced cost-sharing for individuals enrolling in qualified health plans (i.e., support for individuals 100-400% FPL)</td>
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<tr>
<td></td>
<td>• Establishment of the Marketplace, including administrative and product requirements</td>
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<td></td>
<td>• Guaranteed issue, including prohibition of preexisting condition exclusions or other discrimination based health status</td>
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<td></td>
<td>• No Lifetime/Annual Limits</td>
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<td>• Fair premiums; Rating limitations to age (3:1), smoking, geography, family size</td>
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<td>• Comprehensive health insurance coverage including Essential Health Benefits</td>
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<td>• Out of pocket maximum</td>
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<td>• Individual mandate</td>
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<td>• Extension of dependent coverage to under 26 on parents' insurance</td>
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**Other Dynamics to Watch:**
- Payor participation/competitiveness of carriers in individual market

### Implications for Providers
- Increases in uncompensated care creating margin pressure
- Potential near-term utilization changes for beneficiaries anticipating losing coverage in 2018 if organization is participating in Marketplace products currently
- If the Marketplace (or a restructured version) remains active in 2018, evaluation of whether to participate
**Employer-Sponsored Insurance**

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<tr>
<td>• More latitude for private employers to offer more limited coverage options</td>
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<tr>
<td>o Likely repeal of employer mandate (large employers with 50+) and elimination of minimum coverage standards (e.g., for large employers: preventive services; for small employers: Essential Health Benefits)</td>
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<td>o Likely changes to out of pocket maximums, deductible limits that would facilitate continued cost sharing</td>
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<td>o Dependent coverage extension to age 26 may remain</td>
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<tr>
<td>• Likely repeal of Cadillac Tax but possible replacement policy could seek to normalize tax treatment between individual and ESI market (e.g., capping tax deductible healthcare spending)</td>
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<td>• Broad support for encouraging “consumerism,” e.g., through Health Savings Account-enabled high deductible health plans (HDHP)</td>
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<td>• Continued focus on affordability by employers and continued / increased use and maturation of approaches by employers to manage expenditures (e.g., changes to coverage; benefit buy down, cost sharing; direct to provider, limited network products and value-based approaches; wellness and health promotion strategies)</td>
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<th>Dynamics to Watch</th>
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<td>• Employer shared responsibility provision (50+ employees)</td>
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<tr>
<td>• Guarantee to offer premium assistance for ESI</td>
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<tr>
<td>• Cadillac Tax (40% excise tax on employer plans exceeding $10,200/$27,500 single/family, in 2020)</td>
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<td>• Prohibition of preexisting condition exclusions or other discrimination based on health status</td>
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<td>• Out of pocket maximum</td>
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<td>• Coverage of preventive services, Patient Protections</td>
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<td>• Extension of dependent coverage to under 26 on parents’ insurance</td>
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<td>• Individual mandate</td>
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<tr>
<td>• Multiple reporting and other administrative requirements</td>
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<tr>
<td>• Small group only:</td>
<td></td>
</tr>
<tr>
<td>o Small Business HC Tax Credit and SHOP Market</td>
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<td>o Comprehensive health insurance coverage including Essential Health Benefits</td>
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<td>o Fair premiums; Rating limitations to age (3:1), smoking, geography, family size</td>
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**Employer-Sponsored Insurance**

- Deductible limits

**Other Dynamics to Watch:**

- Competitiveness of labor market/economic growth or recession
- Policy approaches to “replace” Cadillac Tax, address high spending on healthcare and normalize tax treatment between ESI and direct purchase market, for example possible changes to cap tax deductible spending

**Implications for Providers**

- Fewer direct “ACA repeal” changes than individual market – but on a much bigger portion of provider business and revenues
- Potential upheaval in the market may impact providers’ and/or payors’ respective positions and approaches in any upcoming contract negotiations
- The continuation of many dynamics already underway – particularly around employers seeking to address spend and engaging employees to share in more of the spend ( premiums, cost sharing)
- Employers and/or employer coalitions in the market may seek more innovative or direct approaches to address healthcare spend under what may be perceived as a more permissive administration
- Providers may seek opportunities to engage with consumers more directly and/or develop strategies to build direct relationships with the employer market inclusive of service and product offerings

**Scenario Planning and Impact Assessment**

In concert with the market view of dynamics at the national, state and regional level, providers can also preliminarily assess their current exposure to the changes possible by segment, with attention to major financial vulnerabilities. Analyzing sources of revenue and margin by the purchaser segments noted above will allow providers to project at a high-level the impact on their business of the most likely scenarios ahead. At the core of this assessment is an informed perspective on the range of financial consequences for the provider from potential increases in insurance rates if some, or perhaps all, of the ACA’s key coverage expansion provisions are defunded; particularly Medicaid expansion and the creation of a subsidized individual marketplace. By evaluating their pre- to post-ACA experience with uncompensated care and market changes in coverage across both populations, providers can estimate the order of magnitude of potential financial impact. Other analyses to have on hand include an understanding of specific funding streams (e.g., DSH, which may or may not be cut) as well as specific programs (e.g., financial experience associated with voluntary value-based efforts such as Medicare ACOs) that are linked to the ACA.
In our experience, this exercise can facilitate important conversations, particularly between executive leadership teams and boards. For example, getting to an estimate of the financial implications of the range of plausible future-state scenarios will help teams evaluate options for meeting these requirements such as whether cost reduction and revenue optimization approaches are sufficient, or whether more fundamental programmatic changes or even changes to the enterprise business model be needed. A shared understanding can also help direct an organization’s attention and focus to those areas with the highest relevance and exposure. For instance, we expect that the individual market will see most of the change ahead and the corresponding political rhetoric and press coverage. It is helpful to maintain the perspective that while important, the individual market represents a relatively small portion of total lives and spending. The direct purchase market accounts for less than eight percent of insured individuals nationally and less than four percent of national health expenditures, with 13 million enrolled in the 2016 public Marketplace, or about four percent of the US population.¹ ² For a given provider organization, the impact of a destabilized Marketplace could be meaningful – but in most cases such changes will affect a minority of patients. Meanwhile, potential modifications to Medicaid – both directly tied to the ACA and given the desire of some Republican leaders to fundamentally restructure Medicaid funding – could potentially impact a population that represents about a quarter of national health expenditures.

An organized approach to understanding the potential economic and strategic impact of these anticipated changes and the related “triggering events” will enable providers to be nimble as the Trump Administration’s agenda is unveiled in the coming days and months.

Sources:


² Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report for the period November 1, 2015 - February 1, 2016, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS), March 11, 2016.
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