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Communications Enabled

How the Election Made Healthcare Communication Much More Important

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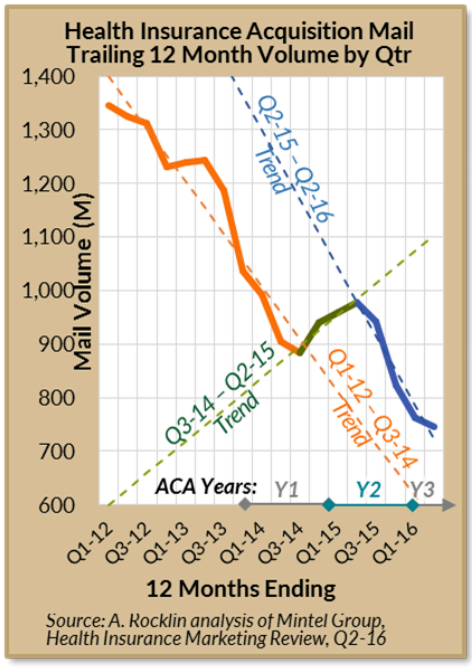
For many of us navigating the shifting landscape of healthcare, the magnitude and abruptness of the likely disruption ahead may have best said by Aetna CEO Mark Bertolini, "If you were to look at our game board of all the possible outcomes that could have happened in the election, this one wasn't even on the sheet. We started with a fresh piece of paper yesterday. We had no idea how to approach it."[1]

Much like the campaigns themselves, the prognostication for healthcare is riddled with random sound bites, biased treatises, and everything in between. Rather than consider all the possibilities that may unfold, I have attempted to distill which key business impacts are most plausible, which areas of uncertainty warrant ongoing attention, and the future role of communication as a driver of business value.



Payer Communication Volume

Not only did the ACA expand coverage to upwards of 20 million previously uninsured people, but it also proved to be a major driver of payer communication volume. One category, health insurance acquisition mail, reversed its historical downward trend and grew in volume in concert with implementation of the ACA[2]. In particular, the selling season for year 2 saw significant mail growth as insurers competed for (presumably healthier) members that didn't enroll in year 1 and a surge of potential Medicare Advantage members losing retiree coverage. Despite continued increases in the number of insureds in year 3, declining mail volumes returned to historical trends as payers tallied losses in their exchange business.

Despite the range of plausible legislative and executive actions by the new administration, nearly all lead to the same outcome: A decreased number of insured Americans. The sidebar outlines some of the ways this could happen, with most scenarios projecting decreases in the number of insureds

in line with estimates by the Commonwealth Fund and RAND Corp[3] of 16 to 25 million by 2018.

Although a decreased number of insureds is likely, the timing of those actions remains unclear. Since the election, Paul Ryan and Mitch McConnell have each cited repeal of the ACA as a top priority, and Kellyanne Conway restated that Donald Trump is considering calling a "special session" of Congress on January 20th to repeal the ACA.

However, it may prove difficult to roll back quickly with so many Americans already covered by the ACA, and a post-election surge in the ongoing open enrollment for 2017 coverage (a record high of 100,000 on November 9 on healthcare.gov). The need for some type of replacement further increases the uncertainty around timing.

Even if experts have over-estimated how many people may lose coverage, a material decline in the number of insureds is likely, along with a corresponding decrease in areas like acquisition mailings. At the same time, the wake of this disruption will create needs for communication solutions that will help payers navigate changes and uncertainties with their members.

Medicaid

In addition to making subsidized insurance directly available to individuals through state and federal insurance exchanges, the ACA expanded the reach and richness of Medicaid coverage for low income populations. Although each state defines and administers its own Medicaid program, the ACA increased federal funding to states willing to adhere to minimum standards for coverage and benefits. Under this arrangement, 31 states have expanded their Medicaid programs under this arrangement.

Signals indicate a move towards block grants or capped federal contributions to the states with fewer stipulations regarding eligible income thresholds and minimum benefits. This puts the particularly vulnerable segment of the 20+ million people who gained coverage through the ACA, at significant risk of losing coverage.

Ways the ACA might be Disabled

The current congress has already held more than 60 votes to roll back all or part of the ACA, culminating in their passage of the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, its expected presidential veto and a failed effort to override it. Similar efforts by the incoming legislature would be much more likely to succeed.

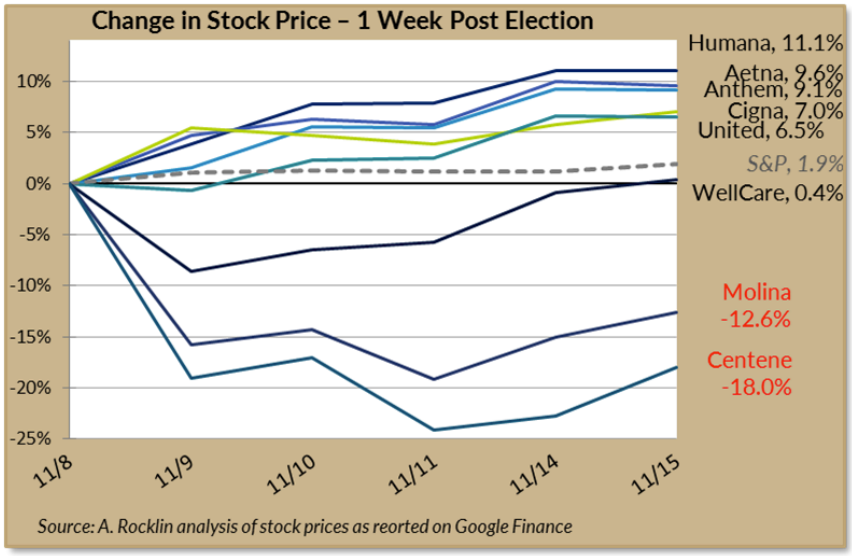
It would require a quite literal act of congress to eliminate provisions of the ACA that are not budget dependent, e.g., guaranteed issue regardless of preexisting conditions and child coverage through age 26. Even if the new Congress isn't ready to enact a full repeal, they can take measures that are less obvious to their constituents, yet effectively disable the ACA.

The budget reconciliation process enables a simple majority without the risk of filibuster to remove budget-related provisions. These could include eliminating premium subsidies used by most enrollees or defanging the financial penalties for non-compliance with individual and employer mandates. Either would undermine the financial viability of the insurance products by slashing revenue or creating a much costlier risk pool.

Another option, within the sole control of the Executive Branch, would be to drop its current appeal to House v. Burwell. That suit, filed by the House, charged that payer subsidies authorized by the Obama administration were not formally appropriated. The court ruled in favor of the House, but declined to enforce it pending appeal. Dropping the appeal would require that payers continue to offer discounts to low-income members, but not receive offsetting subsidies. Increasing losses in this business would lead to more payers withdrawing from the market, or passing along rate increases beyond the means of many customers.

Capital market sentiment appears to echo the view that Medicaid enrollment will be hit harder than commercial or Medicare. The day after the election, trading volume on payer stocks jumped by orders of magnitude over daily averages. One week later, many large commercial payers had gained 6.5% to 11% – far outpacing the S&P rally of under 2%. Notable exceptions included Molina and Centene, each of which has over 80% Medicaid membership concentrations and are heavily involved in the individual exchanges. Despite a similar concentration of Medicaid members, its lack of participation in the individual exchanges may have tempered market pessimism.

If states do take more responsibility with less federal funding, we can expect increased use of the managed care practices used to lower the underlying cost of care for high-risk members. They are likely to award the administration of Medicaid contracts to payers that can guide members through narrow networks and motivate them to reduce unhealthy, costly behaviors. This, of course, depends on effective member engagement and behavioral change – new capabilities that few payers have fully mastered. Expect increased demand for communication solutions that help managed Medicaid administrators better engage and influence members covered by states' diminished Medicaid budgets.



Medicare

Acknowledging calls by Paul Ryan and other Republican leaders to privatize or eliminate Medicare, it would be difficult to undo this 51 year-old program that covers over 57 million Americans[4], with a decade's-worth of Baby Boomers poised to age-in. Any successful initiatives in that direction would likely accelerate the ongoing shift from traditional Medicare into managed care programs like Medicare Advantage. The impact on communication needs will echo the managed Medicaid scenario at federal level.

The significant changes in Medicare will more likely tie to implementation of past regulations rather than significant changes under a new administration. Passed with bipartisan support last year, the Medicare Access and CHIP Reauthorization Act of 2015 known as "MACRA" includes a range of initiatives designed to move providers from fee-for-service to outcomes-based reimbursement beginning January 1, 2017.

The move from volume to value follows a growing trend among commercial insurers with significant implications for healthcare communications. Unless providers are already in at-risk payment arrangements, e.g., accountable care organizations (ACOs), they will participate in the new Quality Payment Program, known as the Merit-based Incentive Payment System (MIPS).

At a high level, MIPS ties provider payment to four types of reported performance: 1) quality;

2) resource use (or efficiency); 3) clinical practice improvement activities; and 4) meaningful use of electronic health records. Providers will begin measuring and reporting performance in the beginning of next year, and CMS will adjust reimbursements beginning in 2019. As summarized in the table below, the first three MIPS requirements create significant needs for communications solutions.

Providers, who have been historically weak in patient communication outside their clinical settings, will lock in partners and solutions in the next year or so to help them improve performance and maximize Medicare reimbursement.

The Medicare timeline may understate the urgency providers actually face to close the communication gaps described above. Payers, known to apply CMS changes to their commercial business have already begun shifting provider payment from volume to value. MACRA is likely to accelerate this shift and heighten the level and urgency of providers' needs for communication solutions that improve their ability to deliver and demonstrate value.

Provider Communication Needs under MIPS

MIPS Requirement	Communication Needs
Quality: Includes a range of clinical screenings, procedures, patient actions and follow-up communications with specific classes of patients	• Personalized patient outreach • Influencing compliance and healthy behaviors among patients outside the clinical setting
Resource Use: Compares resources used to treat similar care episodes and clinical condition groups across practices	• Similar to Quality-related needs for personalized outreach and influence • Focus on patient behaviors affecting ongoing care costs
Practice Improvement: e.g., • Expanded Practice Access • Population Management • Care Coordination • Beneficiary Engagement	• Improve internal communications and related processes • Personalized patient outreach to improve access, engagement, and coordination across providers

Summary

Despite uncertainties around timing and specific legislative acts ahead, one can reasonably expect that many elements of the ACA that previously fueled traditional communications like acquisition mail to be destroyed or hobbled. It is also fair to make assumptions about how those changes will affect payer and provider business and communication needs.

According to an in-depth analysis by the non-partisan Commonwealth Fund, fully enacting Trump's proposals to replace the ACA with a tax deduction, move Medicaid to block grants, and enable interstate insurance sales would add nearly 20 million people to the ranks of the uninsured and increase the federal deficit by nearly $34 billion in 2018. Even scenarios that fall short of these projections would thrust those individuals and taxpayers at large into a difficult situation.[3]

For healthcare leaders focused on effective consumer communication, the impact would be significant and abrupt, yet consistent with important healthcare trends already being driven by market forces. The big surprise is the potential sudden drop in insureds that generated historical volumes and types of traditional communications.

We've witnessed slow move from volume to value and can expect acceleration there as well. Payers and providers will increasingly depend on communication solutions that bring capabilities to drive *effective communication outcomes*. On their own and through partners, successful healthcare businesses will harness the insight, expertise and analytics required to create targeted communications that demonstrably change those consumer behaviors that most affect healthcare costs and outcomes. The election effect will certainly elevate the urgency and importance of these shifts in communication strategy.

Endnotes

1 *Hartford Courant,* "Aetna CEO Says Best Of Obamacare Should Be Preserved," November, 11, 2016
2 A. Rocklin analysis of Mintel Group, Health Insurance Marketing Review, Q2-16
3 E. Saltzman and C. Eibner, Donald Trump's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit, The Commonwealth Fund, September 2016.
4 Centers for Medicare & Medicaid Services (CMS), CMS Program Statistics, accessed November 2016.