

Health reform 2.0: A guide to developing resilience amid an uncertain future for the Affordable Care Act

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The heart of the matter

President Donald Trump and Republican congressional leadership have promised to repeal and replace the Affordable Care Act (ACA). Just how that will happen remains unclear, as demonstrated by the rise and fall of the American Health Care Act in March. For the nation's healthcare providers, payers, pharmaceutical and life sciences companies, new entrants, employers and consumers, uncertainty about when reform will take place and what it will look like makes planning for the future a complicated matter.

And yet, healthcare organizations and companies can make smart moves even as the ACA's fate remains murky. Health organizations should develop strategies that help them become resilient in the face of a broad range of outcomes, focusing on what is known while preparing for the many unknowns. And, surprisingly, plenty is known so far.

With so many proposals being discussed in Washington, lawmakers seemingly could take an infinite number of routes in addressing the ACA. Policy changes could be packaged into a single comprehensive bill, or rolled out in a piecemeal fashion as a series of administrative actions, stand-alone legislation and moves by state legislatures. Yet, three scenarios for addressing the ACA seem

most likely, no matter the regulatory and legislative paths taken to reach to each, according to modeling conducted by PwC's Health Research Institute (HRI) and Strategy&, the firm's strategy consulting practice.

In one scenario, lawmakers could "repeal" by cutting budget-related provisions of the ACA through a process known as budget reconciliation without including their own replacement health-reform provisions. This would be the path closest to erasing the ACA altogether. Lawmakers also could opt to keep the ACA largely intact, choosing to "repair" it by adjusting and improving the 2010 law, a legislative process that likely would require some Democratic support. Lawmakers also could take a more middle-ground approach, opting to "replace" the law by repealing its budget-related provisions through budget reconciliation and replacing them with Republican-favored policies, such as Medicaid block grants. Any actions taken by lawmakers likely

will fall along a continuum into one of these scenarios.

To understand the implications of any legislation moving through Congress, industry stakeholders can focus on these three scenarios and their potential outcomes and start drafting smart, resilient strategies for surviving — and even capitalizing on — what comes next. Understanding each of these policies' implications is the key to planning for them.

An analysis of these three scenarios by HRI and Strategy& found that they produce dramatically different outcomes. The "repeal" scenario, once fully implemented by 2025, likely would leave an estimated 32 million more Americans uninsured than would be under the ACA. "Replace" likely would leave 12 million more Americans uninsured by 2025 than would be under the ACA. Under "repair," the ranks of the uninsured likely would grow by 6 million by 2025, compared to what would be expected under the ACA. The wide range of potential outcomes for likely legislation highlights the need to model the possibilities, and evaluate their consequences. (See Figure 1)

No scenario benefits all of the players in the US health economy. The scenario with the least negative impact on the pharma and life sciences industry—“repeal”—likely would produce the most challenging outcomes for many healthcare providers and insurers. Yet the best scenario for those stakeholders—“repair”—wouldn’t offer the same relief from ACA taxes and fees as “repeal” would for companies that make branded pharmaceuticals and nonretail medical devices.

The number of uninsured will climb higher than it is today under all three scenarios, an analysis by HRI and Strategy& found. Yet, only under “repeal” is the number of uninsured likely to rise higher than in the days before the ACA was enacted, the result of the individual market’s collapse. Under “replace” and “repair,” the number of uninsured likely will remain lower than it was before the ACA was enacted.

Some of these scenarios’ outcomes will depend on what has happened, and what will happen, on a state level. Healthcare providers and payers operating in states that expanded Medicaid may face more dramatic changes under “repeal” and “replace” scenarios. Some states, under a “repeal” scenario, could experience spikes in their uninsured rates of more than 100 percent. Similarly, the effects of proposals such as Medicaid block

grants, part of the “replace” scenario, could be blunted or exacerbated depending on how states decide to handle the changes. Republican congressional lawmakers—and key policy figures such as CMS Administrator Seema Verma—have said they want to give states more flexibility to design their Medicaid programs.¹ Healthcare organizations likely will be more influenced by their state legislators under all three scenarios.

In the face of such uncertainty and possible change, healthcare companies can make some “no regrets” moves to help build resilience no matter the situation:

- **Scenario plan.** Payers, providers, life sciences companies and employers should begin to model various scenarios to better understand the impacts they might have on their business models and plans. What are the volatility ranges for potential scenarios? Organizations also should identify fixed costs and changes that could take disproportionate hits on margins. How would each affect margins and planning? Change also will bring opportunity for some sectors or subsectors, including potential merger and acquisition activity. Companies positioned to take advantage of these opportunities likely will be better poised for growth and longer term resilience.

- **Get fit.** To mitigate the potential impact to earnings, healthcare organizations should embark on a program of reducing their fixed costs. They should consider accelerating automation, investing in efficiency efforts and setting aggressive cost-reduction goals. Doing so will require organizations to focus intently on a handful of capabilities, and become lean elsewhere by using automation, process re-engineering and sourcing through vendors.
- **Bet on growth.** Medical expenditures have increased every year since at least 1961, and spending growth is likely to continue over the long term as well.² Companies should identify where that growth is likely to come from.³ Payers should consider expanding into areas of the market that are growing, such as Medicare Advantage. Payers, providers and life sciences companies can focus on solutions that address affordability for the aging populations eligible for Medicare. As they add jobs, employers continue to add members to their group policies, but they remain frustrated by the continuing cost escalations. This creates opportunities for payers and healthcare providers to accelerate their investments in analytics with proven value.

Figure 1. The new administration likely will take one of three paths in repealing and replacing the Affordable Care Act

The number of uninsured rises under all three scenarios, but coverage varies widely and will impact each part of the US health industry differently

Scenario 1: <i>Repeal</i>	Scenario 2: <i>Replace</i>	Scenario 3: <i>Repair</i>
<ul style="list-style-type: none"> Modeled after H.R. 3762, the 2015 repeal through reconciliation effort vetoed by President Barack Obama Uses budget reconciliation process Repeals ACA taxes, fees and subsidy tax credits Repeals individual and employer mandates Repeals Medicaid expansion Restores Disproportionate Share Hospital funding 	<ul style="list-style-type: none"> Uses budget reconciliation process Repeals individual mandate Replaces income-based tax credits with age-based tax credits, available to individuals/families with incomes up to \$40,000/\$80,000 Funds high-risk pools Converts Medicaid to block grant Expands use of health savings accounts Restores Disproportionate Share Hospital funding 	<ul style="list-style-type: none"> Uses normal procedure to repair the ACA (will require Democratic support) Repeals employer mandate Replaces individual mandate with replacement option, such as continuous coverage Expands use of health savings accounts Funds high-risk pools Widens age-band ratings Gives states more flexibility in Medicaid plan design

	Scenario 1:	Scenario 2:	Scenario 3:
	Repeal only	Medicaid block grants, high risk pools	Stabilize ACA exchanges
Total insured, 2025 (in millions)	-32	-12	-6
Employer	10	5	0
Medicaid	-19	-5	-2
Nongroup	-23	-12	-4
Healthcare providers (Impact: negative, positive)			
Payers (Impact: negative, positive)			
Pharmaceutical and life science companies (Impact: negative, positive)			
% of US population without insurance, 2025 (ACA projection, 2025: 8.1%)	17.2%	11.6%	9.9%

Source: PwC Health Research Institute and Strategy& analysis; Congressional Budget Office, *How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums*, January 2017; and Census data.

Note: All data reflect projected uninsured rate as of 2025.

Industry highlights

President Trump and Republican lawmakers could proceed with legislation that falls somewhere along a continuum, from repealing as much of the ACA as they can to repairing the law. It's possible to draw insights from a close examination of scenarios along this continuum. Here are the highlights, by healthcare sector:

For payers

Some large commercial insurers already have pulled out of the ACA exchanges, citing heavy losses, enrollees that are sicker and older than expected and unpredictable government support of risk programs. Insurers that invested heavily in developing business based on the ACA exchanges and Medicaid managed care have the most to lose under a “repeal” scenario, which HRI and Strategy& predict could lead to the collapse of the nongroup market. “Repair,” however, could present opportunities for these insurers.

Highlights

The ACA exchanges are not doomed. Under “replace” and “repair,” these marketplaces likely will remain relatively stable. Under “repair,” they could improve as lawmakers institute changes to make them more attractive to insurers, HRI and Strategy& found. Under “replace,” age-based premium tax credits, which would be swapped in for the ACA’s income-based ones, could drive older, sicker Americans

out of the market for nongroup insurance, leaving a healthier, younger risk pool. This effect also could make the marketplaces more attractive to insurers. This could be slightly offset by the ACA provision, likely untouchable under budget reconciliation rules and popular with consumers and lawmakers alike, that allows children to stay on their parents’ plans until age 26, keeping these very young consumers out of the nongroup market for part of their 20s.

HRI and Strategy& found that under the “repeal” scenario, however, the nongroup market likely would implode as many younger, healthier Americans opt out in the absence of a mandate and subsidies to help them pay for their premiums and cost-sharing, driving premiums up and leaving only the sickest, costliest Americans still seeking coverage.

Insurers likely will have to decide quickly whether they wish to participate in the ACA exchanges in 2018, with initial rate tables for qualified health plans due to CMS by June 21. Instability in the ACA exchanges in the short-term, as lawmakers weigh options for the law, make participation a riskier business. In March, HHS announced that fewer people had signed up during this year’s open enrollment period than the year before, the first time that has happened.⁴ The enrollment drop could be due to uncertainty over enforcement of the ACA’s individual mandate and a decision by the Trump

administration to diminish open enrollment marketing in its final days.

Under “replace,” Medicaid managed care could expand.

Under “replace,” federal funding for Medicaid would slowly contract, leaving states to decide whether to make up the difference or cut back on benefits and enrollees. Many states also are likely to try to do more with less, which could impact Medicaid managed care programs. Insurers partaking in Medicaid managed care also should monitor how HHS treats state waiver applications. HHS Secretary Tom Price and CMS Administrator Seema Verma already have indicated they intend to encourage states to design their own Medicaid programs, and that they will more freely grant waivers.⁵ This may represent an opportunity for insurers to help implement new programs.

Providers may increase pressure on payers if uninsured rates rise.

Healthcare providers likely would lose under “repeal” and “replace” scenarios. Providers likely will increase pressure on payers to increase reimbursement rates if uncompensated care rises and the Medicaid program contracts. Under a “repeal” scenario, consolidation among providers likely would accelerate, giving them added leverage in negotiations with payers. Payers should continue to strengthen relationships with providers while modeling how consolidation under a

“repeal” scenario, in particular, could shift leverage in negotiations.

Many payers would like to see ACA modifications, not outright repeal.

A survey conducted by HRI of payer executives found strong support for fixing the ACA, as described in the “repair” scenario. Fewer supported repealing and replacing the law. Executives also expressed modest support for many of the provisions embraced by Republican lawmakers, such as expanding use of health savings accounts and revisiting high-risk pools (See survey results on page 15). Payers should continue to voice their support to lawmakers for provisions they find attractive.

Consumers may need more education. If payers are allowed, under any scenario, to offer a wider variety of plans in the nongroup market, consumers will need more education to help them choose and understand coverage. Higher deductibles and narrower networks, if not understood, could lead to consumer dissatisfaction. Consumers losing coverage under “repeal” or “replace” also may need education to help them through the transition. Some may be able to pay for their premiums on their own, but could wind up without coverage thanks to confusion. If lawmakers embrace a continuous coverage provision, which would penalize consumers for failing to maintain coverage for some length of time, consumers also will need education to help them understand the penalty, and whether they are in danger of triggering it.

For providers

Under any reform scenario, healthcare providers likely will experience spikes in uncompensated care without a reversal of the reimbursement cuts they absorbed under the ACA. Under a “repeal” scenario, uninsured rates likely will wind up higher than before the ACA passed. Changes to the Medicaid program, undertaken in both “repeal” and “replace” scenarios, could have long-lasting and significant impacts on many providers, especially those with narrow margins.

Highlights

All scenarios lead to more uncompensated care. Fully implemented, the “repeal” scenario, would leave 32 million more Americans uninsured in 2025 than under the ACA, HRI and Strategy& conclude. Under this scenario, rates of bad debt and uncompensated care would be expected to rise significantly. Charity care would be expected to rise too. Patients without access to insurance are likely to put off preventive care, leading to costlier emergency interventions. Providers may lose access to paying patients, and their patients may be less able to afford their prescriptions, leading to worse health outcomes.

Healthcare providers should model revenues and uncompensated care under each scenario to begin preparing now for likely eventualities. Providers also should be aware that the Community Health Needs Assessment, a requirement of the ACA, likely would not be repealed

under any scenario. Expectations around providing community benefit likely will remain despite added financial pressures. Early and effective communication with stakeholders, including state and federal government agencies, will be crucial to identify regulatory, payment and coverage changes that can affect future provider business.

State and local politics will become even more important. Healthcare providers treating large populations of Medicaid beneficiaries may be exposed to the most financial risk. Efforts to roll back the ACA’s Medicaid expansion and enhanced funding, or efforts to cap Medicaid expenditures under a block grant program, likely would reduce the number of Medicaid enrollees and place long-term stress on state budgets, which could translate into cuts to Medicaid rates, benefits, enrollees, or any combination of the three.

In its analysis of the House Republicans’ first attempt at reform—the American Health Care Act (AHCA)—the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimated that capping federal Medicaid funding using a per capita system would reduce federal spending by \$880 billion over 10 years.⁶ State governments collectively spent \$197 billion on Medicaid in 2015, an average of 15.39 percent of their budgets, and their capacity to increase spending is limited. For rural providers in particular, coverage cutbacks could place their ability to operate at risk.

As federal funding shrinks, healthcare providers' fates will depend more on decisions made at the local and state level. Some states may have the funds to fill the federal funding gap, and the will to do it, while many states may be unable or unwilling. Healthcare providers should explore scenarios for state Medicaid funding should federal lawmakers opt to significantly roll the program back, change the way it's funded or both. Providers also should consider how dramatic reductions in Medicaid funding, along with a rise in the uninsured, may trigger a wave of consolidation.

New entrants may find fertile ground amid the change. As states and insurers seek to reduce costs, providers best able to coordinate care and deliver value may benefit, though it will take time and effort to implement delivery reforms. Companies that can save states money by eliminating waste, managing high-cost patients more effectively, delaying costly conditions or improving outcomes may find ample opportunities for success. Health providers offering low-cost, transparent services also may act as safety nets for uninsured or underinsured consumers.

Uninsured consumers may turn to new entrants to fill gaps in care. Millions of consumers could lose coverage under the “repeal” and “replace” scenarios. Many of these Americans will be lower-income. These price-sensitive consumers may turn to new entrants offering convenient, low-cost care at transparent prices, such as retail clinics, telehealth services, algorithm-based sites and other options. They also may shop around more

aggressively for cheaper prescriptions, and reward companies offering deals. Under “repair,” the uninsured are more likely to be young and healthy, the sorts of consumers who would be more likely to seek care through technology-based services they can find on their smartphones.

For pharmaceutical and life sciences

The ACA had a modest effect on most pharmaceutical and life sciences companies. The law imposed significant rebates on branded pharmaceuticals, blunting the impact of expanding the ranks of the insured. It also produced an annual fee on branded pharmaceuticals companies and an excise tax on companies selling nonretail medical devices. Repeal of the ACA's taxes and fees could provide a modest boost for some companies in this sector, and losing the Medicaid market could have some impact on companies with significant Medicaid sales. But pharma and life sciences companies likely will be more focused on President Trump and Republican lawmakers' efforts in tax reform, and also on policies being discussed on the state and federal level involving drug pricing.⁷

Highlights

Some drug companies could feel a bigger impact if Medicaid shrinks. Under the “repeal” and “replace” scenarios, states will face reduced federal Medicaid funding. In 2015, Medicaid spent more on drugs treating mood and mental disorders, HIV, hepatitis C, asthma and chronic obstructive pulmonary disease and attention deficit hyperactivity disorder than other

drug types. Companies selling these pharmaceuticals could experience revenue drops if states decide to cut back on benefits as funding ebbs. Companies should model Medicaid funding to prepare for possible cutbacks. Companies preparing to roll out high-priced drugs also should consider whether states will erect significant barriers to access.

Tax reform likely will have more impact. President Trump and Republican lawmakers have discussed tax reform, the implications of which could have a widespread effect on pharmaceutical and life sciences companies. These reforms likely will follow health reform. Pharma and life sciences companies should consider assessing the impact of tax and trade reforms to their supply chains. Companies should analyze their operational structures to understand the impact. This analysis is underway at many companies. Relevant considerations include US and foreign taxes, locations of intellectual property and impacts on foreign costs with potential dollar appreciation. (For an exploration of tax reform policies under consideration, please see the sidebar on page 32).

Consumers may push more aggressively for discounts and generics. Consumers, left without coverage, likely will seek more and larger discounts from drug companies, and turn more frequently to generic prescriptions. They also may reward new entrants offering discounts on prescriptions, and shop

around for prices. Lower-income Americans without coverage may forgo prescriptions altogether, and may turn instead to alternative treatments lacking evidence.

For employers

Employers stand to gain the most from “repeal” and “replace,” which eliminate reporting requirements associated with the employer mandate and rescind the so-called “Cadillac” tax on high-cost plans. However, as uninsured rates grow, employers that do not offer their employees coverage may find their workforces are sicker and less productive. Under “replace,” employers with young, healthy workforces may find it more advantageous to drop coverage and allow their employees to use age-based tax credits to purchase it in the nongroup market.

Highlights

All scenarios lead to less paperwork for employers. Under the ACA, companies with more than 50 employees were required to provide insurance to employees working more than 30 hours per week. Under all three scenarios, the employer mandate would be repealed, which would reduce reporting and compliance costs imposed by the ACA.

“Repeal” and “replace” remain advantageous to employers facing the “Cadillac” tax. Under the ACA, a 40 percent excise tax—the so-called “Cadillac tax”—would be implemented on high-cost employer health benefit plans. If this tax was implemented, some employers would be forced to cut health benefits to avoid it. As explored in the “repeal” and “replace” scenarios, eliminating this tax would ease reporting costs for employers. Replacing the “Cadillac” tax with an alternative, such as the “replace” scenario’s cap on the tax exclusion of employer-provided health insurance, may reduce the value of employer-provided health insurance although it could be easier for employers to implement.






Employees may persist in jobs for fear of losing coverage. If employers decide to continue offering coverage, cost savings may be offset if sicker employees feel pressure to stay at their current employer for fear of not getting insurance coverage elsewhere, a return to the “job-lock” environment from before the ACA passed. Younger employees also may forgo expensive employer-based plans for cheap, nongroup ones they can buy with age-based tax credits, eroding group risk pools.

In-depth discussion

Scenario 1: Repeal

Figure 2. “Repeal”: Repeals mandates, subsidies, Medicaid expansion, taxes and fees

Net change in insured, 2025: -32 million Americans (Employer: +10m; Medicaid: -19m; Nongroup: -23m)

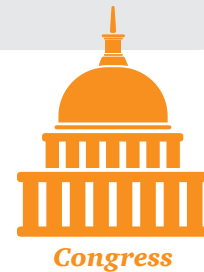
	<i>Impact (decrease, increase)</i>	<i>Detail</i>
Payers: Total premium revenue		Repeal of premium tax credits and cost-sharing subsidies will lead to collapse of nongroup market, leaving payers with small pool of sickest individuals. Most impact to payers that invested heavily in ACA exchanges, such as regional non-profit insurers.
Providers: Hospital revenues		Rollback of Medicaid expansion and collapse of nongroup market leave number of uninsured higher than it was before the ACA. Restoration of DSH cuts will help, but uncompensated care costs will rise. Most impact to rural, critical access and safety-net hospitals in states that expanded Medicaid.
Providers: Uncompensated care		Short- and long-term spikes in uncompensated care as number of uninsured grow and providers struggle to continue care for previously insured patients. Most impact to rural, critical access and safety-net hospitals in states that expanded Medicaid.
Life sciences: Pharma income		Repeal of the ACA annual pharmaceutical fee will be welcomed by branded manufacturers, but this boost is offset by the collapse of the individual market and the roll-back in Medicaid expansion. Generic manufacturers in particular will be hard hit.
Life sciences: Device income		Repeal of the medical device excise tax will benefit device manufacturers and impact their bottom lines in a positive manner.

Source: PwC Health Research Institute and Strategy& analysis

Note: All data reflect projected uninsured rate as of 2025.

Figure 3. What is budget reconciliation?

Republican legislators are using budget reconciliation to repeal the ACA. Reconciliation is a parliamentary procedure in the Senate that allows bills to pass with a simple majority as opposed to the 60 votes that would normally be required to overcome a filibuster. Reconciliation can only be used for legislation impacting revenues, expenses and the debt ceiling. It cannot be used for provisions without a financial impact, for example, guaranteed issue. The method has been previously used to pass parts of the ACA as well as a failed 2015 ACA repeal effort ultimately vetoed by President Obama.



Source: Center on Budget and Policy Priorities

Under the “repeal” scenario, lawmakers would repeal the ACA’s individual and employer mandates along with income-based cost-sharing subsidies and refundable tax credits that help low-income Americans purchase insurance on the exchanges. Under “repeal,” the Medicaid expansion also would be rolled back, as would nearly \$800 billion in taxes and fees on consumers and industry over a 10-year period (See Figure 4).

Lawmakers pursuing “repeal” would use the budget reconciliation process to allow legislation to pass the Senate with a simple majority vote, bypassing the need for Democratic support. The budget reconciliation process can address only provisions of the ACA involving government outlays and revenues, such as taxes and insurance premium support. Under Senate rules, reconciliation likely cannot repeal ACA measures that are unrelated to revenues and outlays, such as provisions

requiring plans to cover essential health benefits and prohibiting plans from denying coverage due to pre-existing conditions.

The scenario would resemble a previous “repeal” bill, HR 3762, which was passed by the House and Senate in 2015 and vetoed by President Barack Obama. The CBO concluded that HR 3762 would reduce budget deficits by \$516 billion from 2016 to 2025. An analysis by HRI and Strategy& indicates the “repeal” scenario would increase the number of uninsured by 32 million under full implementation.⁸ Lawmakers and other policymakers who would like to see the budget deficit and taxes reduced have spoken in favor of this scenario.⁹

The increase in uninsured by 32 million is due to the rollback of the Medicaid expansion and a collapse of the nongroup market, which would be left smaller than it was before the

ACA. That is because this scenario would repeal cost-sharing subsidies, income-based premium tax credits and the Medicaid expansion without repealing parts of the law that govern insurance regulations, such as the provision that prohibits insurers from denying coverage due to pre-existing conditions. Before the ACA launched, 10 million people bought plans on the nongroup market.¹⁰ Under “repeal,” that market would shrink by 23 million people.

The repeal of the annual fee on branded pharmaceutical companies and the medical device excise tax under the “repeal” scenario will be welcomed by impacted companies in those sectors (see figure 2). But “repeal” is the worst scenario for healthcare providers serving many Medicaid and nongroup patients and for insurers that invested heavily in the ACA exchanges and Medicaid managed care.

Figure 4. “Repeal” could mean an end to billions of dollars in taxes and fees

Key ACA funding mechanism	Entity impacted	Detail	Cost of repeal, 2016–2025
Net investment income tax	High-income taxpayers	3.8% tax on income above \$200,000 for single filers; \$250,000 for joint filers	\$157.6 billion
Individual and employer mandate	Taxpayers and employers	Penalty for failure to maintain health insurance Penalty of \$2,000 per employee not provided insurance, minus 30 employees and on a per-month basis	\$210 billion
Health insurer industry fee	Insurers	Annual, escalating fee	\$144.7 billion
Medicare payroll tax	High-income taxpayers	0.9% tax on income above \$200,000 for single filers, \$250,000 for joint filers	\$117.3 billion
“Cadillac” tax (delayed until 2020)	Employers	Excise tax of 40% on value of health plans above a determined value	\$48.7 billion
Chronic care tax	Taxpayers	Raises floor on qualifying medical expenses that can be deducted from 7.5% to 10% of adjusted gross income	\$40 billion*
Flexible spending account contributions tax	Taxpayers	\$2,500 contribution limit on flexible spending accounts	\$18.6 billion
Branded prescription drug fee	Branded pharma companies	Annual fee on manufacturers of branded drugs	\$24.8 billion
Medical device excise tax	Medical device companies	2.3% excise tax on non-retail medical device sales	\$19.6 billion
Over-the-counter medicines exclusion	Taxpayers, OTC drugmakers	OTC drugs no longer qualify as medical expense for tax-advantaged savings accounts	\$5.5 billion
Economic substance doctrine	All enterprise	Requirement that transactions produce benefits other than tax minimization or avoidance	\$5.8 billion

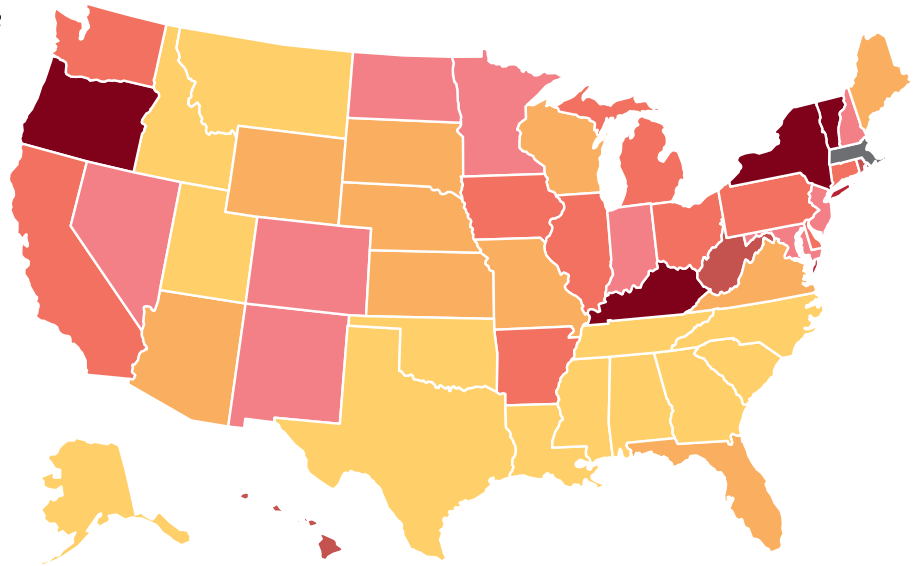
* Estimates are from previous CBO analysis looking at the 2016-2025 timeline

Source: PwC Health Research Institute and Strategy& analysis of Congressional Budget Office data.

Figure 5. Under “repeal,” many states likely would experience increases in their uninsured rates of more than 100%

Estimated percentage increase in the uninsured rate under “repeal” scenario:

- +251%+
- +201%–250%
- +151%–200%
- +101%–150%
- +51%–100%
- +0%–50%



Source: PwC Health Research Institute and Strategy& analysis of the Annual Social and Economic Supplement to the Current Population Survey and Congressional Budget Office publications.

Note: In the absence of the Affordable Care Act, Massachusetts will likely be able to continue elements of their state-level health reform legislation that was originally enacted in 2006. All data reflect projected uninsured rate as of 2025.

This is especially true of healthcare providers and insurers operating in 31 states, and Washington, DC, that expanded their Medicaid programs under the ACA. HRI and Strategy& found that under “repeal,” some states would experience surges in their uninsured rates of more than 100 percent (see Appendix B for the ACA’s impact on state uninsured rates and figure 5 for the estimated impact of “repeal” on state uninsured rates). The uninsured rate in Washington, DC, would rise more than 380 percent. Few states—or the District of Columbia—likely would be able to maintain coverage levels without the federal government’s high level of funding to help pay for Medicaid expansion.¹¹

In contrast to the significant negative effect on healthcare providers and insurers under “repeal,” the pharmaceutical industry would absorb a small decline in revenues. The repeal of the annual fee on branded pharmaceutical manufacturers would be a welcome change for the industry, but this would be offset by the collapse of the nongroup market and the end of the Medicaid expansion. Generic drug manufacturers would be particularly hit by the latter.

Impact on payers

Many insurers, especially those that invested heavily to participate in the ACA exchanges and Medicaid

managed care, could suffer under “repeal.”¹² In Medicaid expansion states with Medicaid managed care plans, some insurers could lose a significant amount of revenue as the program expansion is rolled back.

Insurers—especially regional, nonprofit, mission-driven organizations that committed to participating in the ACA exchanges—could find themselves in a bind under this scenario. If they wish to participate in the exchanges, they will be bound by the law’s remaining parts to offer relatively generous plans without the ability to underwrite, and the majority of their current customers will not be able to afford them. HHS data show that in 2016,

nearly 10.5 million members of the individual exchange market qualified for ACA premium support.¹³ Under “repeal,” only the sickest consumers—and those with considerable financial resources—likely will continue to buy coverage in the nongroup market, exacerbating insurers’ losses on those plans and forcing them to raise premiums even more.

Insurers will need to decide early in 2017 whether to participate in the exchange markets (see figure 6), and with uncertainty continuing around the ACA’s fate, some could decide

to opt out for 2018.¹⁴ A few large national insurers are thinking of pulling out or have already pulled out of the exchanges, which represent a small part of their business.¹⁵

A handful of insurers also invested heavily in expanding Medicaid managed care products in the wake of the ACA’s Medicaid expansion. A rollback of the expansion will significantly impact these insurers, some of which also doubled down on participation in the ACA exchanges.

Impact on providers

Healthcare providers accepted reimbursement cuts under the ACA in exchange for millions more insured patients, and would be substantially affected under “repeal,” which would erase the gain in insured customers without fully restoring the ACA’s reimbursement cuts. The American Hospital Association (AHA) and the Federation of American Hospitals (FAH) estimated that hospitals would lose \$165.8 billion over 10 years under a “repeal” scenario.¹⁶

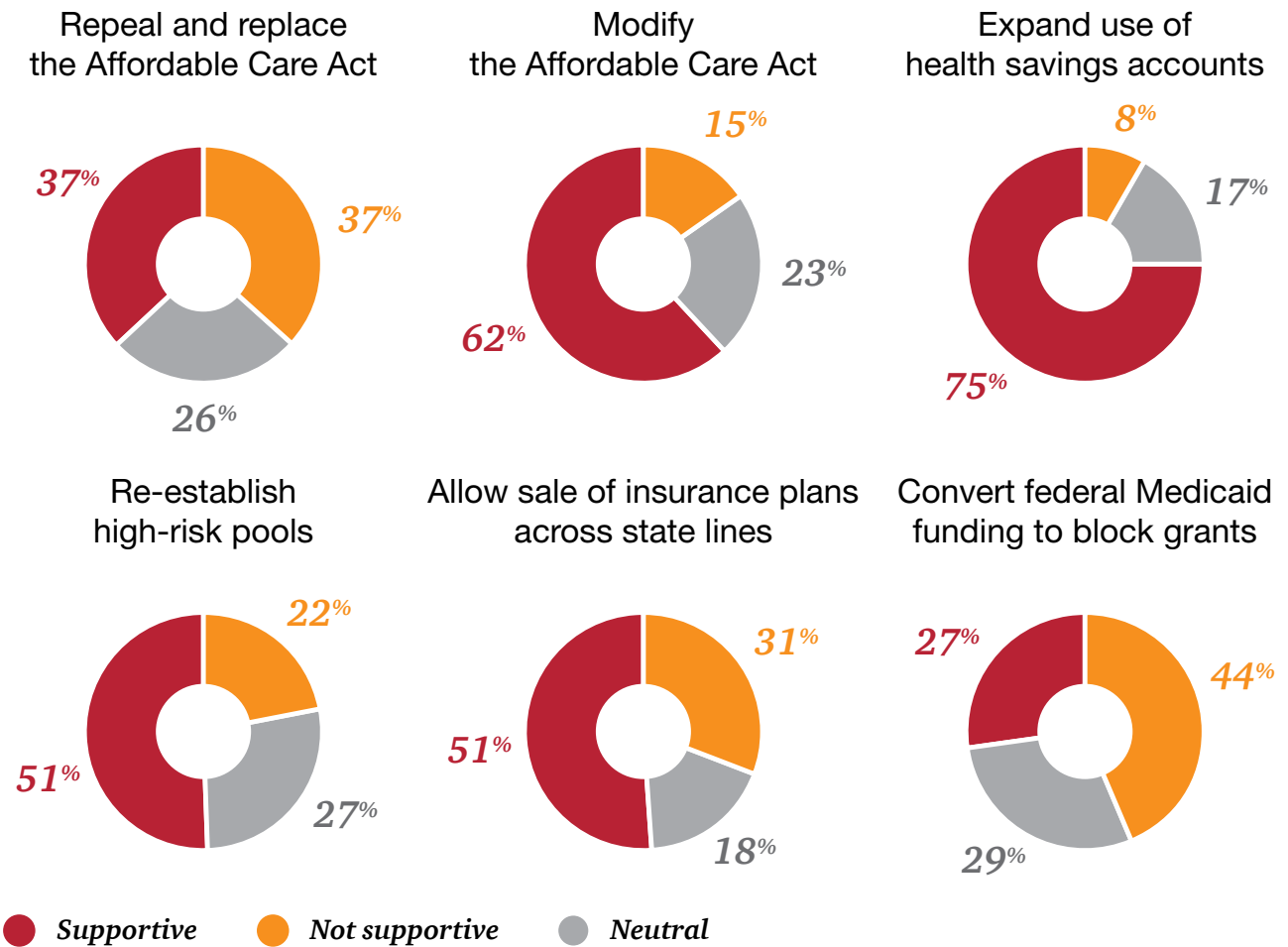
Figure 6. Insurers are working on a tight timeline for the next enrollment season



Source: CMS: “Key Dates for Calendar Year 2017: QHP Certification in the Federally-facilitated Marketplaces”

Figure 7. Payer executives: Modify the Affordable Care Act, expand health savings accounts and restart high-risk pools

After the election, PwC's Health Research Institute asked payer executives to rate their support for each of President Trump's following proposals:



Source: PwC Health Research Institute survey of payer executives 2016-2017

An ACA repeal would result in an increase in uncompensated care by healthcare providers of \$144.6 billion in 2019, according to an Urban Institute analysis.¹⁷

“Losses of this magnitude cannot be sustained and will adversely impact patients’ access to care, decimate hospitals’ and health systems’ ability to provide services, weaken local economies that hospitals help sustain and grow, and result in massive job losses,” wrote AHA President and CEO Rick Pollack and FAH President and CEO Chip Kahn in joint letters to then-President-elect Trump and congressional leaders in December 2016.¹⁸ The American Medical Association (AMA) also urged lawmakers to keep people covered. “It is essential that gains in the number of Americans with health insurance coverage be maintained,” wrote AMA CEO and Executive Vice President Dr. James L. Madara in a January 2017 letter to congressional leaders.¹⁹

To date, the ACA has expanded coverage to nearly 17 million additional people, resulting in greater utilization of provider services.²⁰ The coverage expansion created new patients and new demand for services and led to decreases in uncompensated care.²¹ Rural hospitals and community clinics, many of which already are at risk for closure and which depend heavily on Medicaid, may feel the effects of “repeal” the most.²²

Healthcare provider executives interviewed by HRI expressed concern about a “repeal” scenario. Some providers have made plans assuming economic conditions that could dramatically change. Some have struck risk-based contracts with government and commercial

payers under the assumption that the ACA would continue. Some have invested in new staff, technology and programs for the same reasons. Some have taken on debt to fund capital plans or mergers and acquisition activity under assumptions that may not hold true under a “repeal” scenario.

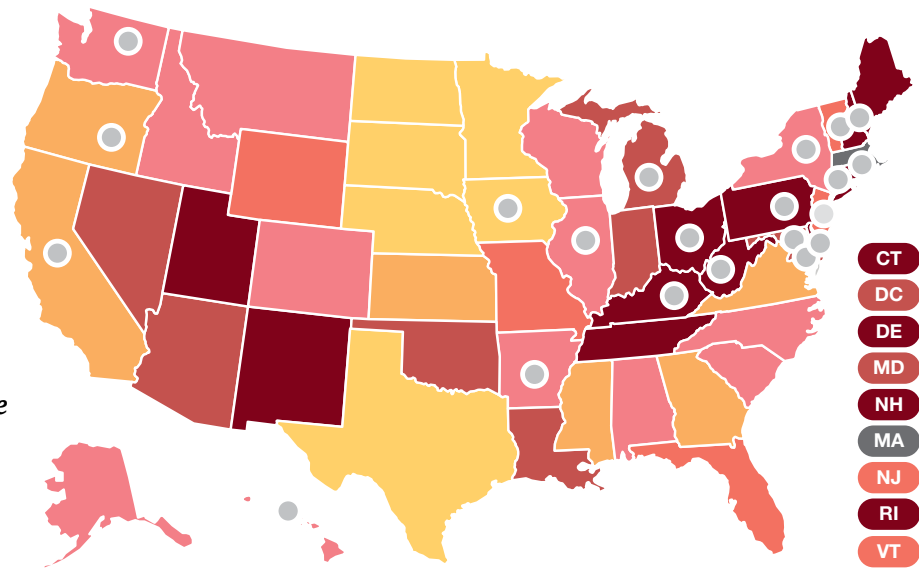
A surge in the uninsured also could exacerbate public health issues, such as attempts to address obesity or the opioid epidemic. HRI and Strategy& found that many of the states with the highest rates of drug overdose deaths would also experience increases in their uninsured rates of more than 150 percent (see figure 8). Almost 12% of Medicaid beneficiaries over the age of 18 have a substance use disorder.²³ Given a rollback in Medicaid coverage, many may no longer be able to seek proper treatment.

Figure 8. Many of the states with the highest rates of drug overdose deaths likely would also experience the highest spikes in uninsured rates under “repeal”

Number and age-adjusted rates of drug overdose deaths by state, US 2015

Age-adjusted deaths per 100,000 people:

- 21.1 to 41.5
- 18.6 to 21.0
- 16.1 to 18.5
- 13.6 to 16.0
- 11.1 to 13.5
- 2.8 to 11
- Increase in uninsured rate of more than 150%



Source: PwC Health Research Institute and Strategy& analysis; CDC drug overdose death data.

Note: In the absence of the Affordable Care Act, Massachusetts will likely be able to continue elements of their state-level health reform legislation that was originally enacted in 2006. Insurance data reflect projected uninsured rate as of 2025.

Impact on pharmaceutical and life sciences companies

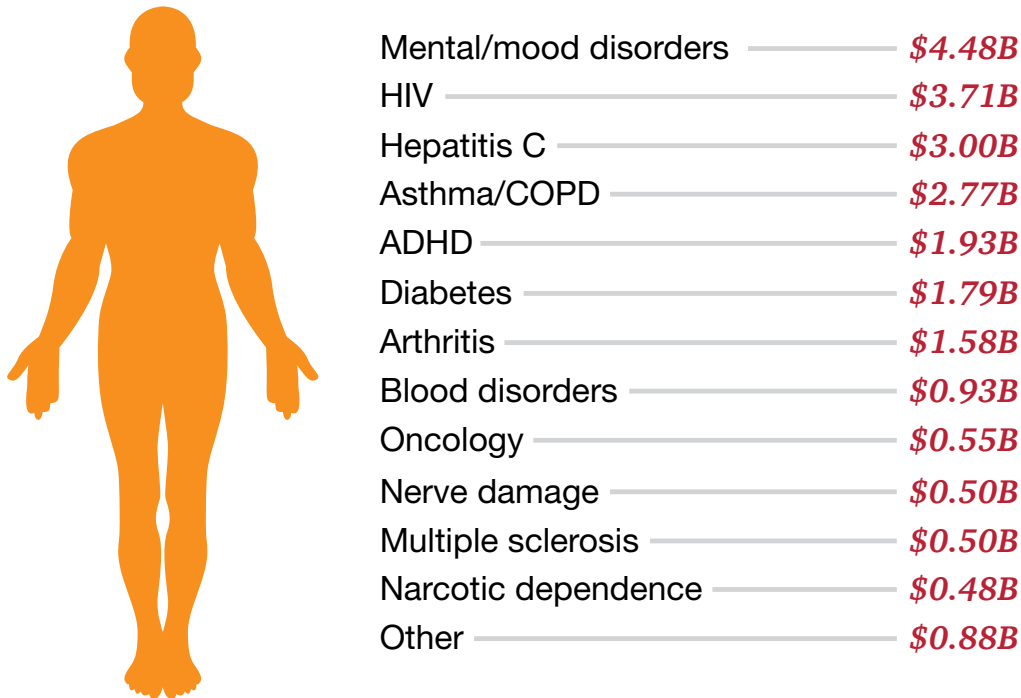
Branded pharmaceutical and medical device companies are likely to experience a mild, negative impact under a “repeal” scenario, with gains from the repeal of the annual fee on branded pharmaceutical manufacturers and the medical device excise tax countered by losses of covered customers (see figure 2). Drugmakers, particularly those making high-priced products, such as treatments for rare diseases, likely

would continue to benefit from the ACA’s prohibitions on setting annual and lifetime limits, rescinding coverage and underwriting for pre-existing conditions, as these provisions would remain in place under the “repeal” scenario.^{24,25}

Generic drugmakers benefited as many of the new prescriptions generated by the Medicaid expansion were filled for their products.²⁶ Makers of drugs treating mental illness and mood disorders, HIV and hepatitis C—the top three types of prescription drugs for Medicaid spending—also may have benefited from the expansion of that program (see figure 9). The ACA also expanded Medicaid coverage to certain smoking cessation drugs, barbiturates and benzodiazepines, aiding companies selling those products.

Figure 9. Cuts to Medicaid likely would impact sales of certain types of drugs, including those for mental and mood disorders more than others

2015 Medicaid spending on top 50 prescription drugs, by type (billions)



Source: PwC Health Research Institute analysis of CMS Medicaid drug spending data

Makers of medical devices may have the most to gain from “repeal.” They gained relatively few patients from the ACA—medical device use is highest among the elderly, who are primarily insured by Medicare—but were hit with a 2.3 percent excise tax on sales of nonretail medical devices. However, weaker revenues for healthcare providers may affect sales of some devices used in hospital settings.

Impact on employers

Employers, which insure 49 percent of Americans, also likely would feel the effects of “repeal.”²⁷ Under the ACA, companies with more than 50 employees were required to provide insurance to employees working more than 30 hours per week. Eliminating the employer mandate might result in some

employers dropping coverage, and fewer compliance and reporting costs for all employers. The elimination of the “Cadillac” tax, in particular, would ease reporting costs for employers.²⁸

However, these cost savings will be offset by increased costs elsewhere. Sicker employees may feel pressure to stay for fear of not getting insurance

elsewhere, leading to “job lock.” Increases in uncompensated care for providers also could be passed on to insurers and, therefore, on to employers in the form of higher premiums. Employers are expected to offer coverage to about 10 million more Americans under the “repeal” scenario as employees put pressure on their employers to offer coverage in the absence of a functional nongroup market, according to the analysis by HRI and Strategy&.

Impact analysis

“Repeal” likely would mean a surge in the uninsured. Rolling back most of the ACA’s signature elements—generous premium supports for low-income Americans and the Medicaid expansion—could result in rapid changes for many healthcare providers and payers. Organizations should consider their short-term abilities to operate, and how they would handle caring for, covering or offering services to a significant






number of patients who lose coverage. Providers also should consider their plans—staffing, expansions, deals, capital projects—in light of this scenario. Payers should consider how, or whether, to continue operations in the nongroup market in the absence of the ACA’s premium subsidies. Pharmaceutical companies may need to quickly ramp up patient assistance programs as millions lose coverage.

Prepare for long-term fiscal impacts. In the absence of a replacement plan, some providers and payers may face a bleaker outlook than they would under the ACA. A substantial increase in the uninsured likely will lead to increases in uncompensated care. Pharmaceutical and life sciences companies should consider how they would put tax savings to work, especially with the possibility that President Trump and Congress may pass tax reform too. (Please see sidebar on tax reform on page 32).

Scenario 2: Replace

Figure 10. "Replace": Repeals ACA mandates; implements Medicaid block grants; funds high-pools and adds means-tested, aged-based tax credits

Net change in insured, 2025: -12 million Americans (Employer: +5m; Medicaid: -5m; Nongroup: -12m)

	<i>Impact (decrease, increase)</i>	<i>Detail</i>
Payers: Total premium revenue		Less valuable tax credits will leave the nongroup market smaller and sicker while Medicaid block grants could eventually squeeze insurers administering Medicaid managed care programs. Most impact to insurers participating in ACA exchanges and Medicaid managed care.
Providers: Hospital revenues		Increase in the uninsured leads to a decreased number of paying uninsured customers. Block-granting Medicaid leads to reductions over the long-term.
Providers: Uncompensated care		Reduction in insured customers leads to a gradual increase in uncompensated care; particularly in states that expanded Medicaid.
Life sciences: Pharma income		Pharma companies, especially those selling mental health, HIV and Hepatitis C drugs, could see slight decrease in revenues over time due to rise in uninsured and block granting. Greater state flexibility in administering Medicaid could mean restrictions on prescriptions.
Life sciences: Device income		Rise in uninsured means fewer paying customers for medical devices.

Source: PwC Health Research Institute and Strategy& analysis

Note: All data reflect projected uninsured rate as of 2025.

Under “replace,” President Trump and lawmakers would use the budget reconciliation process to repeal the individual mandate and the income-based tax credits to subsidize purchase of premiums. They would replace these with premium tax credits based on age that would be available to all participants in the individual market with incomes up to \$40,000 for individuals and \$80,000 for families (with a phase-out of the credits that ends at incomes of \$50,000 for individuals and \$100,000 for families). They would offer some federal funding for state-based,

high-risk pools, and transform Medicaid into block grants.

Fully implemented, “replace” could lead to an estimated 12 million fewer insured individuals than under the ACA, according to an analysis by HRI and Strategy&. Under this scenario, employers would cover an estimated 5 million additional people, partially offsetting a decline in Medicaid enrollment because of the block-granting program and the loss of an estimated 12 million people in the nongroup market thanks to less generous premium supports and the individual mandate repeal.

This scenario does not represent a best- or worst- case scenario for any major sector of the industry, although healthcare payers that specialize in Medicaid managed care could be impacted. Transforming the Medicaid program from an entitlement into a system that hands states a block of money, or a capped amount per enrollee, would lower federal spending on the program over time, allowing for more control over federal nondiscretionary spending (see figure 11 for a brief explanation of Medicaid block grants and capped enrollee funding).

Figure 11. What's a Medicaid block grant? How would a per capita cap system work?

<i>Area</i>	<i>Current Medicaid system</i>	<i>Medicaid block grant/ per capita cap system</i>	<i>Trump administration considerations</i>
Financing	Federal funding is based on actual expenditures	Federal funding is capped per state or based on a pre-set amount or formula	Decide on how to set the total federal amount or per capita rate; choose to cap only certain categories
	Federal and state governments share program costs	State government responsible for program costs over federal capped amount	Set a base year and growth rate for each year; determine how to account for non-expansion states
	Lower-income states pay lower share; special federal match rates for the ACA Medicaid expansion population		
Entitlement/ guarantee of coverage	Eligible people guaranteed coverage; no enrollment caps	Cede more power to states; weaker federal rules on who must be covered; states decide who qualifies for program and what benefits are covered	Determine federal requirements (e.g., essential standard benefits, eligibility categories)
	States must meet core federal requirements for benefits		

Source: CMS National Health Expenditure data, FY 2015; Congressional Budget Office, “Options for Reducing the Deficit: 2017 to 2026.”

Medicaid block grants could come with more freedom for states to administer their programs, even though additional flexibility was not modeled for the "replace" scenario. This flexibility could come through more liberal and streamlined approvals of Section 1115 demonstrations and waivers, which allow CMS to grant states flexibility in administering Medicaid and CHIP. Seema Verma, CMS' new administrator and architect of several states' Medicaid 1115 waiver programs, called Medicaid an "intractable" and "inflexible" program during her confirmation hearing before the Senate Finance Committee in February. "States are in a situation where they are having to go back and forth doing reams of paperwork trying to get approvals from the federal government," said Verma.²⁹

Others also see block grants as a path to more efficient spending and innovation. "When there is a block grant, it creates a partnership between providers and state and federal governments to focus on the provision of better healthcare at a greater value," said Mark D. Birdwhistell, vice president for administration and external affairs at UK HealthCare. "The current structure is completely open-ended."

Healthcare provider groups have expressed concern about Medicaid block-grant programs, which were modeled under "replace," because they could lead to significantly decreased funding and reductions in coverage. "Any Medicaid restructuring should continue the

federal-state partnership that ensures beneficiaries and providers continue to have access to high-quality health care coverage, provides sufficient funding, and treats expansion and nonexpansion states in an equitable manner," wrote the American Hospital Association and 71 state and regional hospital associations in a Jan. 27 letter to President Trump.³⁰

The CBO calculated that spending caps could reduce federal Medicaid spending by \$370 billion to \$690 billion over 10 years, depending on the exact nature of the proposal.³¹ CBO and JCT estimated that a combination of block grants and per capita spending caps, as described in one version of the AHCA, would reduce federal spending by more than \$800 billion over 10 years. Under the "replace" scenario in this report, HRI and Strategy& assumed a per capita cap block grant starting at 95% of states' current per capita expenditures with growth at inflation plus 1 percent per year. HRI and Strategy& also assumed that states that expanded Medicaid under the ACA would be permitted to maintain their expansion, but states that did not expand under the ACA would not be permitted to do so.

Impact on payers

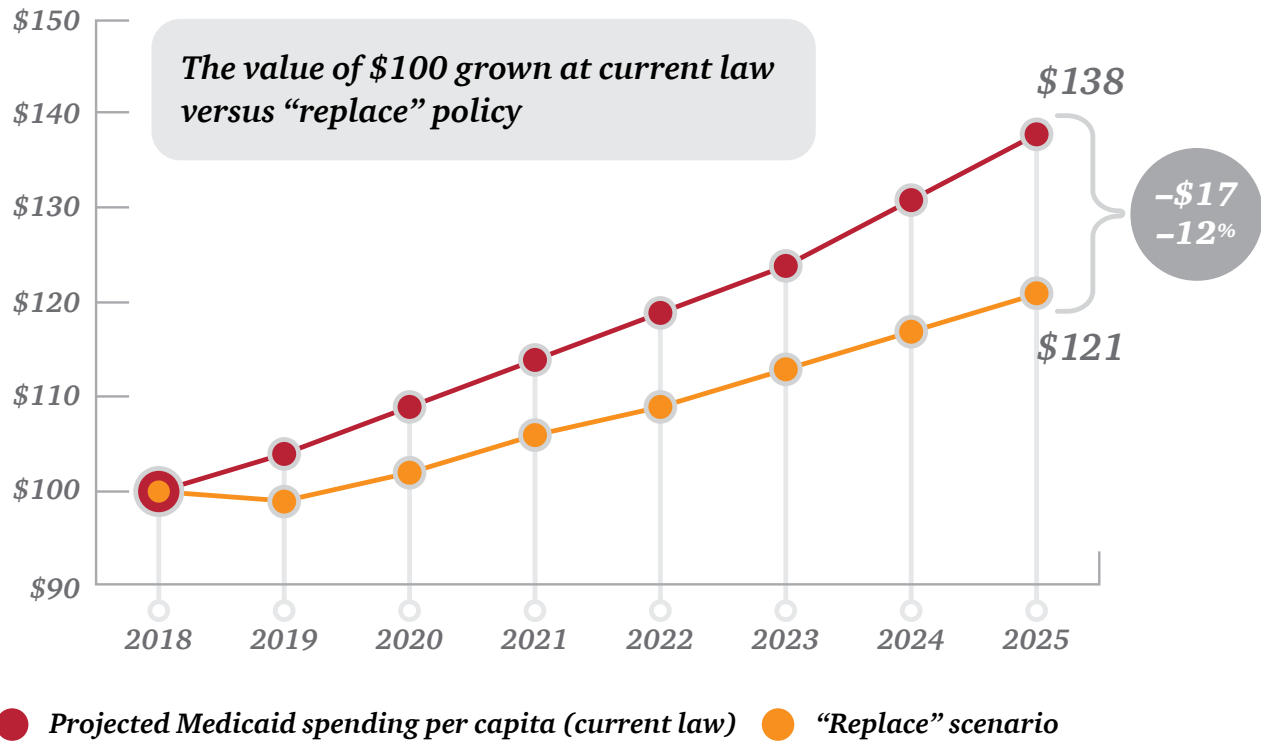
Insurers, particularly those invested in the nongroup markets, could lose out under "replace" as an estimated 12 million Americans leave the individual insurance market because of less generous subsidies and a lack of an individual mandate. Lawmakers' plans to expand the use of health

savings accounts could have a small positive effect by allowing pre-tax dollars to pay for more care, though these vehicles have mostly been used by higher-income Americans so far.

High-risk pools, modeled as part of the "replace" scenario, could help make ACA exchanges more attractive to payers. The pools would help provide coverage for the sickest, most expensive consumers, thereby taking them out of insurers' other risk pools. The impact of the high-risk pools would depend on funding available to them. If they are poorly funded, their impact would be modest. The CBO/JCT has previously determined that adequately-funded risk-pools would "exert substantial downward pressure on premiums in the nongroup market" and would also "encourage participation in the market by insurers."³²

Under a block-grant scenario, states also would be responsible for deciding how to handle the gap between growing healthcare costs and capped federal funding by finding efficiencies, cutting benefits, filling the gap, reducing the number of enrollees or some combination of all four. Medical expenditures have historically outpaced consumer inflation, and state budgets would be constrained more and more over time, resulting in additional cost pressures on managed care programs (see figure 12). HRI and Strategy& estimate that the primary mechanism used by states would be reductions in enrollment, thus decreasing Medicaid enrollees by 5 million by 2025.

Figure 12. The federal contribution to Medicaid spending likely would grow more slowly over time under the “replace” scenario



Sources: PwC Health Research Institute and Strategy& analysis; Congressional Budget Office, “The Budget and Economic Outlook: 2017 to 2027,” January 2017; CMS, February 2017 National Health Expenditure Projections. Note: “Replace” policy assumes a 5% reduction in Medicaid funding in 2019 compared to current baseline, and then growth at the Consumer Price Index (CPI) plus 1%

Impact on healthcare providers

Under “replace,” federal funding for Medicaid likely would grow more slowly than current projections. While states would have a lot more freedom to experiment and design their programs, they also would have to make hard choices about raising taxes, finding new sources of revenue and changing eligibility, benefits and reimbursement rates. Providers, already unhappy with Medicaid reimbursement rates, may be pressed harder still.

State budget flexibility also is limited. State governments collectively spent \$197 billion on Medicaid in 2015, an average of 15.39 percent of their budgets. If the federal government pushed all Medicaid funding and responsibility to the states, an unlikely proposition, Medicaid would make up an average of 32.8 percent of all state expenditures, according to an HRI and Strategy& analysis of 2015 Medicaid spending data (see Appendix C). This gap, between 15.39% and 32.8%, is funding that

will be reduced over time under the per capita cap system.

This flexibility is further curtailed by unfunded state pension and retiree healthcare obligations, which will reach an estimated \$1.75 trillion in 2017.³³ Some states, such as Illinois, already have poor credit ratings and likely would have little ability to make up shrinking federal funding for Medicaid.³⁴

Hospitals located in states that expanded Medicaid and serve a disproportionately high number of low-income individuals will feel the squeeze most (see figure 13). Under this scenario, the impact of these reductions would be offset, in part, by restoration of Disproportionate Share Hospital funding. Providers of long-term care to frail elderly Americans may face changes to Medicaid funding over time. Healthcare providers set up as integrated, managed care delivery systems may have the least to lose under a block-grant plan. State efforts—or mandates—to save money likely will require these types of providers to coordinate care and divert patients into appropriate

venues for cost-effectiveness, which is their forte.

Impact on pharmaceutical and life sciences companies

Because all taxes and fees are assumed to be retained under “replace,” life sciences companies are not expected to benefit under this scenario. Instead, the number of uninsured would rise by 12 million by 2025, a boost in uninsured potential customers at a time when drug companies are being pressured politically to lower drug prices.³⁵

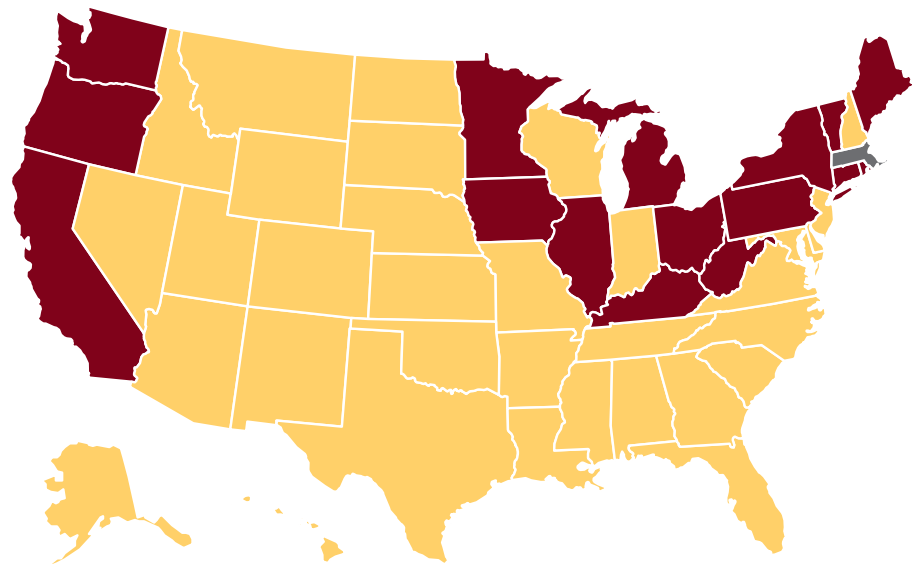
Block-granting Medicaid under a per capita cap system would result in

other challenges over time. Medicaid spent \$57 billion on pharmaceuticals in 2015 before required rebates, and just 25 drugs made up 31 percent of all spending.³⁶ Cash-strapped states might curtail access to high-cost, breakthrough drugs to protect their budgets. Just a small handful of new drugs, like the three new hepatitis C drugs introduced from 2013 to 2015, could put state budgets at risk by exceeding the states’ capacity to accommodate the drug costs over the short term (see figure 14). Companies that rely heavily on Medicaid populations for revenues, such as manufacturers of mental health drugs, could feel the most impact.

Figure 13. “Replace” likely would lead to moderate increases in uninsured rates over time compared to “repeal”

Estimated increases in the uninsured rate under “replace” scenario:

- +0%–50%
- +51%–100%



Source: PwC Health Research Institute and Strategy& analysis of the Annual Social and Economic Supplement to the Current Population Survey and Congressional Budget Office publications.

Note: With the Affordable Care Act replaced, Massachusetts may be able to continue elements of their state-level health reform legislation that was originally enacted in 2006. The state would still face losses from reduced Federal Medicaid funding under the per capita cap system. All data reflect projected uninsured rate as of 2025.

Figure 14. Medicaid drug spending can spike due to arrival of high-price products

<i>Medicaid spending on three hepatitis C drugs, by year</i>							
Year	Drug 1		Drug 2		Drug 3		Total
	Total spend	Rx filled	Total spend	Rx filled	Total spend	Rx filled	
2012	\$0	0	\$0	0	\$0	0	\$0
2013	\$4m	144	\$0	0	\$0	0	\$4m
2014	\$1,386m	50,377	\$0	0	\$94m	3,039	\$1,480m
2015	\$618m	27,228	\$210m	8,612	\$2,175m	78,467	\$3,003m

Source: PwC Health Research Institute and Strategy& analysis of CMS Medicaid Drug Spending Dashboard 2015 data. Spending amounts do not reflect rebates paid by pharmaceutical companies.

Impact on employers

Employers likely will cover an estimated 5 million additional employees under the “replace” scenario, according to an analysis by HRI and Strategy&. Although the employer mandate is repealed, employees may have less interest in remaining in the nongroup market with less generous subsidies, on average, reversing some of the movement from employer-sponsored insurance to the nongroup market that occurred under the ACA. In addition, the absence of the individual mandate likely will raise nongroup market premiums, providing further incentive for workers to seek out employer-sponsored insurance.

Also under this scenario, the excise tax on high-value employer health insurance, also known as the “Cadillac” tax, would be repealed and replaced with a cap on the tax exclusion of employer-provided health insurance. This change will likely be easier for employers to implement,

but it could lead to larger reductions in the employer-provided health insurance’s value than was expected under the “Cadillac” tax.

Impact analysis

Conduct an analysis of the Medicaid program’s impact. Organizations that are heavily reliant on the program are likely to experience substantial reductions in Medicaid-related funding over the long term under a block-grant scenario. Enrollment cuts may have a strong impact over time on providers, who would see increased rates of uncompensated care. Pharmaceutical companies dependent on Medicaid populations may see similar pressure or restrictions on the prescribing of their drugs, particularly high-priced breakthrough treatments.

Assess opportunities amid change. Companies that can save states money by eliminating waste, managing high-cost patients more effectively, delaying costly conditions






or improving outcomes may find ample opportunities for success under a block-grant model. New entrants such as ride-sharing companies could, for example, help patients get to needed appointments, reducing the use of costlier ambulances. As the number of uninsured rises, retail health providers offering low-cost, transparent services also may act as safety nets for those who still require access to care.

Communicate with partners early and often. In a cost-constrained environment, healthcare companies can ill afford surprise costs. Early and effective communication with stakeholders—including companies, employers and the government—will be crucial in a market where trust between parties is at a premium.

Scenario 3: Repair

Figure 15. "Repair": Stabilizes ACA marketplaces through series of reforms, gives states more flexibility for Medicaid programs

Net change in insured, 2025: -6m Americans (Employer: 0; Medicaid: -2m; Nongroup: -4m)

	<i>Impact (decrease, increase)</i>	<i>Detail</i>
Payers: Total premium revenue		Expanded age-bands and more control over design of their plans will give insurers participating in the ACA exchanges a small boost; Healthier enrollees could exit the nongroup market if the replacement for the individual mandate is not strong enough
Providers: Hospital revenues		Little change to slight loss due to loss of mostly healthy insured; perhaps small decrease for providers with a lot of Medicaid patients
Providers: Uncompensated care		Little change to slight increase due to loss of mostly healthy insured; perhaps small increase for providers with a lot of Medicaid patients
Life sciences: Pharma income		Little change due to loss of mostly healthy insured
Life sciences: Device income		Little change due to loss of mostly healthy insured

Source: PwC Health Research Institute and Strategy& analysis
 Note: All data reflect projected uninsured rate as of 2025.

Under “repair,” lawmakers would make market-friendly tweaks to the ACA. This scenario would require a handful of Democratic votes in the Senate to change provisions that cannot be manipulated through budget reconciliation. Under this scenario, according to an analysis by HRI and Strategy&, the number of uninsured would rise by an estimated 6 million people, and the impact on industry would be modest (see figure 15).

While the individual and employer mandates would be eliminated, the former would be replaced under the “repair” scenario by provisions such as a continuous coverage requirement. Medicaid expansion provisions would remain in effect, and insurers would get more flexibility to set higher, and lower,

premiums in the nongroup market through a widening of the age-rate bands. In some ways, the Trump administration already has taken some steps toward this scenario, submitting a proposed rule in February aimed at stabilizing the ACA exchanges.³⁷

Under this scenario, states would gain more flexibility in designing their own Medicaid programs through the expanded use of Section 1115 waivers. Many health policymakers are in favor of making it far easier for states to gain approval for changes to their Medicaid programs. Newly-installed HHS Secretary Price and CMS Administrator Verma released a joint letter to governors across the country encouraging innovation in state Medicaid programs. “Today, we commit to ushering in a new era

for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population,” they wrote. “States, as administrators of the program, are in the best position to assess the unique needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.”³⁸

Verma’s co-authored letter suggests that the waivers may be more freely granted in the future. Indiana’s Healthy Indiana Plan 2.0, which she helped design, features HSAs and deductibles for enrollees and requirements that most enrollees pay something toward their coverage for substantial benefits, or risk temporarily losing some benefits (see figure 16).

Figure 16. Medicaid Section 1115 waivers may be granted more freely under the new administration

States may start designing plans similar to those implemented by Indiana and Arkansas

<i>Indiana</i>	<i>Arkansas</i>
Established: January 1, 2015	Established: January 1, 2014 Amended: January 1, 2015
Those in Medicaid are enrolled in a health plan with a \$2,500 deductible.	All those newly eligible for Medicaid under the expansion will be enrolled in a plan on the exchanges with Medicaid funds covering the cost of premiums.
Members also are granted an HSA with a \$2,500 balance	Members from 50–138% of the Federal Poverty Level (FPL) are required to make monthly contributions ranging from \$5–\$25 to an HSA to be used for co-payments and coinsurance
Members must make monthly contributions of 2% of their income or else they are bumped to the lower Medicaid option with skinnier benefits.	Cost-sharing at the point of service is imposed on those over 100% FPL who do not make monthly contributions.

Source: PwC Health Research Institute and Strategy& analysis of Medicaid Section 1115 waivers

Impact on payers

Insurers have been seeking changes to shore up the health of the individual insurance exchanges.³⁹ If even a small number of companies drop out of the ACA exchanges, as some have already pledged to do, some areas would be without a single insurer offering a “silver”-rated plan (see figure 17).⁴⁰ Silver-rated plans are designed to cover 70 percent of expenditures on average and are the only level of plan that can be paired with ACA cost-sharing subsidies for low-income consumers. In 2016, 70 percent of all

those enrolled in the health insurance exchanges were enrolled in silver-rated plans.⁴¹

Under “repair,” insurers also would be able to charge older customers five times more than younger customers, while the sickest, and most costly members, would be shifted to high-risk pools. This shift could help them attract younger, healthier customers by offering lower premiums.

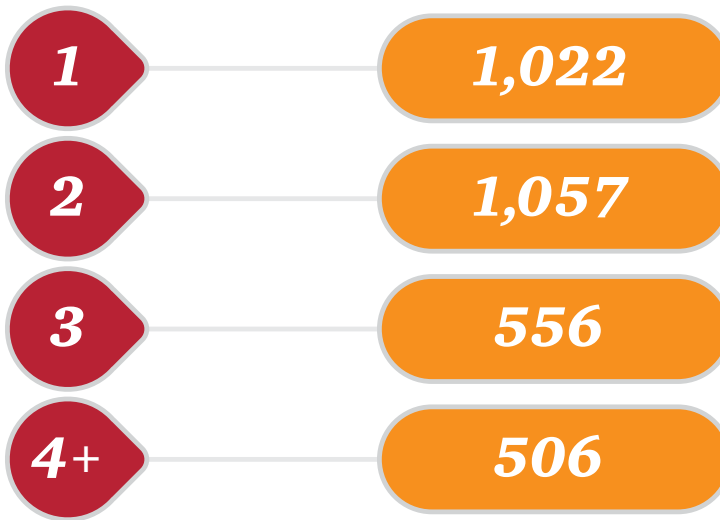
In contrast, the individual mandate would be replaced with a continuous coverage provision, which may not

be as effective in encouraging the healthiest of Americans to sign up for a plan. While the individual mandate was far from a panacea—6.5 million people paid the penalty in 2016—a lack of incentives to sign up might encourage only the sick to enroll, harming insurers and leading to an increase in premiums.⁴² An estimated 52 million adults have a pre-existing condition, and insurance companies would benefit from requiring them to maintain continuous coverage to ensure they don’t drop coverage until they become ill and require costly coverage.⁴³

Figure 17. As insurers question their participation in the Affordable Care Act exchanges, consumers may face even fewer options

Number of carriers offering 2017 on-exchange coverage

Number of counties



*Data is based on 2017 participation, Silver metal tier.

Note: States that price health plans by zip code may have varying carriers within a single county.

Sources: PwC Health Research Institute and Strategy& analysis of Qualified Health Plan data from HealthCare.gov, the Robert Wood Johnson Foundation, and exchange data for the following states: Colorado, Washington, Minnesota, New York, Vermont, Rhode Island, Idaho, California, Connecticut, Massachusetts, Washington DC and Maryland.

Though the continuous coverage requirement seems like a likely replacement for the mandate—and was modeled for an analysis by HRI and Strategy&—other potential replacement options include automatic enrollment in a basic health plan unless individuals opt out, increased subsidies for those in

the individual market and premium surcharges for failure to obtain prior coverage. Absent a working mechanism to compel enrollment, additional insurers may exit the nongroup market, leading to fewer—or no—choices for consumers (see figure 18).

Though the loss of an estimated 4 million insured enrollees in the nongroup market could reduce revenues and make existing plan pools more expensive on average, the loss of coverage likely would be modest compared to the other two scenarios.

Figure 18. Policymakers have alternatives to the ACA's individual mandate to encourage healthy people to sign up for coverage

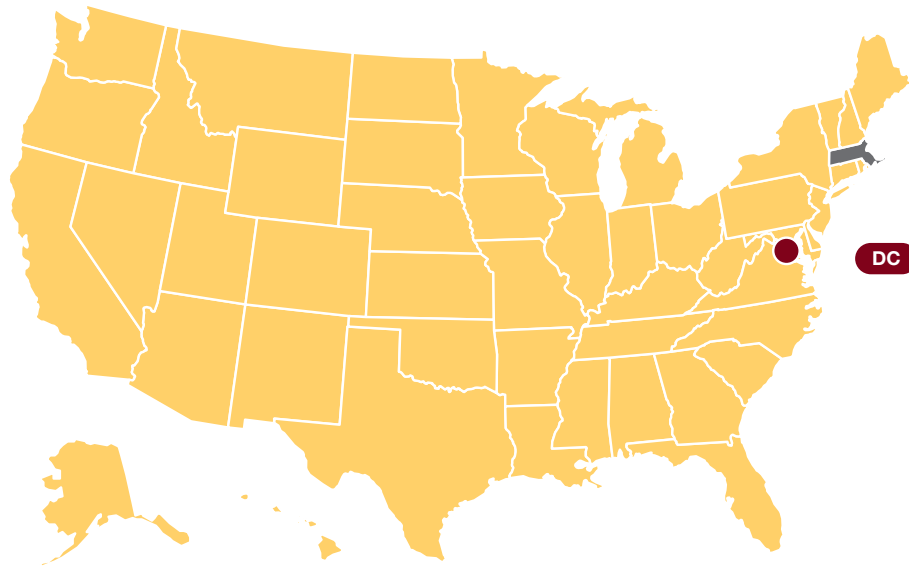
<i>Alternative</i>	<i>Explanation</i>	<i>Benefits/Drawbacks</i>
Continuous coverage	Provision would protect anyone who has maintained continuous insurance coverage from losing their insurance coverage or facing higher premium rates. The American Health Care Act championed by Republicans employs this strategy.	Would protect insurers from adverse selection by sick enrollees but may disproportionately lead to lack of insurance among those who temporarily lose their job or suffer financial difficulty. Short-term insurance policies would need to be developed.
Premium surcharge	Individuals would be forced to pay higher premiums if they fail to enroll in the initial open enrollment period.	A similar system is already used by Medicare Parts B and D. However, the surcharge may not be enough of a penalty to attract healthy individuals and may discourage insurance after a lapse.
Automatic enrollment	Everyone eligible for subsidies in the individual market would be auto-enrolled in a basic health plan. Subsidies would be used to pay for the basic health plan coverage. Greater coverage could be purchased at the enrollees' expense.	People are less likely to opt out of coverage than to opt in, resulting in a larger, healthier risk pool. However, the plan is logistically complicated and costly. Those with the greatest health care need are most likely to purchase higher value coverage, which may exacerbate risk differences.
Higher subsidies	To attract healthy enrollees, the government would increase subsidies to the point at which potential enrollees feel compelled to purchase coverage.	Would encourage exchange participation among the healthy, but additional subsidies would require additional tax revenues. This option would be costly for the federal government.

Source: PwC Health Research Institute and Strategy& analysis

Figure 19. “Repair” likely would lead to modest increases in uninsured rates

Estimated increases in the uninsured rate under “repair” scenario:

- +0%–50%
- +51%–100%



Source: PwC Health Research Institute and Strategy& analysis of the Annual Social and Economic Supplement to the Current Population Survey and Congressional Budget Office publications.

Note: All data reflect projected uninsured rate as of 2025. The impact in Massachusetts will vary based on how provisions of the repair plan interact with provisions in Massachusetts’ own health reform initiatives which were passed in 2006.

Impact on healthcare providers

Healthcare providers could see a modest, manageable decline in revenues attributable to a small decrease in the number of the insured. However, HRI and Strategy& anticipate that many of those who would drop coverage in the nongroup market would be the healthiest enrollees who are light users of the healthcare system anyway. As a result, rates of uncompensated care are likely to remain about the same or go slightly higher (see figure 19).

Some healthcare providers may see some positive impact if their state chooses to obtain a Section 1115

waiver for its Medicaid program. That flexibility could lead to greater emphasis on value-based care models in various states, with potential links between traditional industry members and new entrants. Providers best able to coordinate care and deliver value may benefit, though it will take time and effort.

Broader access to HSAs, especially if states begin to use them as part of their Medicaid programs, could have a negative effect on some healthcare providers. People with HSAs—most often associated with high-deductible health plans—tend to use fewer elective healthcare services, and the effect is exacerbated for low

earners. Some studies indicate that people with HSAs tend to use the emergency department more often, a possible sign that needed care is being delayed.⁴⁴

Impact on pharmaceutical and life sciences

Life sciences companies likely would experience little change under this scenario. The continuance of most ACA protections likely will benefit branded pharmaceutical companies, such as specialty drug companies that benefited from the ban on lifetime limits for insurance coverage. While the loss of insurance for several million enrollees won’t help the

industry and could slightly increase patient assistance program costs, it is not expected to have a major impact on revenues because many of those losing insurance would be either relatively healthy or coming off of Medicaid, where industry losses would be softened by no longer paying substantial Medicaid rebates. Expanded access to HSAs may be somewhat detrimental to the industry, depending on how they are implemented. Research has shown that enrollees in plans with an HSA tend to refill fewer prescriptions.⁴⁵

Impact on employers

Employers likely won't experience much change under "repair." The repeal of the employer-based mandate likely would, as in other scenarios, prove helpful in minimizing compliance and reporting burdens imposed by the ACA. The comparatively small rise in uncompensated care at hospitals likely will keep provider costs stable, and therefore keep premium increases stable. Employers also may find that additional tax advantages for HSAs will make them more attractive for some employees.

As with other sectors, employers should closely track the status of the "Cadillac" tax, implementation of which has been delayed, or of a replacement.⁴⁶ Its repeal could be a boon to many employers offering high-value plans, but its revenues—or the revenues of a different tax on employers—could be needed to pay for "repair."

Impact analysis

Under "repair," the ACA will survive intact, signaling stability in health reform for years to come.

Healthcare organizations that have invested heavily in adapting to the ACA may find comfort in its relative continuance. Companies will benefit by being able to focus on their competencies, taking advantage of new ACA modifications and making investments. Payers in particular could benefit from changes that make participating in the ACA exchanges more profitable and predictable, such as allowing insurers to charge more for older patients or incentivizing enrollees to maintain coverage. These changes would allow insurers to enjoy the benefits promised by the law even if they are still required to submit to its restrictions and fees.

Consider how changes will work together. The ACA has famously been compared to a three-legged stool; without even one of the legs—income-based tax subsidies for insurance, guaranteed issue of insurance despite pre-existing conditions, and the individual mandate—the legislation wouldn't work. Companies need to consider how changes to the ACA might create adverse incentives, leave gaps in coverage, or advantage or disadvantage their partners and suppliers. With the rollout of a new framework, companies that are quick to take advantage of new efficiencies or solve key challenges can create new products or expand their market share.

Watch for how other issues are sorted out. Repairing the ACA likely also will require addressing other issues—not included in the models developed by HRI and Strategy&—that could help the law operate more smoothly. Three ACA programs—the so-called 3R's—were established to protect insurers operating on the exchanges against adverse selection, giving health plans that attract sicker and higher-risk enrollees payments as buffers against higher costs.⁴⁷ The programs didn't deliver as much funding as expected.

One of the R's—risk adjustment—was highly criticized by smaller, newer insurers that had to make substantial and even debilitating financial contributions to the program because they attracted younger, healthier customers. The other two programs—risk corridors and reinsurance—suffered from funding shortfalls, failing to collect enough money to cover payments owed to plans with higher-risk enrollment and obligations to other agencies required under law. Both the risk corridor and reinsurance programs were sunset at the end of 2016. Under a repair scenario, Congress and the administration may choose to reinstate these programs to provide more market stability.

But how the Congress and the courts handle these programs going forward also could have a substantial impact on industry stakeholders such as payers. The same can be said of the many ACA-related regulations and the administration's regulatory approach. Health organizations should understand how the regulatory landscape related to the ACA could change under the new administration.

Sidebar: Tax reform

President Donald Trump and Republican lawmakers have proposed significant overhauls of the US tax code and have indicated they would like to pass these reforms shortly after they address the ACA (see figure 20).⁴⁸

Plans from President Trump and Republican leaders suggest lowering corporate taxes and creating incentives to encourage US-based manufacturing. An “America First” tax code would represent a pivot away from policies that led to offshore intellectual property holdings and a manufacturing base distributed across the globe. As a result,

pharmaceutical, medical device and medical equipment companies may benefit from re-evaluating and potentially restructuring their supply chains and legal structures.

President Trump’s proposal reduces the US corporate tax rate to 15 percent from 35 percent.⁴⁹ The plan also includes a mandatory one-time tax rate of 10 percent on unremitted foreign earnings. President Trump also has said that he will renegotiate trade deals such as the North American Free Trade Agreement (NAFTA), and he has suggested a “border tax” on products imported

to the US by companies formerly operating in the US. A presidential memorandum signed in his first days in office pulled the US out of the Trans-Pacific Partnership negotiations and agreement.⁵⁰

Republican lawmakers have put forward their own plan, which has similarities to the president’s proposal. Their tax blueprint, advanced by House Speaker Paul Ryan, R-Wis., and House Ways and Means Committee Chairman Kevin Brady, R-Texas, proposes lowering the corporate tax rate to 20 percent.⁵¹ The plan would levy a one-time

Figure 20. President Trump and Republican lawmakers have proposed comprehensive tax reform, which could impact insurers and life science companies

<i>Tax reform proposal under consideration</i>	<i>Explanation of action</i>
Corporate tax rate	Reduction from 35% to 15%–20%
Repatriation of foreign holdings	One-time, 10% tax on unremitted foreign earnings
Foreign dividends	100% exemption on all foreign dividends
Alternative minimum tax	Tax would be repealed
Border tax	Enactment of territorial tax system and border tax adjustments with a lower rate for pass-through entities
R&D tax credit	Repeal of corporate tax incentives except for R&D credit
Capital investment	Expensing of capital investment and disallowance of interest deduction
Charitable contribution limits	Would place limits on personal, itemized deductions for charitable giving

Source: PwC Health Research Institute and Strategy&, “Tax reform proposals could impact pharma, medical device and equipment supply chains,” 2017.

repatriation tax on unremitted foreign earnings at an 8.75 percent rate on cash held overseas and a 3.5 percent rate on noncash foreign assets. The blueprint also includes a “border adjustment” provision that exempts exports from taxation and disallows a deduction for imports.

Changes to the tax code could affect for-profit healthcare companies. Providers may be impacted modestly if limits on personal, itemized deductions are enacted and incentives are reduced for charitable giving by the wealthy. For-profit insurers also could be impacted by a lower corporate tax rate, and, modestly, from a border adjustment, which could affect offshore claims processing and other operations.

But perhaps no health industry would be affected as much as the life sciences industry. The establishment of tax incentives to favor stateside production could lead some life sciences companies to start reconsidering the structure of their supply chains, which stretch across the globe. Manufacturers are in the process of discerning what US tax and trade reforms could mean for their companies. Some of the top industry executives representing the largest US-based pharmaceutical companies have suggested an openness to moving workforces back to the US should tax and trade reforms occur, according to an HRI analysis of post-election earnings calls and other public statements. Several other executives have suggested that repatriated dollars could be used to repay company debt, fuel new business development or reinvest in US-based projects.

Impact analysis

Pharma and life sciences companies should consider assessing the impact of tax and trade reforms to their supply chains. Companies should analyze their operational structures to understand the impact. This analysis is underway at many companies. Relevant considerations include US and foreign taxes, intellectual property locations and impacts on foreign costs with potential dollar appreciation.

Access to overseas capital may drive new investment activity. Pharmaceutical companies that repatriate overseas cash could drive up deal activity for drug candidates and companies. Competition for new assets could, in turn, lead to higher valuations and product deal amounts. Other companies may decide to invest in new manufacturing or R&D programs, or to initiate stock buybacks. The Trump administration proposal and the House GOP tax plan preserve the R&D tax credit, which lowers the after-tax cost of funding research and development.

Moving pharma and life sciences operations back to the US will take time. It took years for companies to get their global operational structures to their current state. It will take the industry years to unwind them to reflect changes brought about by reform. Companies also should consider the operational and regulatory ramifications of reshoring manufacturing operations. The time and resources of building a new manufacturing facility are substantial, as regulators need to

inspect and clear a facility prior to it being used. Some medical device manufacturers may find it difficult to source all component parts from US manufacturers. Legal changes to reshore companies on paper, however, can happen relatively quickly if deemed necessary.

Healthcare companies likely will be looking for certainty in the direction provided by US reform. While specific legislation has not been introduced, companies likely will be looking for long-term certainty for tax reform. This could especially be true of pharma companies. Lead times for new products and facilities are long even with a potential decrease in regulation. Companies should carefully make these business decisions in the face of uncertainty, taking into consideration the opportunities tax reform may present to restructure operations.

Conclusion

As the healthcare industry assesses the potential effects of impending healthcare and tax reform, companies should carefully consider potential impacts to their business and what they should do to survive, maintain their market position or excel.

Regardless of what shape reforms take, companies can embrace “no regrets” actions that can set themselves up for success.

- Invest in quality and value.** Consumers and payers likely will demand greater value. Companies can embrace new care and contracting models that create high-quality, high-value outcomes. When cost constraints lead to lower reimbursements, companies that can provide value likely will pull ahead of their competitors and attract customers. Quality and outcome incentives likely will be largely immune from reform, though federal incentives may decline or change.
- Become resilient to uncertainty and change.** It is no longer enough for companies to merely survive. They should be resilient and turn uncertainty into strategic advantage. Companies that adopt six attributes of enterprise resilience—adaptive capacity, agility, relevance, reliability, trust and coherence—likely will stand a better chance of evolving in a new environment. Identify risks, understand their relevance to your business, confront or avoid those risks, and create teams ready to make necessary changes.

Figure 21. New entrants may provide partnership opportunities across all scenarios

New entrant type	Explanation
The low-cost transparent providers	If fewer consumers have access to insurance, pharmacies and providers that offer low-cost, transparent services could see additional business by serving those populations for their basic health care needs. Opportunity will be further driven by expansion of HSAs and HDHPs.
The cost savers	Medicaid block grants and waivers are a massive opportunity for providers and new entrants. If they can show how they can save the state money by diverting patients from costlier resources, they can capture significant revenues.
The simplifiers	A complex health care environment—made more so by the unwinding of the ACA, the creation of a new system or the modification of the ACA—will create new opportunities for technological innovators to simplify complex processes and make them user friendly for customers and companies.
The facilitators	The increased use of HSAs will present opportunities to financial services companies who offer access to funds and allow consumers to invest.

Source: PwC Health Research Institute and Strategy& analysis

- **Change under any scenario could invite new entrants.** Under all three scenarios modeled by HRI and Strategy&, fewer people likely will be insured than under the ACA. Companies can compensate for lost customers and opportunities by becoming more efficient, cutting costs and investing for growth. Working with partners, including new entrants, can help companies quickly scale up using highly specialized expertise (see figure 21). Companies—especially life sciences companies—should invest in collaboration models that drive medical outcomes and value, and in analytics or machine-learning methods that affect medical cost outcomes in innovative ways.
- **Focus on your customers and their experiences.** Consumers are increasingly engaged in managing their own health in the New Health Economy, and the ACA accelerated those trends. Companies should invest in making their products accessible and consumer-friendly. Dissatisfied customers may take their business—and in some cases, their HSA dollars—elsewhere, and tell others about their displeasure, often on social media. Consumer-driven products and distribution models can stand out in an environment where fewer people have access to health insurance, and help preserve or grow market share.
- **Innovate.** Innovation likely will remain essential in the healthcare ecosystem. Payers, providers, life sciences companies and employers likely will need to develop new products, delivery methods, care models, contract designs, customer experiences and other improvements to stay competitive. Investment rates may differ and depend on market conditions, but companies that fail to invest likely will be vulnerable to competition.
- **Use data you already have.** Companies are amassing mountains of valuable data. As more systems go digital, companies likely will be able to find more efficiencies and growth opportunities. Investments in capturing, managing and leveraging data can help companies grow, provide better care and develop new market segments.
- **Seek integration.** Payers and providers may experience significant cost pressures as health reform progresses, especially if the government reduces funding for programs like Medicaid. Gaining scale can create efficiencies—and bargaining power—that come from spreading investment across a larger population. For regional and midsize players, it might make sense to consider horizontal integration. And vertical integration of payers and providers may create investment synergies while hedging market risks.

Appendices

Appendix A: Modeled assumptions for health-reform scenarios

For this paper, HRI and Strategy& modeled three potential health-reform scenarios based on our analysis of existing, recent reform proposals in Congress. These scenarios—“repeal,” “replace” and “repair”—all assume the inclusion of certain key policy elements, listed below.

The new administration likely will take one of three broad paths in repealing and replacing the Affordable Care Act

Reform category	Key policy elements	Scenario		
		1	2	3
Individual and employer requirements	Repeal individual and employer mandates	●	●	●
Coverage and access options	Increase use of health savings accounts		●	●
Private health insurance reforms	End ACA income-based cost sharing subsidies and premium tax credits	●	●	
	Age-based refundable tax credits for premiums in non-group market (Under 18: \$1,650; 18 – 34: \$2,200; 35 – 49: \$3,850; and Over 50: \$5,500)		●	
	Eligibility for the tax credit is limited to those with incomes below \$40,000 for individuals and \$80,000 for families (credits would phase-out until incomes of \$50,000 for individuals and \$100,000 for families).		●	
	Underwriting allowed for discontinuous enrollees			●
	Federal start-up funding for high-risk pools		●	●
	Widen age bands from 3:1 to 5:1			●
Public program changes	Roll back Medicaid expansion	●		
	Give states more control over Medicaid plan design		●	●
	Convert Medicaid funding to block grants (Per capita federal contributions reduced by 5% in 2019 and grown by CPI+1% for future years)		●	
	Restore Disproportionate Share Hospital funding	●	●	
ACA funding	Repeal industry ACA taxes and fees	●		

Source: PwC Health Research Institute and Strategy& analysis

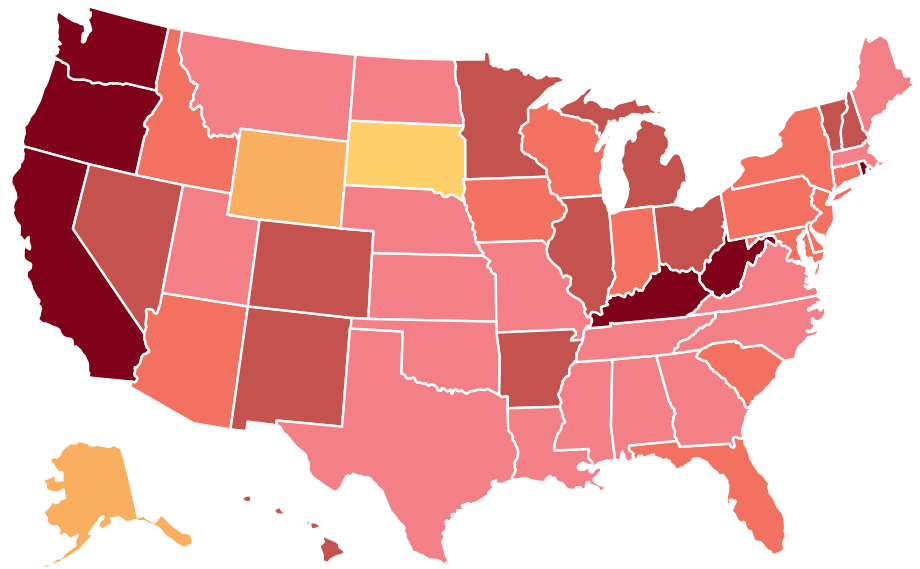
Appendix B: The ACA's impact on uninsured rates across the US

More than 20 million Americans gained healthcare coverage in the years following ACA passage in 2010. Some states—particularly those that expanded Medicaid—recorded dramatic decreases in their uninsured rates.

Many states experienced dramatic reductions in their uninsured rates after passage of the Affordable Care Act

Percentage reduction in uninsured rates after the passage of the ACA (2013 to 2015):

- 50%+
- 40%–49.9%
- 30%–39.9%
- 20%–29.9%
- 10%–19.9%
- 0%–9.9%



Source: PwC Health Research Institute and Strategy& analysis of Census Bureau health insurance historical data

Appendix C: Analysis of state Medicaid spending under a block-grant scenario

HRI and Strategy& analyzed state FY 2015 Medicaid spending data, using data from the Henry J. Kaiser Family Foundation and the National Association of State Budget Officers (NASBO). The analysis shows the total Medicaid spending as a percentage of state spending, underscoring the large share of Medicaid spending that would be diminishing under a block grant scenario.

*Assumes FMAP funding is added to state budgets, increasing them by FMAP amount. HRI and Strategy& then took total Medicaid expenditures for each state and divided them by the newly increased budget to calculate the total Medicaid percentage of the budget less federal funds.

Location	Total Medicaid Spending	Federal Medical Assistance Percentage (FMAP)	State Medical Assistance Percentage (SMAP)	Value of FMAP	Value of SMAP	Total state spending less federal funds	Total state Medicaid spending as % of total state spending	Total state Medicaid spending as % of total state spending if states are granted control of FMAP funding*
United States	\$532,233,348,782	63%	37%	\$334,300,819,455	\$197,932,529,327	\$1,286,138,279,670	15.39%	32.8%
Alabama	\$5,294,253,591	70%	30%	\$3,684,800,499	\$1,609,453,092	\$17,441,000,000	9.23%	25.1%
Alaska	\$1,421,672,896	59%	41%	\$834,521,990	\$587,150,906	\$10,493,060,000	5.60%	12.6%
Arizona	\$10,640,737,029	74%	26%	\$7,916,708,350	\$2,724,028,679	\$22,745,600,000	11.98%	34.7%
Arkansas	\$5,536,506,974	79%	21%	\$4,351,694,482	\$1,184,812,492	\$16,668,800,000	7.11%	26.3%
California	\$85,438,074,091	63%	38%	\$53,398,796,307	\$32,039,277,784	\$160,295,000,000	19.99%	40.0%
Colorado	\$7,358,339,263	61%	40%	\$4,451,795,254	\$2,906,544,009	\$25,678,000,000	11.32%	24.4%
Connecticut	\$7,853,582,804	59%	41%	\$4,602,199,523	\$3,251,383,281	\$23,624,560,000	13.76%	27.8%
Delaware	\$1,861,996,175	60%	40%	\$1,117,197,705	\$744,798,470	\$7,706,000,000	9.67%	21.1%
Florida	\$21,476,052,754	60%	40%	\$12,971,535,863	\$8,504,516,891	\$47,131,000,000	18.04%	35.7%
Georgia	\$9,750,156,735	68%	33%	\$6,581,355,796	\$3,168,800,939	\$31,679,000,000	10.00%	25.5%
Hawaii	\$2,012,418,150	64%	36%	\$1,287,947,616	\$724,470,534	\$10,616,000,000	6.82%	16.9%
Idaho	\$1,729,535,449	72%	28%	\$1,245,265,523	\$484,269,926	\$4,429,800,000	10.93%	30.5%
Illinois	\$17,039,177,220	60%	40%	\$10,240,545,509	\$6,798,631,711	\$49,133,312,710	13.84%	28.7%
Indiana	\$9,328,435,988	69%	31%	\$6,417,963,960	\$2,910,472,028	\$19,037,000,000	15.29%	36.6%
Iowa	\$4,563,170,736	64%	36%	\$2,911,302,930	\$1,651,867,806	\$15,653,000,000	10.55%	24.6%
Kansas	\$3,040,559,561	57%	43%	\$1,730,078,390	\$1,310,481,171	\$11,131,000,000	11.77%	23.6%

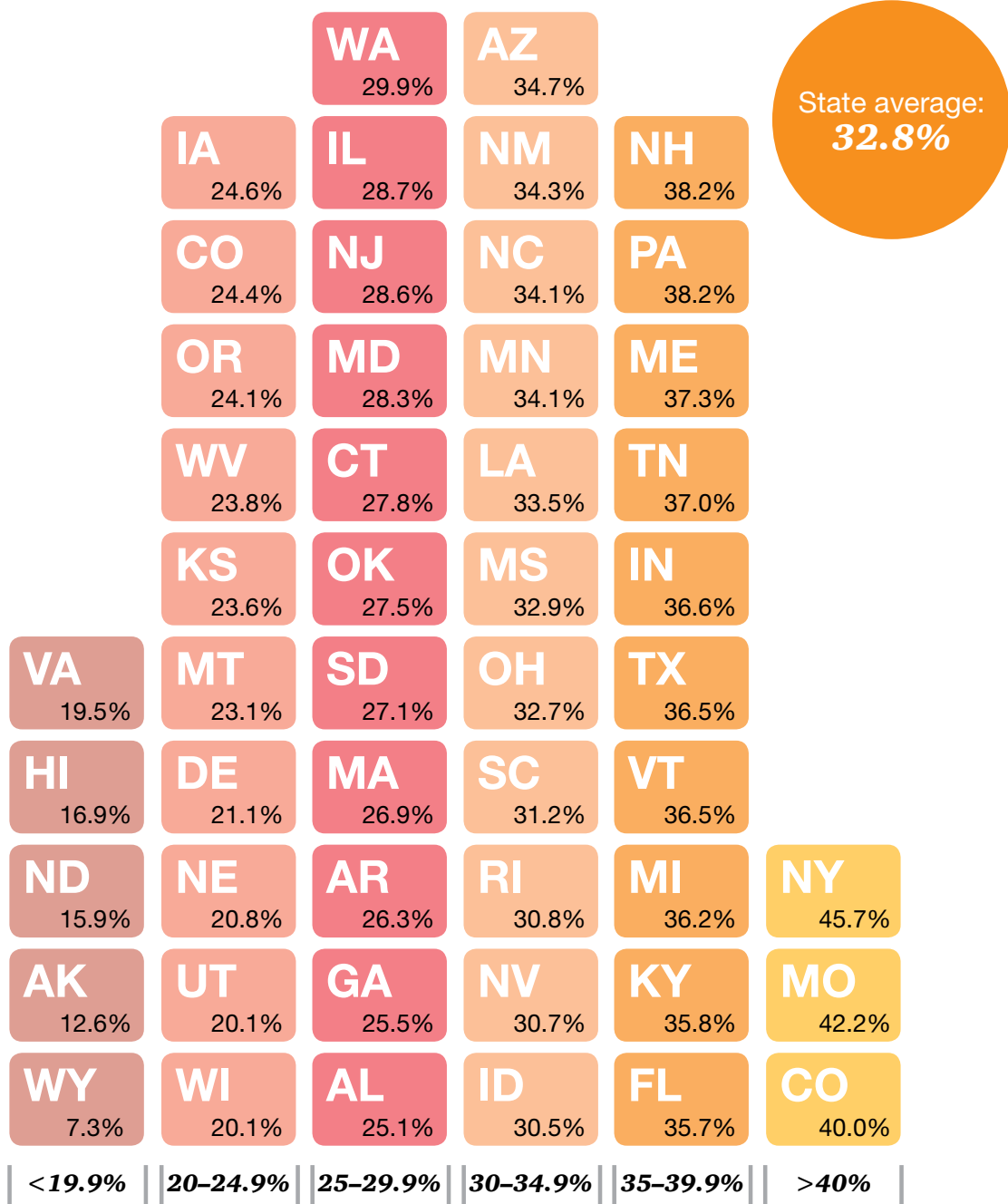
Notes: All years 2015 Federal Fiscal Year. PwC analysis of state spending data from the Henry J. Kaiser Family Foundation and NASBO. Highlighted states are nonexpansion states; white are expansion states.

Location	Total Medicaid Spending	Federal Medical Assistance Percentage (FMAP)	State Medical Assistance Percentage (SMAP)	Value of FMAP	Value of SMAP	Total state spending less federal funds	Total state Medicaid spending as % of total state spending	Total state Medicaid spending as % of total state spending if states are granted control of FMAP funding*
Kentucky	\$9,499,418,704	80%	20%	\$7,561,537,288	\$1,937,881,416	\$18,984,000,000	10.21%	35.8%
Louisiana	\$8,058,371,246	63%	37%	\$5,052,598,771	\$3,005,772,475	\$18,991,855,650	15.83%	33.5%
Maine	\$2,580,219,327	63%	38%	\$1,612,637,079	\$967,582,248	\$5,304,000,000	18.24%	37.3%
Maryland	\$9,552,933,956	60%	40%	\$5,712,654,506	\$3,840,279,450	\$27,999,000,000	13.72%	28.3%
Massachusetts	\$15,564,425,180	56%	44%	\$8,731,642,526	\$6,832,782,654	\$49,234,314,370	13.88%	26.9%
Michigan	\$15,949,108,357	73%	27%	\$11,595,001,776	\$4,354,106,581	\$32,471,900,000	13.41%	36.2%
Minnesota	\$10,935,757,369	58%	42%	\$6,386,482,303	\$4,549,275,066	\$25,706,480,000	17.70%	34.1%
Mississippi	\$5,156,588,865	74%	26%	\$3,821,032,349	\$1,335,556,516	\$11,841,000,000	11.28%	32.9%
Missouri	\$9,608,165,422	64%	36%	\$6,158,834,036	\$3,449,331,386	\$16,603,600,000	20.77%	42.2%
Montana	\$1,149,693,473	68%	32%	\$778,342,481	\$371,350,992	\$4,194,000,000	8.85%	23.1%
Nebraska	\$1,888,075,933	54%	46%	\$1,012,008,700	\$876,067,233	\$8,057,100,000	10.87%	20.8%
Nevada	\$3,127,537,716	75%	25%	\$2,355,035,900	\$772,501,816	\$7,835,000,000	9.86%	30.7%
New Hampshire	\$1,731,859,115	59%	41%	\$1,018,333,160	\$713,525,955	\$3,515,000,000	20.30%	38.2%
New Jersey	\$14,234,989,570	61%	39%	\$8,740,283,596	\$5,494,705,974	\$40,949,000,000	13.42%	28.6%
New Mexico	\$4,933,671,468	79%	21%	\$3,907,467,803	\$1,026,203,665	\$10,497,100,000	9.78%	34.3%
New York	\$59,806,137,548	55%	45%	\$32,713,957,239	\$27,092,180,309	\$98,148,000,000	27.60%	45.7%
North Carolina	\$13,483,308,436	66%	34%	\$8,925,950,185	\$4,557,358,251	\$30,637,290,000	14.88%	34.1%
North Dakota	\$1,091,177,153	61%	39%	\$668,891,595	\$422,285,558	\$6,210,000,000	6.80%	15.9%
Ohio	\$21,597,810,622	69%	31%	\$14,902,489,329	\$6,695,321,293	\$51,152,458,000	13.09%	32.7%
Oklahoma	\$4,996,967,825	64%	37%	\$3,173,074,569	\$1,823,893,256	\$15,016,000,000	12.15%	27.5%
Oregon	\$8,066,724,366	78%	22%	\$6,275,911,557	\$1,790,812,809	\$27,185,948,940	6.59%	24.1%
Pennsylvania	\$23,394,254,112	56%	44%	\$13,077,388,049	\$10,316,866,063	\$48,178,000,000	21.41%	38.2%
Rhode Island	\$2,598,444,116	59%	41%	\$1,538,278,917	\$1,060,165,199	\$6,891,000,000	15.38%	30.8%
South Carolina	\$5,963,805,943	71%	29%	\$4,222,374,608	\$1,741,431,335	\$14,900,000,000	11.69%	31.2%
South Dakota	\$813,084,998	56%	44%	\$456,140,684	\$356,944,314	\$2,545,000,000	14.03%	27.1%

Location	Total Medicaid Spending	Federal Medical Assistance Percentage (FMAP)	State Medical Assistance Percentage (SMAP)	Value of FMAP	Value of SMAP	Total state spending less federal funds	Total state Medicaid spending as % of total state spending	Total state Medicaid spending as % of total state spending if states are granted control of FMAP funding*
Tennessee	\$9,144,520,686	65%	35%	\$5,953,082,967	\$3,191,437,719	\$18,788,000,000	16.99%	37.0%
Texas	\$35,802,825,013	59%	41%	\$21,087,863,933	\$14,714,961,080	\$76,981,100,000	19.12%	36.5%
Utah	\$2,196,174,625	71%	29%	\$1,557,087,809	\$639,086,816	\$9,369,000,000	6.82%	20.1%
Vermont	\$1,634,622,218	60%	40%	\$987,311,820	\$647,310,398	\$3,494,000,000	18.53%	36.5%
Virginia	\$8,103,268,228	51%	49%	\$4,108,356,992	\$3,994,911,236	\$37,346,000,000	10.70%	19.5%
Washington	\$10,621,146,074	65%	35%	\$6,893,123,802	\$3,728,022,272	\$28,581,000,000	13.04%	29.9%
West Virginia	\$3,675,438,530	77%	23%	\$2,822,736,791	\$852,701,739	\$12,625,000,000	6.75%	23.8%
Wisconsin	\$7,974,598,543	59%	41%	\$4,689,063,943	\$3,285,534,600	\$35,020,000,000	9.38%	20.1%
Wyoming	\$566,400,158	51%	49%	\$288,864,081	\$277,536,077	\$7,425,000,000	3.74%	7.3%
Average								
Nonexpansion average	\$152,470,344,473	62%	38%	\$94,510,974,427	\$57,959,370,046	\$21,515,565,560.53	12.90%	30.3%
Expansion states average	\$379,763,004,309	65%	35%	\$239,789,845,027	\$139,973,159,282	\$28,301,372,065.16	12.82%	34.0%

The ability of states to expand their Medicaid programs under a block grant scenario may be limited

Medicaid as a percentage of state spending under a block grant scenario (FY2015 data)



Source: PwC Health Research Institute and Strategy& analysis of state spending data from the Henry J. Kaiser Family Foundation and NASBO. Federal fiscal year 2015.

Appendix D: HRI and Strategy& analysis of scenario impacts on the healthcare industry, by sector

Each health-reform scenario (see Appendix A) would affect each sector differently, with individual plan elements affecting each sector in either a positive, negative or neutral way. HRI and Strategy& analyzed each scenario with an eye toward employers, life sciences companies, healthcare payers and healthcare providers.

Sector: Life sciences					
Topic	Sector impact	Explanation	Scenario		
			1	2	3
Repeal of annual fee on companies that make branded pharmaceuticals	Positive	Under an ACA repeal, the pharmaceutical sector stands to benefit from the elimination of the annual fee on companies that make branded pharmaceuticals.	●		
Repeal of medical device excise tax	Positive	The ACA requires a 2.3% excise tax on device company revenues. Its repeal would be especially helpful for smaller medical device startups.	●		
Allow underwriting for noncontinuous coverage	Neutral	May increase chances that patients cannot purchase insurance, but new underwriting policies could help to stabilize the insurance market, causing broader, more positive effects. Additionally, fewer insured patients could lead to an increase in charity care.			●
Medicaid block grants	Negative	Shifting to a Medicaid block-grant system would cap federal funding, reducing states' abilities to pay for breakthrough drugs or new treatments. States may also implement bundled payment systems to further drive prices down.		●	

Sector: Payers					
Topic	Sector impact	Explanation	Scenario		
			1	2	3
Repeal of the individual mandate	Negative	The repeal of the individual mandate could destabilize insurance markets by permitting the healthiest plan participants to drop out, leaving only the sickest, costliest members. Insurers may leave markets or raise rates significantly in light of uncertainty. Alternatives to the individual mandate, such as requirements for continuous coverage or auto-enrollment in health plans, may reduce this strain.	●	●	●
Repeal of income-based cost-sharing subsidies and premium tax credits	Negative	HHS data show that in 2016, nearly 10.5 million members of the individual exchange market qualified for ACA premium support. If tax subsidies go away through the reconciliation process, enrollment in marketplace plans may plunge.	●	●	
Add age-based refundable tax credits for premium support	Negative	With tax credits no longer related to income and geographic area, many lower-income beneficiaries, particularly those in high-cost areas, will lack sufficient funds to purchase insurance.		●	
Underwriting allowed for discontinuous enrollees	Positive	Insurers will be able to raise premiums for those who have not maintained continuous coverage, protecting themselves from the added risk of providing coverage to these individuals.			●
Medicaid block grants	Negative	Medicaid managed care organizations would likely feel increasing cost pressure if Medicaid shifts to a block-grant system capping spending at a set amount for the year. Insurers that rely on state Medicaid managed care plans for business could be pressured by states to reduce margins and find savings, especially over time, unless federal funding matches medical cost inflation trends.		●	
Repeal Medicaid expansion	Negative	Insurers benefited from the Medicaid expansion by administering managed care plans.	●		
Widen age bands from 3:1 to 5:1	Positive	Congress may permit insurers to widen their age rating bands from the ACA's requirements of 3:1 to a wider 5:1 range.			●

Sector: Health providers					
Topic	Sector impact	Explanation	Scenario		
			1	2	3
Repeal employer and individual mandates	Negative	A repeal of the individual and employer mandate will lead to a reduction in the number of insured individuals, thus contributing to an increase in uncompensated care for providers.	●	●	●
Increase use of health savings accounts	Negative	If costs are transferred to consumers via high deductible health plans, people will be less likely to seek care given their rising out-of-pocket costs. Lower-income individuals in particular will be affected negatively because they're not typically able to take advantage of an HSA's tax benefits.	●	●	
End ACA income-based cost-sharing subsidies and premium tax credits	Negative	Those who receive subsidies and tax credits will no longer be able to afford coverage leading to a decrease in the total number of insured and an increase in uncompensated care.	●		
Restore Disproportionate Share Hospital funding	Positive	The restoration of DSH payments will be positive specifically for providers in states that didn't expand Medicaid. The DSH payment reductions were in response to the decrease in uncompensated care costs that came with the ACA. States choosing not to expand Medicaid haven't seen as substantial a decrease in uncompensated care as those that expanded under the ACA.	●	●	
Age-based refundable tax credits for premiums in nongroup market	Negative	With tax credits no longer related to income and geographic area, many lower-income beneficiaries, particularly those in high-cost areas, will lack sufficient funds to purchase insurance.		●	
Underwriting allowed for discontinuous enrollees	Negative	With individuals facing underwriting for not maintaining continuous coverage, there is a risk these enrollees could be priced out of the market, preventing them from obtaining coverage and contributing to a rise in uncompensated care.			●

Sector: Health providers					
Topic	Sector impact	Explanation	Scenario		
			1	2	3
Federal start-up funding for high-risk pools	Neutral	High-risk pools would provide coverage to individuals with severe, chronic health problems. Given that those individuals are already covered under the ACA, there would be no change in their coverage.		●	●
Give states more control over Medicaid plan design	Neutral	Assuming no changes in federal funding, giving states more control over plan design should not result in any substantial changes in coverage.		●	●
Convert Medicaid funding to block grants	Negative	A Medicaid block-grant system might lead states to pressure providers to lower rates, either through reduced reimbursements or a shift to outcomes-based or capitated payment models. Such a shift might reduce average provider profitability, though those able to efficiently provide and manage care could benefit.		●	
Medicaid expansion rollback	Negative	A substantial rollback of Medicaid eligibility standards and federal funding under a “repeal” scenario would result in millions losing access to their healthcare. Providers, such as those providing in-patient care may face a sharp increase in uncompensated care as the expansion ends. Long term, many providers serving populations predominantly reliant on Medicaid will face significant decreases in revenue.	●		
Repeal industry ACA taxes and fees	Neutral	Industry taxes and fees have not affected the provider sector as they have the payer and pharmaceutical sectors.	●		

Sector: Employers					
Topic	Sector impact	Explanation	Scenario		
			1	2	3
Repeal of the employer mandate	Positive	Under the ACA, companies with more than 50 employees are required to give insurance to employees working more than 30 hours per week. Eliminating the mandate will reduce compliance and reporting costs, and lead to some companies dropping insurance. However, a collapse or major reduction in the nongroup insured market could pressure employers to offer coverage themselves.	●	●	●
The “Cadillac” tax	Positive	The elimination of the “Cadillac”—or 40% excise—tax on employer-provided insurance would be praised by employers. If the tax were in effect, employers would be forced to reduce employee health benefits to avoid it.	●		
Broader use of HSAs	Neutral	Expanded eligibility to save for, and use, Health Savings Accounts is likely to help wealthier employees, but probably not low-income ones.		●	●
Subsidies	Negative	Plans to offer consumers a tax subsidy permitting them to purchase insurance plans outside their workplace could incentivize healthy individuals to leave in pursuit of less expensive insurance, leaving employers with only the sickest employees, raising costs.		●	●

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About this research

For this paper, PwC's HRI and Strategy& modeled three potential health-reform scenarios based on our analysis of existing, recent reform proposals in Congress. These scenarios—"repeal," "replace" and "repair"—all assume the inclusion of various key policy elements, listed in Appendix A.

PwC modeled the insurance coverage outcomes under the "repeal", "replace", and "repair" scenarios using its healthcare simulation model. The latest version of the model is based on the March 2016 Annual Social and Economic Supplement of the Current Population Survey.⁵² The model estimates the number of eligible people who would gain, keep, or lose health insurance coverage through an employer-sponsored health plan, Medicaid, and nongroup coverage in the individual market under various changes in premiums, tax credits, and health program eligibility. The model also accounts for individuals choosing to enroll in no health plan.

The estimates of the impact of the "repeal" scenario for this report were further refined to match the Congressional Budget Office estimates of the health insurance impacts of HR 3762.⁵³ The healthcare simulation model is used to distribute the national-level changes in insurance coverage estimated by CBO to the state level and to also estimate changes across socioeconomic groups.

The simulation of the impact of the "replace" scenario at the state and socioeconomic subgroup level was based on benchmark changes in insurance coverage, which were informed by actuarial judgment as well as the methodology behind the Congressional Budget Office estimate of the American Health Care Act.⁵⁴

The simulation of the impact of the "repair" scenario at the state and socioeconomic subgroup level was based on benchmark changes in insurance coverage, which were informed by actuarial judgement and previous firm estimates of the impact of the ACA.

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