# The Affordable Care Act and Beyond: Winners and Losers in the New Era of Healthcare

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Bruised, bloodied but still standing, the Affordable Care Act (ACA) is moving forward, bringing the most sweeping changes to the American healthcare system since the establishment of Medicare and Medicaid in 1965. Signed into law in 2010, the ACA has survived a U.S. Supreme Court challenge, a national election, a rebellion by conservative legislators that shut down the government for two weeks and an embarrassing technology meltdown when the government healthcare website launched in fall 2013.

But now that these crises have passed (for the most part) and the ACA's provisions are beginning to take hold, there will be unprecedented demands on healthcare providers and payers for efficiency, quality and transparency. Healthcare consumers will have to develop a new consciousness about costs. Health systems will have to market themselves in different ways to potential patients, and all these changes will create challenges for private equity (PE) firms and others looking to invest.

The FTI Journal recently convened a blue ribbon panel of healthcare experts to share their perspectives on the ACA and to discuss how it will reshape healthcare and its stakeholders in the near future.

## The ACA Today

**Phillip Polakoff, M.D., FTI Consulting:** Nobody can argue that the American healthcare system is not in trouble. We need improved access, better care, lower costs and higher health quality. Healthcare now accounts for 18 percent of U.S. gross domestic product. That's $3 trillion a year. Quality still is an elusive term. If you look at quality on a worldwide basis, we're not getting what we're paying for. We're paying $13,000 or $14,000 per person for healthcare now. No other country is paying more than $5,000 or $6,000 per person. So we have some issues here. And as the Affordable Care Act moves forward, we have to address all of them. We must deal with medical liabilities, demographic changes, mergers, consolidations, clinical integration and other changes. So to start our discussion, the question is: What has been the biggest effect of the ACA so far on your sector?

**Mollyann Brodie, Ph.D., Kaiser Family Foundation:** The biggest impact has been on partisan politics. If you self-identified as a Democrat, you liked this bill; if you self-identified as a Republican, you didn't. That still is the case. While the ACA has been on the front pages for three straight years, we've seen lots of misinformation and misunderstanding and very little change in opinion. There's been a massive amount of media attention, yet our polls and data tell us the public still doesn't understand what the ACA actually means for business, policy, society in general or individuals. Now that the real provisions of the ACA have started to kick in, consumers need information that will help them assess what the law actually is going to mean for them going forward.

**Michael Kluger, Altaris Capital Partners:** Many Americans are starting

to realize that they might lose their healthcare insurance. I think that's significant for the country because it's forcing people to take stock and focus on how they can get insurance. The healthcare.gov technical problems can be fixed. But once the benefit designs are available and people are using the marketplace, it will sink in that healthcare is not free. That's actually a good thing because you can't truly reform healthcare until people begin to value what they have and what they don't have.

**Marian Dezelan, North Shore-LIJ Health System:** My organization's healthcare system is the 14th largest in the United States. People see us as a hospital system, but we really are a health organization. Hospitals treat people who are sick. Health organizations try to keep people well. Our goal now is on building a broad ambulatory network and having a large number of employed physicians who, to be part of our health system, must meet quality standards. We also are forming our own insurance company, and that's going to be a narrow network. You're going to see more of this, especially as the very large insurers consolidate and the rest of the insurance market becomes more fragmented. Some hospitals will begin refusing to take insurance that doesn't reimburse enough, particularly if they are taking on more risk and are facing the dual pressures of controlling costs and improving the quality of care. Likewise, the insurers will say, "If you don't give me good quality care, I won't let my members see you anymore." So I think there's a whole layer to this that the media hasn't talked about yet.

**Richard Zall, Proskauer:** The implementation of health reform has been so troubled that we've lost sight of the very real problems it was designed to address. Insurance reform needed to happen: Pre-existing conditions were preventing people from getting insurance, and policies were subject to lifetime limits that were cutting off consumers from insurance. Improving access is vital: We are the only industrialized nation in the world that has so many millions of its people without insurance. We also need to control costs and to deliver better quality. The clouds surrounding the ACA launch have obscured these issues. But it may surprise you to learn that our clients — hospitals and others on the delivery system side, along with employers — already are moving forward to reform the system. Providers are aggressively consolidating to achieve economies of scale so lower costs and improved quality can be achieved. Hospitals are integrating with physicians; employers and insurers are moving from a volume-based, cost-cutting model to a value-based system aimed at better outcomes.

## The ACA Tomorrow

**Phillip Polakoff:** What do you think will be the biggest changes in healthcare delivery over the next three years, and how will your organization address these changes — from a policy, public perception, public outreach, advocacy, education and communications perspective?

**Mollyann Brodie:** We are going to see some major issues arise because some states are expanding Medicaid, and others are not. In some states, you can be very poor, but you still won't get access to insurance; in other states, you can be less poor and get subsidies. This all will play out in the public, the media and the advocacy communities. For many, it will be a rude awakening. For example, in one of our studies, we found that undocumented Californians think the law will benefit them. They have incredibly high expectations, and it will be interesting to see how these people and their communities react once it is realized that, in fact, the new law won't help them.

The other big concern I see is that, for the first time, healthcare could become a real voting platform. Over the next year, as we approach the 2014 midterm elections, we will see a great deal of anxiety and strategizing on both sides over this issue.

**Richard Zall:** People will be paying a bigger share of their healthcare costs, and this will force them to shop more responsibly and carefully. Tools like the health exchanges and websites will assist people in comparison shopping. Greater price transparency will help consumers decide whether they want to go to a high-cost hospital or get better results at a lower cost somewhere else. As a result, the marketplace will become more aggressive.

We also will see different models for providing care. There will be alternatives to going to the general practitioner's office and relying on a doctor to tell you what you need. We already are seeing this with innovations such as retail clinics and telehealth [healthcare delivered via videoconferencing, streaming media and other electronic tools]. And on the provider side, we're seeing a real paradigm shift, from the siloed organization with specific specialties and hospitals to more coordination and integration. That's why we're seeing a lot of transactions — both mergers and acquisitions (horizontally and vertically) — across hospital systems, home care and ambulatory care. Ultimately, this will lead to a more efficient and effective delivery system.

**Michael Kluger:** Today's healthcare is based on reaching out to sick people and making them better. The most complex and challenging cases bring the greatest reimbursements and margins. This will change, and health organizations will be focused not on treating illnesses but on keeping people healthy. That's a pretty dramatic shift. Providers also are starting to realize they actually have to make money at the Medicare rate. They can't just find sick people, charge accordingly and hope there is enough margin in that total amount to subsidize everything else that has to be done. The market basket is really the Medicare rate, and the key to succeeding at that rate is to keep the population healthy. That forces a re-engineering of the provider system — using technology, outsourcing and partnering to integrate medical care. This will be like General Motors retooling in the face of foreign automobile

competition. And it's this second step that will transform the system.

## Roles and Challenges for Private Equity

**Phillip Polakoff:** What role will private equity play in this new healthcare model? Right now, a large amount of money is sitting on the sidelines.

**Michael Kluger:** Interestingly, the biggest sources of capital are the provider systems and payer networks. Their re-engineering dwarfs whatever the largest PE firm is capable of doing. As a private equity person, I can look at investing in medical devices, healthcare information technology or services, and I can follow themes within each. The key is to find businesses that offer a good return on investment for all the constituencies of the healthcare economy: consumers, payers, employers, providers and regulators. If these constituencies all can say, "That's a good business — it's adding value to what we care about," then it's worth a look. But going forward, the risks will be greater for PE firms. For example, some players in the home care industry have thrived just by supplying high-margin infusion drugs and not worrying about administering them (that was somebody else's problem). There was a great deal of money to be made from investing in such narrow slices of healthcare, but that will be much harder to do in the future. And I think that's healthy.

Healthcare will never be free. You're in trouble if you have invested in a business that earns revenues by providing free services to the consumer without adding any real value for the other constituencies.

## How Healthcare Marketing Will Change

**Marian Dezelan:** Today, for example, if you are covered under a United Healthcare plan, you probably can go to any hospital or urgent care clinic in Manhattan. You can visit whichever doctor your referring physician recommends even if it's the orthopedist he golfs with on the weekend. You can ask your friends which doctors they like and can go to them. But tomorrow, consumers will be evaluating provider quality before they even have a need for the service, which is a monumental shift in retail purchase behavior. This will affect how healthcare providers market themselves.

Currently, people don't look at evidence and facts when they decide where to seek care. Some people spend more time driving around to save a nickel on a gallon of gas than they do choosing a healthcare plan or provider. They also put a lot of stock in hospital rankings such as those in U.S. News and World Report. We've studied the methodologies used, and what's interesting is that U.S. News is looking specifically for hospitals that are the best places to go for especially complicated cases. But that's not necessarily the preference when you need a hip replacement or something more routine. But people respond to these third-party rankings, and consumers react to emotional advertising, too.

All this is going to change. In the future, people will select insurance plans that provide access to a preferred destination for care, whether it's preventive, overall wellness or treatment when something goes wrong. Providers will need to be more transparent and aid people in taking additional responsibility in making these choices.

Consider that in the one-year period ending June 30, health systems and hospitals in the New York metro area alone collectively spent more than $45 million in mass marketing such as TV and radio ads, which is $9 million more than in the prior year. Most of the money was spent to promote a brand. In the future, we will see fewer and bigger providers that will need to compete more aggressively with one another, and their investments in marketing likely will go up. Those marketing dollars should be spent not on brand building but on the engagement and relationship building that must occur with consumers. People will find they will be much healthier if they have a continuum of care throughout their lives rather than the episodic care available today. Providers will have to change how they market themselves to the general public, focusing on that ongoing relationship.

## Winners and Losers

**Phillip Polakoff:** What do you think will separate the winners from the losers in the next few years in healthcare delivery? And will we ever embrace the World Health Organization's broader view of health — as a state of physical, emotional and social well-being, not simply the lack of illness or infirmity?

**Mollyann Brodie:** One of the current challenges is that many of the people who have the most to win come from populations that historically have been disenfranchised and often don't make a lot of noise in the political system. These people will have the most trouble navigating some of these complex healthcare systems that we've all been talking about today. In this new environment, where access to health insurance does not necessarily mean access to healthcare, the winners will be sophisticated consumers who have the most active advocates, are in the best community networks or have knowledgeable [or influential] friends and family. But there will be some losers: people who actually could benefit but who don't have the political or economic capital to advocate for themselves.

**Richard Zall:** The winners in the provider realm will be those who can deliver care faster, less expensively and with better outcomes. The bar is getting higher; consumer expectations are increasing. The provider, medical device and pharma sectors all have seen reductions in the total dollars allocated to the system. It will be more difficult going forward to make money by just showing up. You will have to recruit

people who know what they're doing and can deliver and be able to think about things differently.

Molly made a good point earlier about winners and losers in the Medicaid system. I worry about that. The Supreme Court ruling on Medicaid was surprising in so many respects, including Justice Roberts casting the deciding vote to uphold Obamacare. I was taken aback when the court ruled that states don't have to expand Medicaid, that it [the mandate] is coercive and they have a choice. Well, many states have not expanded Medicaid. So there's an anomaly in that folks who are working but whose income is below 135 percent or 150 percent of the poverty level will not get coverage. Yet in other states, those who are eligible for the exchanges and have income as high as 400 percent over the poverty level will be eligible for subsidies and insurance.

**Marian Dezelan:** The winners will be providers that can diversify their revenue streams because revenues and margins will continue to go down. Even today's best-run systems probably don't make more than a 3 percent or 4 percent margin on core operations.

I also predict that best practices and innovative concepts — once shared in a collegial environment among doctors and hospitals — will be commercialized. If one organization comes up with a great new idea for improving patient safety and a hospital three states away wants to learn about it, the response will be, "That's wonderful! We'll sell it to you!" The winners will be those that invent ways that allow others to be more efficient, be quality focused, have better outcomes, and somehow are able to bundle all that and offer it as intellectual capital.

**Michael Kluger:** The goal of improving quality while doing things more efficiently and incurring lower costs will become even more difficult to accomplish. It's like moving from regular tic-tac-toe to three-dimensional tic-tac-toe. Not only do you have to achieve all three goals, but you have to do so for several constituencies at once. You can't make your service less expensive, more efficient and better for the payer at the expense of the consumer. The winners will be focused not just on the revenues that are coming in the door and making profits today but also on what is needed to sustain the organization long term. That means new roles for financial and analytical people. For nonprofits, it could lead to moving into some for-profit ventures that will allow the entities to grow outside their core market and give them improved access to capital.

## Who Will Help the Patient?

**Marian Dezelan:** A healthcare system's employees will become more critical. Our organization has 45,000 people, and, in the future, patients will ask more frequently for help. So it will be most important for us to find better mechanisms for internal communication. Many people on the front lines don't even have computers — the nurses at a patient's bedside, for example.

**Richard Zall:** People who can assist consumers in navigating the future healthcare systems will be in demand. At the moment, it's a free-for-all, and it remains to be seen who will fill that gap. Everyone wants to be there, including the insurance companies that say they have the claims data. But I'm not sure if insurance organizations can be trusted purveyors of that information. The providers want to be there as well, and those with effective systems will do well. And then there's a whole cottage industry of navigators and data analyzers that are saying, "Deal with us, consumer. We can do it."

**Michael Kluger:** We're seeing 100 to 150 deals a year in these advocate cottage industries. This growth is being driven by the need for transparency of costs, guidance with navigation through the system and second opinions. Patients need someone to advocate for them: You can't ask a hip surgeon whether he will do a good job on your hip.

**Phillip Polakoff:** Thank you all for participating. I'm very encouraged that despite the different vantage points from which we look at the future, we have some key perspectives in common, and we share an optimism about the possibilities. It clearly will take a concerted effort over a period of time for any organization to move itself from fee-for-service to outcome-based reimbursement. The winners will be those that are entrepreneurial in tackling the risks. ■

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