
Top health industry issues of 2011

Health reform prompts industry
players to undergo makeovers

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December 2010

At a glance

2011 is a makeover year for health industry organizations reacting to and preparing for new rules and payment models. Continuing cost pressures and new customer demands require a fresh look at existing roles of industry players.

Introduction

The new health reform law will prompt most organizations to do strategy makeovers as they react to and prepare for new rules and payment models in 2011. Of course, Congress will be coping with its own makeover as the new Republican majority in the House and increased membership in the Senate contemplate action ranging from incremental changes to full repeal of the health reform law. While efforts to repeal the entire health reform legislation are unlikely to succeed given the president's veto power and Democratic control of the Senate, industry changes wrought by health reform are far from over. In fact, they've only just begun.

In the wake of all of this activity, consumers may get left behind as the industry tosses around the pros and cons of health reform terms such as health insurance exchange and accountable care organization (ACO). For this year's *Top Health Industry Issues*, PwC's Health Research Institute asked consumers their point of view on several issues related to reform. Key findings include:

- Only half of consumers said they would stay within an ACO-like organization for all of their care.
- Less than half of consumers know what a health insurance exchange is.
- Nearly three-fourths of consumers said they would trade employer-sponsored insurance for higher pay.
- Currently, eighty-six percent of consumers do not access their medical records electronically.
- More than one-third of consumers said costs and waiting times would increase as a result of healthcare mergers.
- Consumers seek health information from media companies more than from government, healthcare companies, and consumer companies combined.

Booming business in health information technology

2011 looks to be a record year for health information technology (HIT) spending, boosted by new government regulations and tight deadlines by which to meet them. More than \$88.6 billion was spent by providers in 2010 on developing and implementing electronic health records (EHRs), health information exchanges (HIEs) and other (HIT) initiatives.¹ Next year, HIT and consulting vendors are expected to see a 10% to 20% hike in revenues, according to industry analysts.² That surge is a sign of technology's critical place in health system improvement. Whether it's establishing "meaningful use" of EHRs within provider organizations, working with multiple players to establish new population management models like

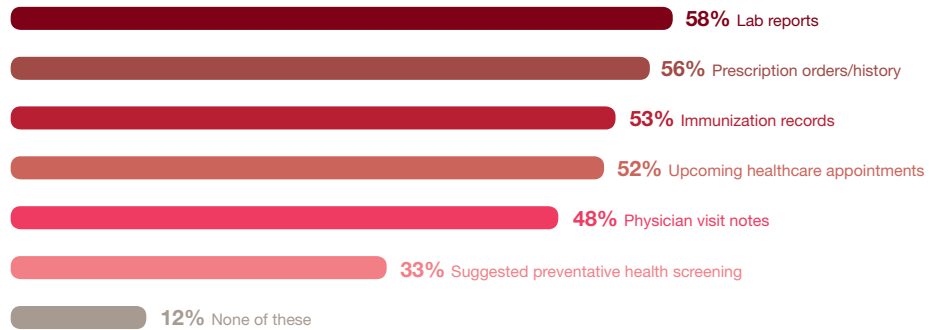
ACOs, or using technology to drive down costs in pharma/life sciences companies, more skilled resources are needed to pull it all off.

The pressure is on healthcare executives, especially chief information officers, who face new risks, knowing that new care delivery models, payment bonuses, and quality measurements are dependent on their designing an IT structure that can support the information exchange. For providers, the year will go better if they fit together all of the compliance efforts around EHRs, ICD-10 coding preparation, and HIPAA 5010 transactions to improve care and meet patient demands.

¹ Kenneth Brant, "Forecast: Enterprise IT Spending by Vertical Industry Market, Worldwide, 2008-2014, 1Q10 Update," Gartner, Apr. 30, 2010.

² Richard Close, Jeffries & Company, Inc., e-mail message to author, Nov. 17, 2010.

Figure 1: Consumers' electronic access to health information



Source: PwC HRI Consumer Survey, 2010

“Meaningful use”: Hospitals and physicians can start drawing down on stimulus payments in 2011, but they have to achieve at least stage one of the government’s new “meaningful use” criteria for EHRs. For example, stage one requires that providers have the capability to provide patients with electronic copies of their health records upon request. That would be a sea change for patients. Of the consumers surveyed by PwC, only 14% said they currently access their medical records electronically; nearly half (49%) call the doctor’s office to request paper medical records. Of those who can access their electronic medical records, approximately 40% to 50% can’t access information such as lab tests or physician visit notes (See Figure 1). These percentages could point to providers’ inability to provide the records electronically or consumers’ lack of awareness of available tools. In fact, 44% of consumers surveyed by PwC didn’t know what EHR stood for.

The policy goal of EHRs is to allow consumers to participate in shared medical decision-making. In 2011, providers need to start that process by loosening their grip on medical information and by soliciting consumer input on how they want to receive it. So far, few have. Only 13% of consumers surveyed said they’d been asked to provide input into what they’d like to see in their electronic medical records or how they’d like to use them. A majority of consumers who have electronic medical records said they use them only for their own information (54%); only one third (34%) use them to share information among primary care specialists.

For an in-depth discussion about “meaningful use” see *Ready or not: On the road to meaningful use*.

HIPAA 5010 and ICD-10: Aside from the “meaningful” use of EHRs to provide and deliver care, back-end business operations have their own work to do in 2011. As a part of the HIPAA administrative simplification effort, rules governing electronic transactions between providers, payers, and clearinghouses are coming on line in 2012 and 2013. ICD-10, a new coding system that will add five times the number of current diagnosis and inpatient codes, requires providers and payers to use HIPAA 5010, a new version of the current nine electronic transactions including eligibility checks and claims transactions. Converting to HIPAA 5010 transactions requires more than 1,300 modifications, which must be made by January 2012. Health insurers are slightly ahead of providers in preparing for this, but providers can catch up quickly by working with payers in implementation planning. Providers, payers and vendors should be testing and training internally for HIPAA in the beginning of 2011 so that they can begin external testing among trading partners throughout the remainder of the year.

Electronic medical device reporting (eMDR): Technology will also play a part in the tightly regulated medical device arena, where accountability doesn’t stop after the sale. The Food and Drug Administration will increasingly hold medical device companies accountable for quality and compliance by ensuring device traceability after the sale. This could range from initial calibration to patient and physician support throughout the life of the device. The government wants manufacturers, healthcare facilities, and importers to reduce paper and go to reporting adverse events (e.g., deaths, injuries, malfunctions) through a federal electronic gateway. A proposed rule on eMDR was published in November 2009, and a final regulation is expected in 2011. Organizations will have a year to get into compliance.

Implications

Beyond specific regulatory requirements, strategic discussions about ACOs will bring in players such as insurers, as well as technology and pharma companies. These organizations have an opportunity to be the aggregators of performance data throughout the continuum of care, to help consumers navigate the system and adhere to provider treatment regimens, and to help business leaders and physicians make decisions.

- Rather than charging forward to simply meet compliance deadlines that boost Medicare and Medicaid payments in 2011, the C-suite needs to weave together all of the compliance projects with strategic, financial, and operational goals.
- Merger and acquisition activity could be seen as a way to share the increasing costs of health information integration. Some insurers are partnering with providers as they plan integrated IT testing, but there are many more opportunities to collaborate.
- Device companies have an opportunity to use technology for increasing the traceability of medical devices throughout the supply chain. Beyond tracking support, technology can help providers manage outcomes and help device makers determine the root causes of adverse events.

Gearing up to redefine health insurance: From MLRs to insurance exchanges

Legislating coverage was the first step. Implementing coverage is the next. And, that implementation has new guardians. The percent of insurance premium dollars allocated to providing care, known as the medical loss ratio (MLR), will be a primary focus of the government and the health insurance industry.

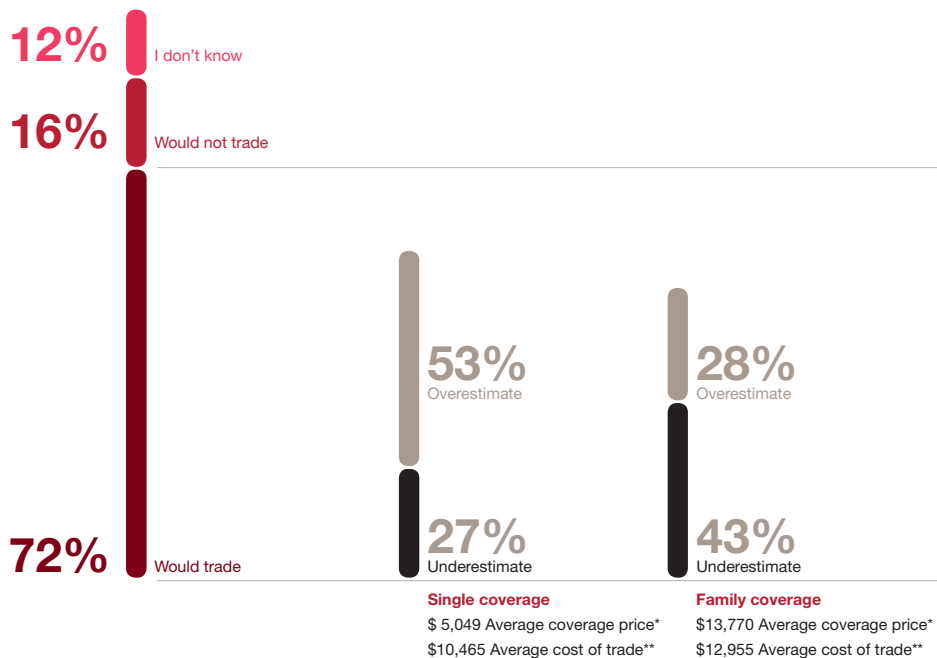
In 2011, health plans must start reporting their MLRs for individual and small group health insurance for each state in which they do business. The deadline won't be until 2014 for state health insurance exchanges to connect individuals and small businesses with health insurance, but states must apply for certification by January 2013 or let the federal government set up an exchange for them.

The new health reform rules significantly impact profit margins for health insurers by setting a floor for MLRs: 80% for small employers, currently defined as those with fewer than 50 employees, and 85% for large employers. That means that if insurers don't spend what the law mandates as the minimum percentage on medical services, they must provide a rebate for customers, beginning in August 2012. While insurers are not expected to want to pay rebates—estimated at up to \$4.9 billion from 2011 to 2013—they may opt to do so rather than underprice their products in the first year.³ Since 59% of Americans get their insurance through their employers the new pricing and rebate scenarios will make it an interesting year.

³ "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act Rule." Federal Register 75 (Dec. 1, 2010): 74864, <http://federalregister.gov/a/2010-29596>.

Figure 2: Employees' willingness to trade their employer-based insurance

How much of a pay increase per year (before taxes) would your employer have to offer for you to trade your health insurance benefit?



Source: PwC HRI Consumer Survey, 2010

*Source: Kaiser Family Foundation, <http://ehbs.kff.org/?page=charts&id-1&sn=6&p=1>

**Source: PwC HRI Consumer Survey, 2010

Leading up to the health insurance exchanges, employers may continue weighing the advantages of staying put with employer-based coverage. However, according to PwC's consumer survey, 72% of consumers said they would be willing to trade their health insurance for an increase in salary. Yet, the survey indicated that consumers may not know the full value of their health insurance benefits (See Figure 2). Forty-three percent of consumers with family coverage said they would trade their insurance coverage for a salary increase of equal value to or less value than the average annual family coverage cost (\$13,770), while 27% of consumers with

single coverage would make the trade for the same value as or less value than the average premium for single coverage (\$5,049) annually.⁴ Overall, consumers overvalued their single coverage and undervalued their family coverage.

As employers determine which direction to turn regarding health insurance, they need to remember the importance of health insurance coverage in terms of worker recruitment and retention. Consumers surveyed by PwC said that coverage was very important in their decision to work for a company: coverage for themselves topped the list (70%), with coverage during retirement (58%) second

and dependent coverage (53%) third. When asked whether they would still get insurance from their employer if they could get better insurance outside the company, 28% said they would.

Beginning in the second quarter of 2011, the federal government will provide grants to plan and establish online insurance marketplaces, called American Health Benefit Exchanges and Small Business Health Options Program exchanges. With 13.8 million people expected to enroll in health insurance exchanges in 2014, states, health plans and employers have much work to do. Currently, less than half (46%) of

⁴ *Employer Health Benefits 2010 Annual Survey*, Kaiser Family Foundation/Health Research & Educational Trust, 2010, <http://ehbs.kff.org/?page=charts&id-1&sn=6&p=1>.

consumers surveyed by PwC know what a health insurance exchange is. Forty-three percent of consumers said they would consider using a health insurance exchange to purchase their health insurance, and 56% would be willing to use an exchange if they could get better coverage.

State legislative activity around the exchanges is expected to be high in 2011 although three states have a running start. Massachusetts and Utah currently have state-run exchanges, and California passed legislation in late September to establish its exchange. States like Texas, which have a biennial legislative session, must make decisions in 2011 if they want to have health insurance exchanges certified in 2013.

As the definition of a qualified health plan for the exchanges is clarified in 2011, plans can help influence that meaning. This definition will likely be seen as a standard for health insurance companies regardless of their participation in the exchanges. For example, Wisconsin's department of insurance conducted a survey of individual and small plans and found that more than 80% of policies currently sold will have to be modified to meet the coverage and cost sharing requirements under the Patient Protection and Affordable Care Act. Additionally, the pricing will have to be revamped to meet the 3:1 premium range that will be allowed. This could prompt small plans to fold or sell, leaving larger plans to decide what they want to do—proactively purchase smaller plans or wait to take over the membership.

Implications

- As employers and health insurers work with state agencies to influence development of the new health insurance exchanges for consumers, states may become laboratories of innovation. Different flavors of implementation and interesting insurance experiments could emerge.
- Definitions on what a qualified health insurer is in an exchange will drive definitions outside of that marketplace. Health insurers will want to size the individual and small employer markets and provide input to the legislative process around measuring quality and meeting standards of care.
- Employees' willingness to trade their health insurance for an increase in pay may challenge the commonly held view that insurance is a differentiator in recruiting and retaining employees. Employers need to model scenarios to inform their strategy decisions around offering benefits. Tax policies and federal subsidies will also be key considerations for employers and consumers.
- Consumers need a better way to understand the value of their health insurance coverage. States, employers and health plans need to gain a better view of what their customers value and what drives their decisions.

For an in-depth discussion on health insurer reform issues, see *Healthcare reform sector implications: Payer*.

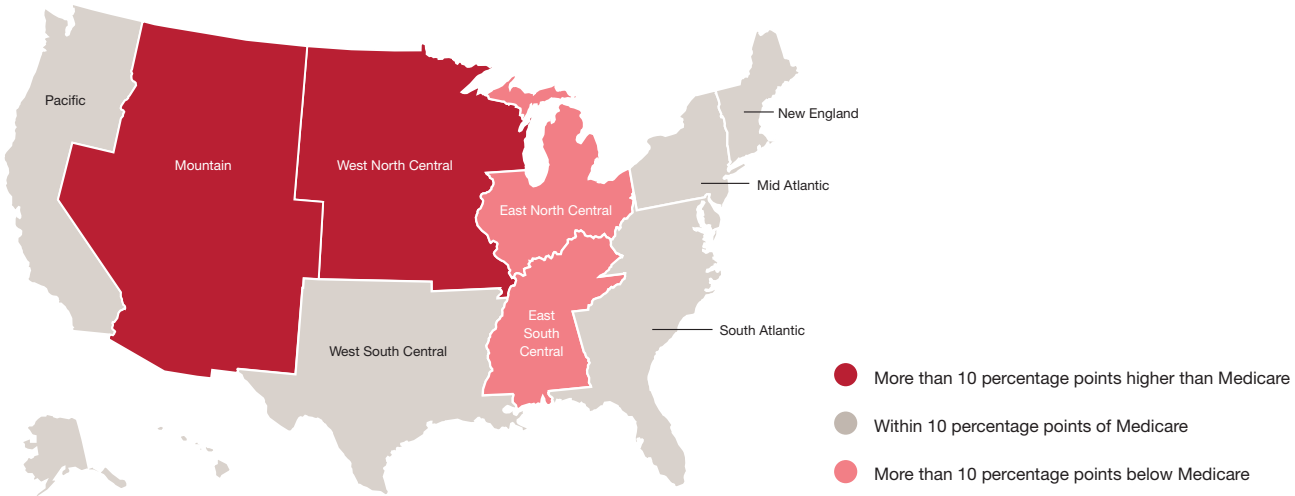
ACOs: Is this the next big thing or not?

The health reform law will create a new type of care model, called the accountable care organization (ACO). It's already created a large amount of buzz within the industry although less than a third (28%) of consumers surveyed by PwC were familiar with the term ACO. That will soon change. Will ACOs be the next big thing? Are they the 2010s' version of HMOs? Under the health reform law, ACOs focus on managing a discrete Medicare population. However, ACO has already become a metaphor for the larger issue of population health management by disparate parties within the health system—parties that are looking for a new way to provide care while managing costs. Under this broader description, ACOs encompass a spectrum of models that include physicians, hospitals, payers, and vendors under a basic premise of shared risks and rewards based on patient outcomes.

2011 could be a make-it-or-break-it year for ACOs. The Centers for Medicare and Medicaid Services administrator Donald Berwick MD is in the driver's seat, but could have a rough ride given Republican gains in the Senate. Berwick has praised the potential of ACOs to drive innovation that reduces costs and improves care. Berwick's recess appointment expires in 2011, and he likely faces a difficult Senate confirmation process to retain his position.

One of the biggest risks for ACOs will be managing a patient population itself. That risk is twofold: keeping people in the ACO and engaging them to stay healthy. Under the Medicare model, beneficiaries may either be assigned to an ACO or have the ability to opt in or opt out. Regardless, the ACO would be accountable for all aspects of each beneficiary's healthcare. All well and good, except that beneficiaries may

Figure 3: Consumers' willingness to always stay within a group responsible for their care (total US population vs. Medicare population)



	US region	Medicare	Percentage point difference
New England (CT, MA, ME, NH, RI, VT)	49%	57%	-8
Mid Atlantic (NJ, NY, PA)	47%	52%	-5
South Atlantic (DC, DE, FL, GA, MD, NC, SC, VA, WV)	52%	42%	10
East North Central (IL, IN, MI, OH)	55%	67%	-12
East South Central (AL, KY, MS, TN)	59%	73%	-14
West South Central (AR, LA, OK, TX)	52%	59%	-7
West North Central (IA, KS, MN, MO, ND, NE, SD, WI)	47%	23%	24
Mountain (AZ, CO, ID, MT, NM, NV, UT, WY)	28%	8%	20
Pacific (AK, CA, HI, OR, WA)	51%	44%	7
Total population average	50%	48%	

Source: PwC HRI Consumer Survey, 2010

want to use physicians and hospitals outside the ACO, and those non-ACO providers may drive up costs.

To determine how likely consumers would be to stay within an ACO, PwC asked consumers about that prospect. Half of consumers surveyed said they would always stay with a hospital or group of

physicians if they knew that hospital or group was accountable for their care. Providing incentives for patients to be a part of this accountability model could be the difference between profits and losses for an ACO. These incentives could include shared savings models, in which individuals pay more or less depending on whether their provider is a part of their

ACO—the same concept as in- and out-of-network costs.⁵

According to PwC research, consumers in the Mountain states are far less likely to stay within an ACO-like organization as are consumers in other regions of the country. While about half of individuals surveyed said they'd always stay with

⁵ Anne D. Sinaiko, Ph.D., and Meredith B. Rosenthal, Ph.D., *Patients' Role in Accountable Care Organizations*. New England Journal of Medicine, Nov. 10, 2010.

a provider for their care, slightly fewer Medicare beneficiaries (48%) said the same.

However, there was wide variation among different regions of the country. For example, in the Mountain states, only 8% of seniors were willing to stay within an ACO-like organization for their care compared with 73% in the East South Central states (See Figure 3). And their tendency to go outside a provider group differed within the region, depending on age. For example, in the Mountain states, 28% of consumers said they would stay within an ACO-like organization—a 22-point difference from the overall population. On the other hand, the Mid-Atlantic region was relatively homogenous, with 47% of the overall population saying they'd stay within an ACO-like organization for care, and 52% of the older population.

Most of the organizations that want to be ACOs under the Medicare Shared Savings program are already getting ready. Some organizations insist that they already fulfill the description of ACOs in which patient care is coordinated and savings are distributed among providers.

Implications

- Increased discussions around ACOs are fueled by mounting pressure to find new care models that cut costs and prepare for new outcomes-based payments. Organizations need to understand that if ACOs succeed, fee-for-service models may decline and capitation-like payment could increase.
- The right infrastructure, with the proper leadership to manage populations that aren't tied to an ACO, will be the foundation for sustainability. ACO discussions are leading to increases in physician employment. Health plans, pharma and life sciences companies should consider moving from vendors to being partners with providers.
- Consumers may need to be convinced of the advantages of an ACO. With half of consumers surveyed saying they would always stay with an ACO-like group, organizations should segment patient populations to manage expectations, risks, and outcomes associated with their health and behaviors.
- Care pathways will be important, but providers need to close the gaps between pathways as well. This is where pharma companies and health insurers can connect all of the players to increase adherence and care management.

For an in-depth discussion about physician-hospital alignment, see *From courtship to marriage—Part I: Why health reform is driving physicians and hospitals closer together.*

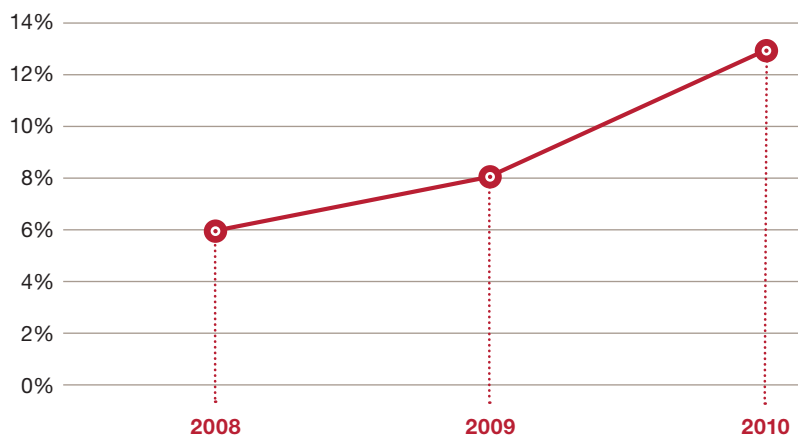
For an in-depth discussion of the information technology (IT) infrastructure required for better physician-hospital alignment, see *Designing a health IT backbone for ACOs.*

Nowhere else to cost shift: Consumers could continue to reduce utilization

In 2011, for the first time, most employers are expected to have a deductible of \$400 or more built into their employer-sponsored health insurance. The trend in rising deductibles has been remarkably fast. In 2008 and 2009, the most common plan had no deductible, according to PwC's survey of 700 employers. By 2010,

the most common plan among employers surveyed by PwC had deductibles of \$400 to \$999. In addition, according to the PwC survey, high-deductible plans are now the primary plans for 13% of employers surveyed in 2010, up from six percent in 2008 (See Figure 4).

Figure 4: Percent of employers that say a high-deductible plan is the one with the highest enrollment



Source: PwC Touchstone Survey, 2010

This level of deductibles is expected to trickle down to providers. Research has shown that as consumers are forced to pay higher deductibles, they reduce utilization because they have nowhere else to shift their portion of the costs. That's likely to be especially true in a slowly recovering economy. With coinsurance as with high deductibles, workers become more aware of the full cost of the drugs or services they're using and consequently would be more likely to shop around for, delay or avoid services.

A record number of Americans—10 million—are now covered by health savings account/high-deductible health plans, according to America's Health Insurance Plans.⁶ This is triple the number of people from three years ago, and it's expected to increase.

Employers also are increasing the level of coinsurance. For example, cost-sharing for prescription drugs has been based on co-pays for the past 20 years, but in 2010, one-third of employers said they were using coinsurance instead, up from 26% two years ago, according to the PwC survey.

With more employees being squeezed with high-deductible plans and coinsurance, their increased cost sensitivity will push them to make hard decisions on how often to go to the doctor or what prescriptions to fill. The danger lies in whether short-term cost avoidance could lead to more expensive conditions in the long term. Sixty percent of consumers surveyed by PwC said they expected to continue paying more out of pocket for healthcare.

Implications

- Physicians and pharmaceutical companies will be affected first because consumers' first dollar spending tends to be on office visits and drugs, which are paid under high deductibles.
- Fewer physician visits reduces sales of other medical products regardless of patient cost-sharing. When patients don't go to the doctor, fewer lab tests, imaging scans and other diagnostics are ordered.
- Looking for a way out of paying more for acute medical care, consumers could start seeking more preventative services, especially if they are given the incentive to do so.
- Rather than bluntly implementing higher deductibles, more companies will look at value-based benefit design in which cost-sharing is linked to the value of services. This type of design could increase patient adherence to taking certain medications while discouraging overutilization of low-value medical services.

For an in-depth look at medical cost trends, see *Behind the numbers 2011*.

⁶ America's Health Insurance Plans (AHIP) Center for Policy Research, January 2010 Census Shows 10 Million People Covered by HSA/High-Deductible Health Plans, May 2010, <http://www.ahipresearch.org/pdfs/hsa2010.pdf>.

M&A: Deals will bond the familiar and unfamiliar as organizations look to fill strategic gaps

Deal activity in all health sectors is on an upward trend that will continue into 2011. Companies will be looking for growth as well as to fill in services along the continuum of care. With continued low interest rates and more cash on hand, healthcare organizations will be encouraged to discuss deals that help them manage future risks and tackle costs. The activity could traverse unlikely terrain as suppliers buy providers, as health plans team with providers, and as pharma/life sciences companies get into more services along the care pathway. However, healthcare organizations could have competition for acquisitions. The numbers of private equity funds interested

in healthcare is on the rise. For example, one such buyer, Cerberus, recently paid \$895 million for Caritas Christi, a struggling six-hospital Catholic health system in Boston.⁷ Look for more private equity investment activity throughout the health industry. Here's the outlook by sector:

In pharma/life sciences: Revenues in various sectors of the pharma/life sciences industry are expected to decline 1% to 12% from 2009 and 2014, depending on the subspecialty, prompting companies to scramble for new products.⁸ Since its acquisition of Wyeth, Pfizer has grown its footprint through strategic buys

⁷ "Caritas Sale: What's in It for Cerberus?" Morning Edition. WBUR, National Public Radio. Nov. 9, 2010, transcript, <http://www.wbur.org/2010/11/09/caritas-sale-5>.

⁸ Goldman Sachs, *Unlocking value in healthcare: A call to action for the road ahead*, Sept. 21, 2010.

such as King Pharmaceuticals—to boost its pain market presence—and Biocon to extend its diabetes presence in India.⁹ Medical device companies are expected to make deals that will consolidate lines of business, improve revenues, and increase market coverage.¹⁰ St. Jude Medical, a global medical device company with a focus in cardiac, neurological and chronic pain treatment, acquired AGA Medical Holdings, a device company with specialties in the treatment of structural heart defects and vascular abnormalities, in a deal valued at \$1.3 billion.¹¹

Strategic mid-market buys, characterized as deals of \$100 million to \$500 million, also are likely to be the focus in 2011. An example is Novartis AG's \$250-million acquisition of Aires Pharmaceuticals, Inc., whose focus is on cystic fibrosis and pneumonia.¹² Over-the-counter growth trends also will extend to transactions in emerging markets. For example, sanofi-aventis boosted its over-the-counter presence with the \$520.6 million acquisition of BMP Sunstone in 2010, adding brands in the Chinese consumer healthcare market, including vitamin and mineral supplements and cough and cold treatments.¹³

In provider/payer: The lines are blurring between provider and payer sectors as they formulate post-reform strategies. The ramp-up began in 2010 with such deals as Coventry Healthcare's purchase of two Midwestern plans owned by Catholic hospital systems, and People's Health, a small, physician-owned Medicare Advantage plan on the Gulf Coast buying Stanocola Medical Center, an insurer that covered predominantly ExxonMobil employees and Louisiana residents.

Two other deals also got the industry buzzing about what could be. Humana agreed to pay \$790 million for Concentra, a Texas-based provider of 300 stand-alone medical centers,¹⁴ and McKesson, the nation's largest medical supply distributor, said it would pay more than \$2 billion for US Oncology, a company that manages 1,300 physicians.¹⁵

On the plus side, consumers may be open to new relationships brought on by provider mergers. For example, HRI's consumer survey found that 78% of consumers said they prefer to use a retail clinic partnered with a local hospital for primary care services compared with

9 Elsevier Engineering Information Company Reports, Pfizer to acquire King Pharmaceuticals Inc., Oct. 12, 2010.

10 Irving Levin Associates, Inc., *Medical Device Acquisition Report, First Edition, 2010*.

11 Business Wire, *St. Jude Medical, Inc. Commences Exchange Offer to Acquire Shares of AGA Medical Holdings, Inc.*, Oct. 20, 2010.

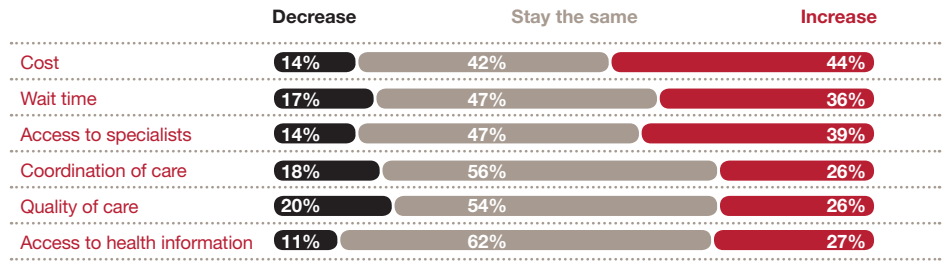
12 BIOWORLD Today, *Aires Gives Novartis \$250M Option, Gets \$20M Series B*, Nov. 15, 2010.

13 PR Newswire (U.S.), *E. J. McKay Advises BMP Sunstone on Its USD520.6-Million Sale to sanofi-aventis*, Nov. 1, 2010.

14 Reuters Significant Developments. *Humana, Inc. Announces Intent to Acquire Concentra*, Nov. 22, 2010.

15 Business Wire, *McKesson to Purchase US Oncology in a Transaction Valued at \$2.16 Billion*, Nov. 1, 2010.

Figure 5: Consumers' concerns on their local hospital/health system being acquired



Source: PwC HRI Consumer Survey, 2010

22% who prefer an independent company owned by a retail pharmacy. This presents an opportunity for retail pharmacies to work more closely with providers to boost their business in primary care.

However, consumers have some concerns as well. For example, when asked their top concerns if their local hospital was acquired by a larger health system, 44% said they thought costs might increase, and 36% said they thought wait times would increase (See Figure 5). Approximately one in five consumers said coordination of care and quality of care would decrease, although over half don't anticipate any changes in these areas.

Implications

- Health industry organizations need to identify their core capabilities and then scan the market to fill in gaps as they look for new partners to help them deliver a continuum of care. For example, pharma companies need to involve themselves in key care pathways that improve outcomes and drive sales. And amortizing the investment cost of health IT will be a big factor in strategic partnerships.

- Health organizations involved in mergers may have to convince skeptical individuals about how the deal benefits consumers.
- As health reform implementation moves toward bundled payments and shared responsibility, health organizations have new opportunities to work together to share financial risks and rewards. Bringing the care experience of providers, the analytics and risk management of payers, and the outreach experience of pharma together, will create new deals with old players.
- Organizations contemplating mergers and acquisitions need to model and weigh the benefits and risks of buying versus not buying and then, if buying, integrating versus owning as a stand-alone business.

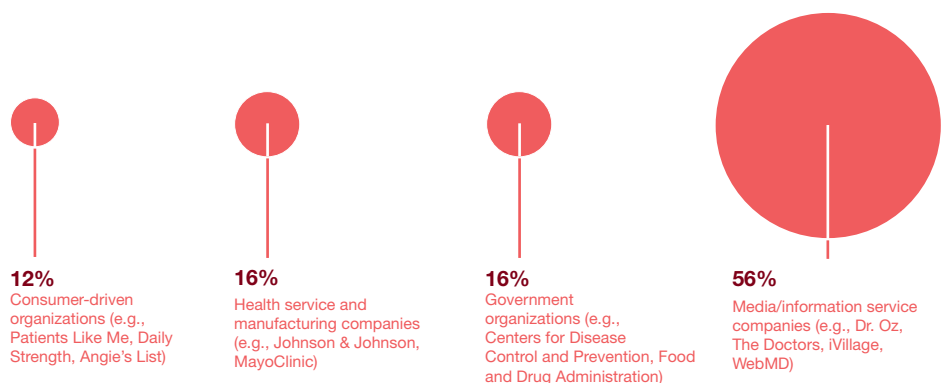
For more discussion on provider M&A strategies, see *Breakthroughs: Hospital merger and acquisition strategies*.

Follow-me healthcare: Patients look to health organizations that are always on

Rapid innovation and the adoption of digital technologies are dramatically changing customer expectations of the health industry. Physicians and patients expect increasing amounts of health-related information, anytime and anywhere. Organizations realize that the best way to influence outcomes is to engage patients. And to engage them, the industry needs to understand how patients want to connect.

Although healthcare organizations are spending tons of resources to produce online content, individuals seek healthcare information from third-party media and information service companies three and a half times more than any other online health information source (See Figure 6).

Figure 6: Sources consumers are most likely to use for online healthcare information



Source: PwC HRI Consumer Survey, 2010

What patients really like about these sites is the ability to customize their interactions with them. To crack the patient “engagement” code, health organizations should resist trying to redirect individuals and instead follow them through solutions that extend their current actions.

Individuals surveyed said they use online tools and resources (54%) second only to consulting a physician (75%) when gathering information on treatments and conditions. Mobile health monitoring on the person or at the home is another area of opportunity to connect to patients. Eighty-eight percent of physicians surveyed by PwC said they would like their patients to track their health information, and 40% of individuals would buy a personal health monitoring device or pay for a monthly subscription to send health information to their providers.

Pharmaceutical companies have nearly perfected their ability to deliver sophisticated, customized treatment information to physicians, through both in-person and electronic detailing. However, the information flow to patients is less reliable. Patients haven’t been as open to seeking this information from pharmaceutical companies. According to the PwC survey, only 11% of individuals said they would go to a pharmaceutical company to gather information on

healthcare treatments or conditions. And only 11% of individuals said they would alert a pharmaceutical company directly if they had a bad reaction to a drug.

Pharma companies have typically been removed from the end customers, but some are seeing opportunities to become more visible and boost revenues at the same time. While pharma companies must constantly search for new drugs to replace those that go off patent, they recognize that payers want to reduce overall costs. One way to do so is by getting patients to take their drugs appropriately. An estimated 50% of patients don’t take their drugs as prescribed, which results in an estimated \$290 billion a year in avoidable healthcare services.¹⁶ Why don’t patients take their drugs? It’s different for different patients and different drugs, and the key is to engage the patient to find out why. For example, Switzerland-based Merck Serono developed a smart electronic injection device with two-way Bluetooth capability that could track all injections (e.g., fertility, growth hormone) made. Nurses made reminder calls within 30 minutes of a missed injection. And at one point, they were able to detect an increase in injection site reactions, changed the needle depth by three millimeters and improve the patient dropout rate by 10%. The strategy helped the company gain over 50% of new patients for several therapy areas and created a platform for future therapeutics to be administered.

¹⁶ New England Healthcare Institute, *Thinking outside the Pillbox: Medication Adherence and Care Teams: A Call for Demonstration Projects*, September 2010.

Implications

- Individuals engage with organizations they trust and in ways that fit their lifestyles. Gaining customer interaction IQ by capturing behavioral insight and interaction data will boost the health industry's ability to activate them in wellness, prevention, or chronic disease management. This will be particularly important as new population management models (e.g., accountable care organizations) emerge that balance consumer choice with managed accountability.
- Information about poor results from medication can now easily go viral. Pharma companies can monitor social media channels as one avenue of information retrieval and communication.
- As more payers turn to performance-based pay, the business model for providers and pharma/device companies centers on improving care through connectivity and better information that leads to healthier outcomes and greater efficiency.

For an in-depth discussion on mobile health, see *Healthcare unwired: New business models delivering care anywhere*.

About this research

This annual report discusses the top issues for health industry organizations including healthcare providers, health insurers, pharmaceuticals and life sciences companies and employers. In fall 2010 PwC's Health Research Institute commissioned an online survey of 1,000 US adults representing a cross-section of the population in terms of insurance status, age, gender, income, and geography. The survey collected data on consumers' perspectives on health reform topics and preferences related to their healthcare usage and payments.

About PwC

PwC firms provide industry-focused assurance, tax and advisory services to enhance value for their clients. More than 161,000 people in over 150 countries in firms across the PwC network share their thinking, experience and solutions to develop fresh perspectives and practical advice. See www.pwc.com for more information.

Health Research Institute

PwC Health Research Institute (HRI) provides new intelligence, perspectives, and analysis on trends affecting all health-related industries, including healthcare providers, pharmaceuticals, health and life sciences, and payers. HRI helps executive decision-makers and stakeholders navigate change through a process of fact-based research and collaborative exchange that draws on a network of more than 4,000 professionals with day-to-day experience in the health industries. HRI is part of PwC's larger initiative for the health-related industries that brings together expertise and allows collaboration across all sectors in the health continuum.

PwC Health Research Institute

Kelly Barnes

Partner, Health Industries Leader
kelly.a.barnes@us.pwc.com
(646) 471 2720

Serena Foong

Senior Manager
serena.h.foong@us.pwc.com
(617) 530 6209

David Chin, MD

Principal (retired)
david.chin@us.pwc.com
(617) 530 4381

Tony Lopez

Research Analyst
amanda.lopez@us.pwc.com
(267) 330 2698

Sandy Lutz

Managing Director
sandy.lutz@us.pwc.com
(214) 754 5434

Colleen Chelini

Research Analyst
colleen.m.chelini@us.pwc.com
(415) 498 7853

Benjamin Isgur

Director
benjamin.isgur@us.pwc.com
(214) 754 5091

Sarah Haflett

Research Analyst
sarah.e.haflett@us.pwc.com
(267) 330 1654

Health Research Institute Advisory Team

Joe Alban
Principal
joe.albian@us.pwc.com
(312) 298 2018

Michael Galper
Partner
michael.r.galper@us.pwc.com
(213) 217 3301

Daniel Garrett
Partner
daniel.garrett@us.pwc.com
(267) 330 8202

Sandra Hunt
Principal
sandra.s.hunt@us.pwc.com
(415) 498 5365

Warren H. Skea
Director
warren.h.skea@us.pwc.com
(214) 682 7235

Michael Swanick
Partner
michael.f.swanick@us.pwc.com
(267) 330 6060

Michael Thompson
Principal
michael.thompson@us.pwc.com
(646) 471 0720

Health Research Institute Contributors

Karla Anderson
Principal
karla.s.anderson@us.pwc.com
(703) 918 4522

John Dugan
Partner
john.k.dugan@us.pwc.com
(267) 330 2464

Maxim Duprat
Director
maxim.m.duprat@us.pwc.com
(973) 236 5022

Steven Elek
Partner
steven.elek@us.pwc.com
(267) 330 2240

Todd Evans
Director
todd.d.evans@us.pwc.com
(312) 298 3368

Anthony Farino
Partner
anthony.l.farino@us.pwc.com
(312) 298 2631

Todd Hall
Director
todd.w.hall@us.pwc.com
(617) 530 4185

Nadia Leather
Director
nadia.m.leather@us.pwc.com
(646) 471 7536

Thaddeus Kresho
Partner
thaddeus.c.kresho@us.pwc.com
(678) 419 4151

Ken Madrigal
Manager
kenneth.l.madrigal@us.pwc.com
(646) 471 1220

John Moran
Managing Director
john.s.moran@us.pwc.com
(619) 744 8177

Hemant Ramachandra
Managing Director
hemant.g.ramachandra@us.pwc.com
(973) 236 5546

Robert Valletta
Partner
robert.m.valletta@us.pwc.com
(617) 530 4053

Mark Williams
Principal
mark.j.williams@us.pwc.com
(312) 298 2975

Art Karacsony
Director
attila.karacsony@us.pwc.com
(973) 236 5640

Health Industries Marketing

www.pwc.com/us/healthindustries
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www.twitter.com/PwCHealth

*To have a deeper conversation about how
this subject may affect your business, please
contact:*

Kelly Barnes

Partner, Health Industries Leader
kelly.a.barnes@us.pwc.com
(646) 471 2720
Dallas

Joe Alban

Principal, Healthcare Provider Leader
joe.albian@us.pwc.com
(312) 298 2018
Chicago

Michael Galper

Partner, Healthcare Payer Leader
michael.r.galper@us.pwc.com
(213) 217 3301
Los Angeles

Michael Swanick

Partner, Pharmaceutical and Life Sciences Leader
michael.f.swanick@us.pwc.com
(267) 330 6060
Philadelphia