

# ***Medical Cost Trend:*** Behind the Numbers 2014

*June 2013*

Health Research Institute



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### ***The heart of the matter***

Defying historical patterns—and placing added tension on the health industry—medical cost trend in 2014 will dip even lower than in 2013. Aggressive and creative steps by employers, new venues and models for delivering care, and elements of the Affordable Care Act (ACA) are expected to exert continued downward pressure on the health sector.

Medical cost trend measures spending growth in healthcare services and products—a key ingredient in setting the coming year’s insurance premiums. For 2014, PwC’s Health Research Institute (HRI) projects a medical cost trend of 6.5%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI projects a net growth rate of 4.5%.

For an industry that until recently had consistently seen double-digit growth, the ongoing slowdown poses immediate financial challenges. At the same time, the imperative to do more with less has paved the way for a true transformation of the health ecosystem, from fee-for-service medicine to consumer-centered care that rewards quality outcomes.

Great uncertainty hangs over 2014, the watershed year for ACA implementation. Millions more Americans are expected to gain coverage through Medicaid or new online marketplaces. No one knows exactly who will enroll, what their medical needs will be, or how the industry will manage them. But none of these changes will likely directly affect the medical cost trend. Total spending will rise with the cost of caring for the newly insured, but the rate of growth, which is based on unit cost, should remain at some of the lowest levels since the government began measuring national health expenditures in 1960.

Even so, the headlines will be dominated by news of insurance premium increases, primarily in the individual market. The seeming contradiction between rising premium rates and slow spending growth can be explained by how the health system manages risk and uncertainty. When faced with covering a newly insured, largely unknown population, health plans sometimes increase premiums to guard against financial risks.

Industry executives, policymakers, and academics continue to debate whether the nation is finally reining in healthcare costs or just experiencing a temporary respite from skyrocketing growth rates. Historically, medical inflation jumps after the nation recovers from a recession. But changes in how the industry operates and how average consumers choose healthcare appear to be having a more sustained effect.

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### ***An in-depth discussion***

For 2014, PwC's Health Research Institute (HRI) projects a medical cost trend of 6.5%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI projects a net growth rate of 4.5%.

## ***Executive summary***

Healthcare organizations, hurt by a squeeze on reimbursements and what might best be described as a recession “hangover,” have spent the past few years adapting to more modest growth rates. The industry will continue those efforts in 2014, including pushing care to locations and personnel that cost less.

The tepid economic recovery continues to impact the health sector. The slowdown—and even decline—in personal wealth has tamped down demand for healthcare. As we reported a year ago, the sluggish recovery has created a “new normal” in healthcare spending patterns.

Individual consumers, bearing more financial responsibility for their medical bills, are questioning and sometimes delaying procedures, imaging, and elective services. New delivery models, such as accountable care organizations (ACOs) are promising, but their prospects for significant savings remain largely unproven.

The ACA will also play a role in the slowdown in 2014, with hospitals working to hold down expensive readmissions (or face the law’s penalties) and employers being given greater power to influence employee behavior through increased or discounted premiums—up to 50% in some cases.

Each year, HRI issues its projection for the following year’s medical cost trend based on activity in the market that

serves employer-based insurance. For its 2014 projection, HRI interviewed industry executives, health policy experts and health plan actuaries, whose companies cover a combined 95 million members. In this year’s report, we identified:

### ***Four factors deflate medical cost trend in 2014***

- Care continues to move outside costly settings such as hospitals to more affordable retail clinics and mobile health. Consumers value the convenience, and costs can be as little as one-third of the bill in a traditional healthcare site.
- Major employers such as Walmart, Boeing, and Lowe’s now contract directly with big-name health systems for costly, complicated procedures such as heart surgery and spinal fusion. The employers are making the move to “high-performance networks” far away from the home office in the belief that even with travel costs, these networks still deliver overall savings.
- The federal government’s new readmission penalties take direct aim at waste in the health system, estimated to be as high as 30%. According to government data, hospital readmissions dropped by nearly 70,000 in 2012, and this trend is expected to accelerate through 2014 as hospitals focus on discharge planning, compliance and the continuum of care.<sup>1</sup>

- Seventeen percent of employers in PwC’s 2013 Touchstone Survey today offer a high deductible health plan as the only option for employees. And more than 44% are considering offering it as the only option. When consumers pay more for their healthcare, they often make more cost-conscious choices.

### ***Two factors inflate medical cost trend in 2014***

- Until recently, widespread adoption of generic medicines helped dampen overall medical inflation, but the rise of expensive complex biologics will nudge spending trends upward. Approvals of new biologics now outpace traditional therapies, and that pattern will continue in 2014 as research efforts target complex cases such as cancer.
- Health industry consolidation has increased more than 50% since 2009—activity that is expected to continue through 2014.<sup>2</sup> Higher prices are sure to follow in some markets. According to a recent report, hospital mergers can lead to price increases of up to 20%.<sup>3</sup> These price increases are especially acute in markets with one dominant system.

### ***What this means for your business***

Employer engagement and individual consumers are powerful and growing forces in the health ecosystem. To succeed, healthcare organizations should fashion strategies around new demands for value.

## Medical cost trend in 2014

PwC's Health Research Institute (HRI) projects that 2014 medical cost trend will be 6.5%—a full percentage point lower than our estimate of 7.5% for 2013.<sup>4</sup> This projection is based on data analysis of medical costs in the large employer market, which covers about 150 million Americans.

The net growth rate, after accounting for benefit design changes such as higher deductibles, will be about 4.5%. In recent years, adjustments to employer benefit plans have helped to reduce benefit cost increases by 1.5 to 2 percentage points by shifting some expenses onto workers and implementing incentives for employees to be more cost-conscious consumers.

The historically low medical cost trend for 2014 did not occur overnight. Utilization of many medical services

slowed over the past decade, as consumers made fewer visits to the doctor's office, postponed procedures, cut back on medications, and reconsidered imaging and elective surgeries. First quarter results for publicly-traded hospitals in 2013 reported a decline in demand for services.<sup>5</sup>

PwC's 2013 Touchstone Survey of large US employers confirms that businesses are increasing cost sharing and plan to continue using that strategy to moderate spending growth. Between 2009 and 2013, emergency room copayments were up 50%, while prescription drug copayments for specialty drugs increased 94%. The average deductible for in-network services is now more than \$1,000, and out-of-network services is more than \$2,000 (see Figure 1).

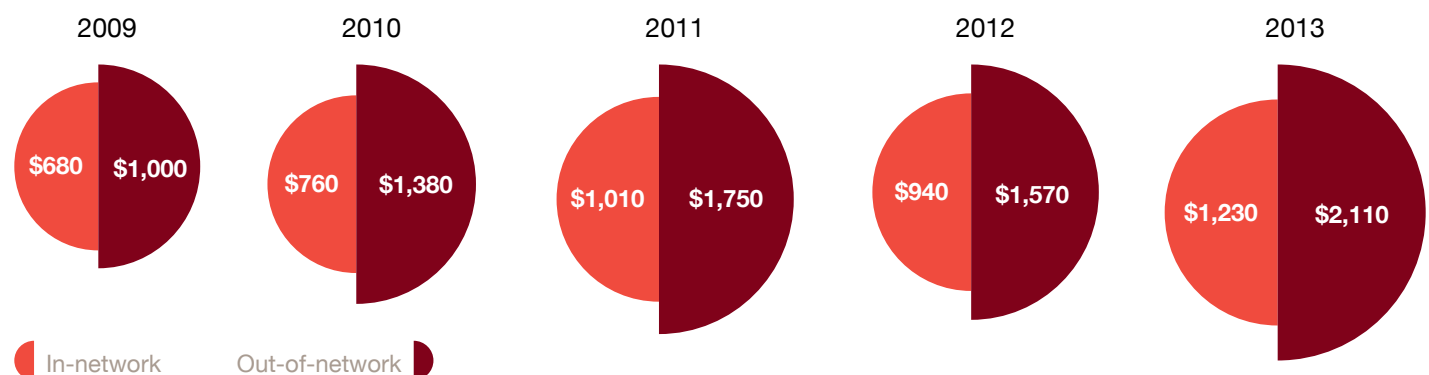
### What is medical cost trend?

Medical cost trend could be defined in several ways; for this report, medical cost trend is the projected increase in costs of medical services assumed in setting health insurance premiums for commercial insurers and large, self-insured businesses. Medical cost trend is the projected percentage increase in the cost to treat patients, or the healthcare spending growth rate. The projection is used by insurance companies to calculate health plan premiums for the coming year. For example, a 10% trend means that a plan that costs \$10,000 per employee this year would cost \$11,000 the following year. The cost trend, or growth rate, is influenced primarily by:

- Changes in the price of medical products and services, known as unit cost inflation
- Changes in the number of services used, or per capita utilization increases

Figure 1. Average deductibles for in and out-of-network visits are increasing\*

### In-network and out-of-network deductibles



Source: PwC 2013 Health and Well-Being Touchstone Survey

\* Calculations are based on employee health plans with a deductible

## Factors affecting 2014 trend

*New care venues, high-performance networks, lower hospital readmissions, and high deductible plans deflate cost trends*

### **Convenient care is cost-efficient care**

Healthcare will continue to move out of hospital and physician offices in 2014. More care will be delivered via the Internet and in locations such as retail centers, a trend fuelled by the rise of cost sharing, the arrival of millions of newly insured patients, and a growing demand for convenience. The new care venues are not only consumer-friendly, but also less expensive. Gaining in popularity, these will slow the rise in medical costs next year.

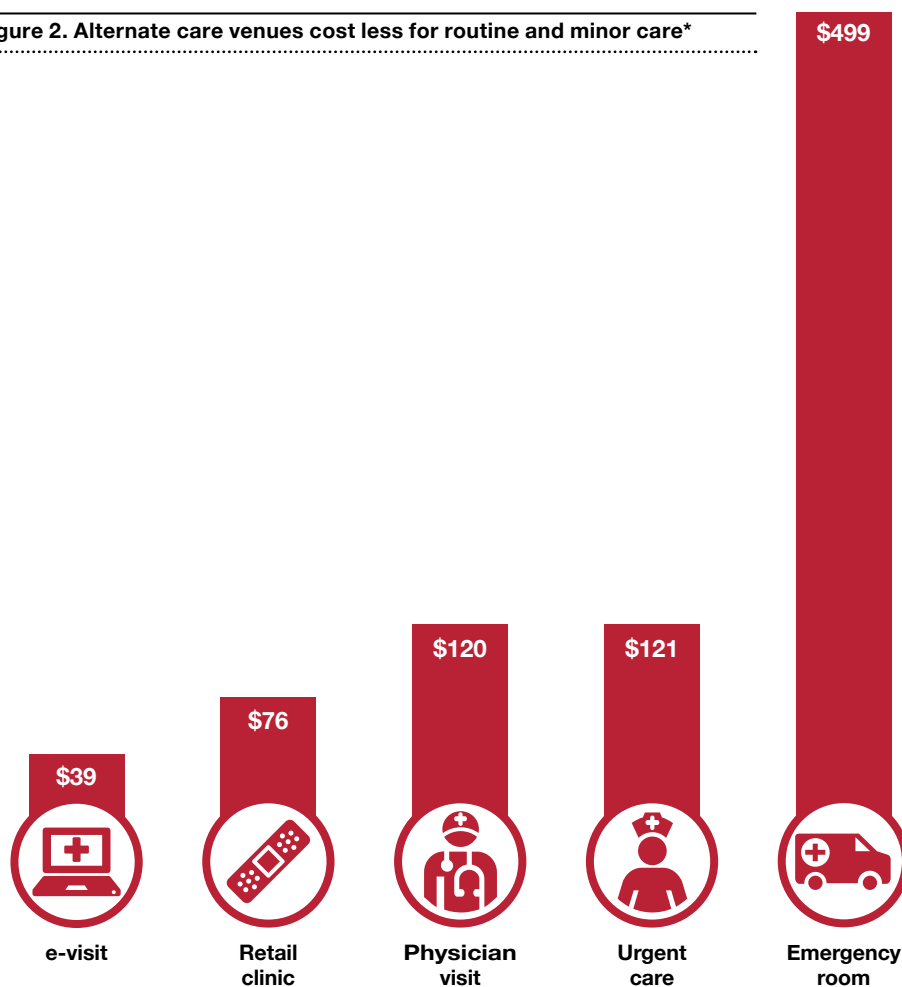
Consumer use of retail clinics nearly tripled over the last five years, according to an HRI survey of more than 1,000 consumers conducted in late 2012. In 2007, 9.7% of consumers had visited a clinic; in 2012, 24% had. Virtual visits also can be consumer-friendly and lower-priced. One industry analysis projects telemedicine visits will grow 55% in 2013.<sup>6</sup>

HRI's analysis of cost of care for simple conditions such as sinusitis or colds shows that these visits in emergency rooms cost almost seven times more than retail clinics and 13 times more than e-visits (see Figure 2).<sup>8</sup> In one calculation of potential savings, HealthPartners, a non-profit insurer based in Minnesota, reported an average savings of \$88 per episode in online clinics versus traditional clinics. Customer satisfaction was also high.<sup>7</sup>

As consumers seek more convenient care, businesses such as Walgreens are responding by offering more sophisticated services, such as chronic health management, in their retail clinics. The clinics will assess a person's chronic condition and guide treatment and management of the illness. With more than half of the nation's population expected to have at least one chronic condition by 2020, the market potential is phenomenal.<sup>9</sup> Chronic illnesses represent 75% of healthcare spending today.<sup>10</sup>

Mary Greal, president of the Healthcare Leadership Council, a Washington, DC-based membership organization for health executives, is "seeing more members pushing full speed ahead to offer more healthcare services in retail clinics and on-site employer clinics to keep employees out of the emergency room and lower costs."

**Figure 2. Alternate care venues cost less for routine and minor care\***



Source: PwC Health Research Institute

\* Minor illnesses include sinusitis, urinary tract infections, common cold, or flu.



### ***High performance- networks deliver more***

Faced with high medical bills, employers are combing the country for doctors and hospitals that can provide high-quality care at a lower price. These newly-formed groups of providers, known as high-performance networks, often specialize in high-cost or high-risk procedures such as heart surgery or transplants. The use of high-performance networks is still in its infancy, but early data suggest the savings range from 10–25% off the total cost.<sup>11</sup>

With money and employee productivity at stake, employers have started to contract directly with providers. This is especially true of large employers that are self-insured and bear the financial risk for their workers' health costs (see Figure 3). For example, Lowe's has chosen Cleveland Clinic for heart surgery. The care is provided for a flat fee, and Lowe's covers all travel expenses.

"We have had good success with the program. The outcomes are good, service is world class, and 98% of those who have used the program are very satisfied," said Randy Moon, vice president of international human resources and benefits at Lowe's. "Costs per episode have been cheaper because of the bundled payment model and Cleveland Clinic's coverage of any follow up treatment. We are now considering offering similar programs for other health situations at Cleveland, as well as utilizing centers of excellence that are more regionally-based."

These "centers of excellence" have such strong quality scores and competitive pricing that the cost of travel is easily recouped, proponents say. Expect to see more large employers embark on this path, helping slow medical inflation.

"Large employers are the vanguard, and they see the value in high quality at a lower cost. That's why a few of the larger companies are pursuing these

### ***Adding confusion to a complicated year, premiums may rise in the individual market***

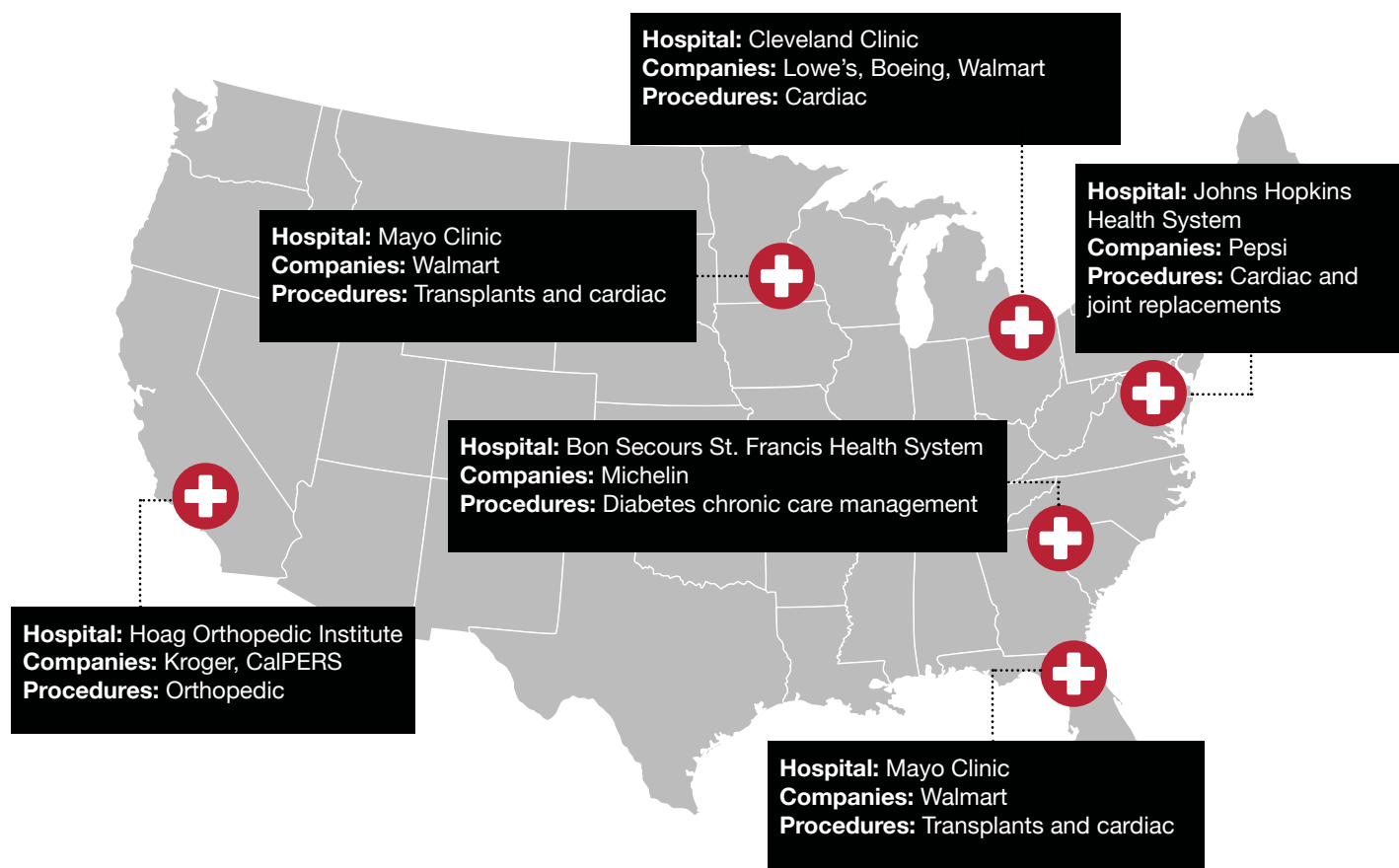
The scope of this research is limited to trends in the large employer market. However, premium costs will generate headlines and likely confuse the public with seemingly contrary signals. A decrease in the overall growth rate does not mean automatic decreases in premiums, particularly those in the individual market. Premium increases tend to be highly variable and depend on many factors such as region, age, and types of plans. When setting premiums, insurers must try to forecast the risk profile of the members—and their medical needs.

In 2014, there will be a new force pushing apart premiums and medical cost trend—the ACA. The law requires virtually every American to have health insurance coverage. Many of the newly insured will participate in new online marketplaces known as exchanges. Insurers face the uncertainty of who will enroll—the sick, the healthy or a combination of the two. A plan dominated by severely ill patients could wipe out reserves; healthier members would help spread the financial risk.

"When there is uncertainty, along comes conservatism," Mark D. Birdwhistell, vice president, administration and external affairs for the UK HealthCare in Lexington, Kentucky, said in an interview. "Health plans will have to accommodate for that uncertainty through increases in premiums to ensure they have all bases covered."

**Figure 3. Large employers partner with providers for specialized services**

*Large employers such as Lowe's and Walmart are partnering directly with hospitals to provide services. Many of these are bundled payments for procedures such as heart surgeries or knee replacements. Some employers pay all related travel costs as well as waive deductibles.*



Source: PwC Health Research Institute<sup>12,13,14,15,16,17,18</sup>

specialized networks directly with health systems,” said Helen Darling, president and CEO of the National Business Group on Health.

In 2012, grocery chain Kroger, signed an agreement with Hoag Orthopedic Institute in Irvine, California and several other hospitals for hip, knee, and spinal fusion surgeries. Employees pay 10 % out of pocket if they choose one of the 19 selected hospitals, compared to 25 % to 50 % for centers not on the list.<sup>19</sup> In 2012, 8% of Kroger employees chose the high-performing

hospitals for surgery, exceeding its goal of 6% utilization. Total costs were 25.5% less for surgeries, and patients using the facilities had no reported readmissions.<sup>20</sup>

The UK HealthCare has built a “virtual high-performance network” in which specialists travel to rural clinics to deliver care for complex cases such as cancer and transplants. “The approach reduces duplication of tests and standardizes treatment, two major cost savers,” said Birdwhistell.

## Readmissions ratchet down

According to the Centers for Medicare and Medicaid Services (CMS), 30-day hospital readmissions for Medicare beneficiaries had been stuck at about 19% for years when the ACA imposed penalties for high readmissions in late 2012. Almost immediately, the rate fell to an average of 18.4%. Even so, more than 2,200 hospitals (two-thirds of US facilities) will face penalties for unacceptably high rates in 2013.<sup>22</sup>

With the penalties set to increase and the public focusing on patient safety, hospitals will act aggressively in 2014 to ensure patients don't require a return trip (see Figure 4). As this activity spreads, it will push down medical cost trend.

Reducing hospital readmissions not only improves care, but it also significantly reduces the cost of

treating hospital-related problems such as infections, falls, and poorly managed follow-up. The cost of readmissions for Medicare patients alone is \$26 billion annually.<sup>23</sup>

The ACA encourages hospitals to get treatment right the first time. The estimated savings from better care is \$630 million in 2014, increasing to more than \$1 billion in 2015.<sup>24</sup>

Some analysts caution that hospitals can record a decline in readmissions if more care is billed as "observational," but many healthcare executives say they are focused on true improvements to care. According to a recent survey, 69% of hospitals had a readmissions reduction program in place. Eighty percent of the hospitals without a program reported that they plan to launch one this year.<sup>25</sup>

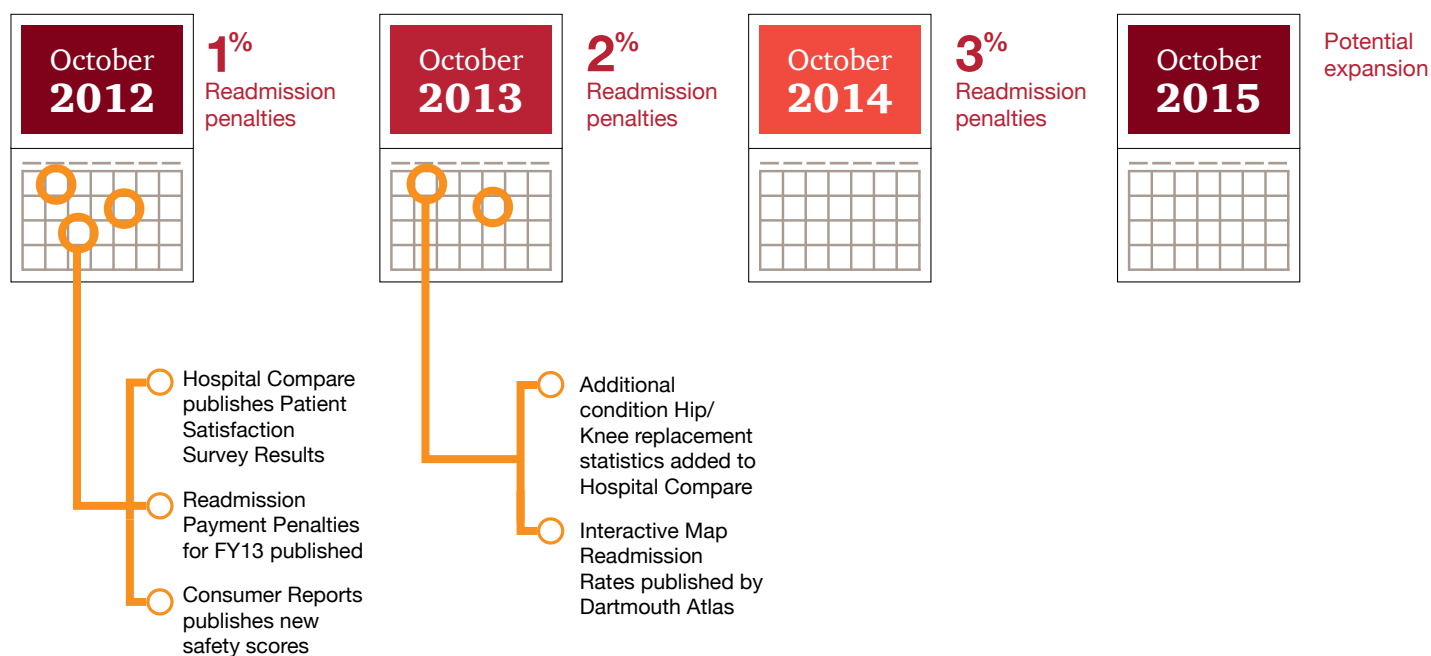
This response is not just about avoiding penalties. An increase in media coverage of readmissions shows the topic is capturing the public's attention and may amplify financial penalties through reputational risk.

Hospitals are not alone in the push to reduce costly readmissions. Insurance giant Cigna, for example, provides hospitals with data to identify patients at risk for readmission. Early identification means doctors and nurses can pay special attention to the risk factors most likely to trigger a return to the hospital.

Many healthcare systems are also creating plans for better follow-up after discharge. Some are even partnering with skilled nursing facilities and home health services.

Figure 4. Hospital readmission penalties increase along with publicly reported results

## Hospital readmissions timeline and highlights of consumer ratings



Source: PwC Health Research Institute<sup>26,27,28,29,30</sup>

## High-deductible going mainstream

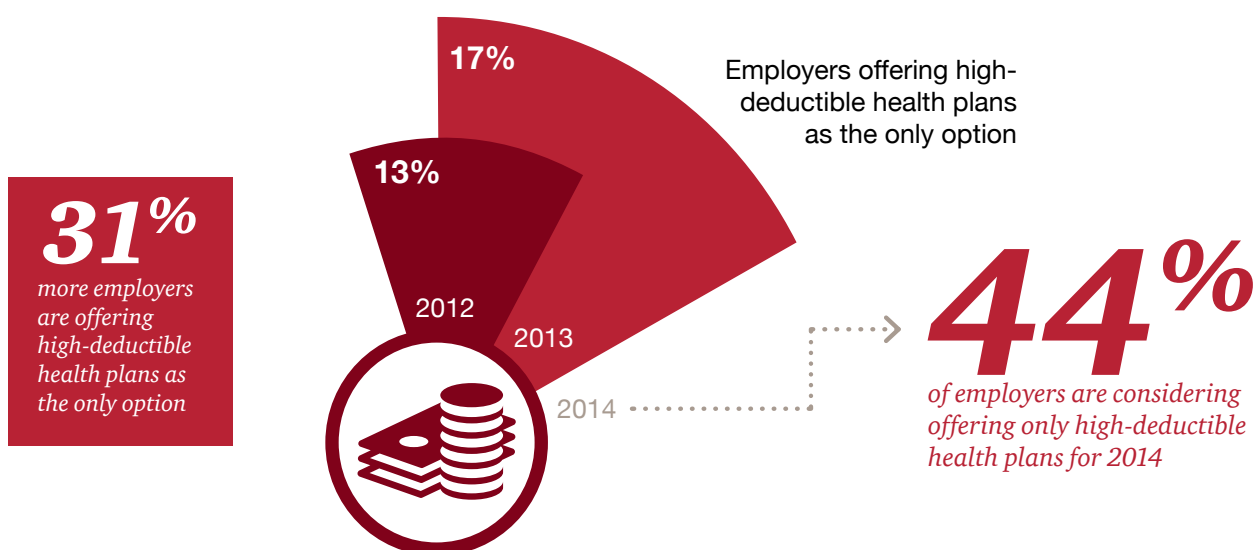
Consumer-driven health plans—insurance coverage with a high-deductible—are set to go mainstream in 2014. According to the 2013 PwC Touchstone Survey of major US companies, 44% of employers are considering offering high-deductible health plans as the only benefit option to their employees in 2014. Already, 17% of employers offer high-deductible plans as their only option in 2013, a 31 % increase over 2012 (see Figure 5).

While medical cost trend does not take into account specific changes in benefit structure, shifts in design ultimately influence consumer behavior, which in turn impacts medical spending and cost patterns. High-deductible health plans, which place greater responsibility on consumers, are designed to promote cost-conscious decisions. A recent study reported families that switched

from a traditional health plan to a high-deductible plan spent an average of 21% less on healthcare in the first year.<sup>31</sup> If 50% of workers with employer-sponsored programs chose high-deductible plans, healthcare spending could be reduced by about \$57 billion, or a 4% decline in total healthcare costs, according to a study in the journal *Health Affairs*.<sup>32</sup>

The ACA, with its new insurance marketplaces, accelerates the move to consumer-driven plans. In 2014, an estimated 12 million consumers will choose a health plan in the new insurance exchanges.<sup>33</sup> HRI demographic analysis and consumer interviews indicate this will be a price-sensitive customer group. Many of the newly insured say they are willing to accept plan features such as higher deductibles in return for lower monthly premiums—as found in the new bronze and silver plans.

Figure 5. High-deductible health plans are becoming more prevalent for employers



Source: PwC 2013 Health and Well-Being Touchstone Survey

**Specialty drug costs cancel out generic drug savings**

The growth rate in drug spending has been declining for years due to the widespread adoption of generic medications. But that is about to change. First-time generic approvals peaked in 2012 with generic versions of medications such as Plavix, Singulair, and Lexapro.<sup>34</sup>

Although generic drug use will remain high, there will be fewer new ones entering the market. And there will be a major counterweight to the spending trajectory—an increase in the use of complex, expensive specialty drugs.<sup>35</sup>

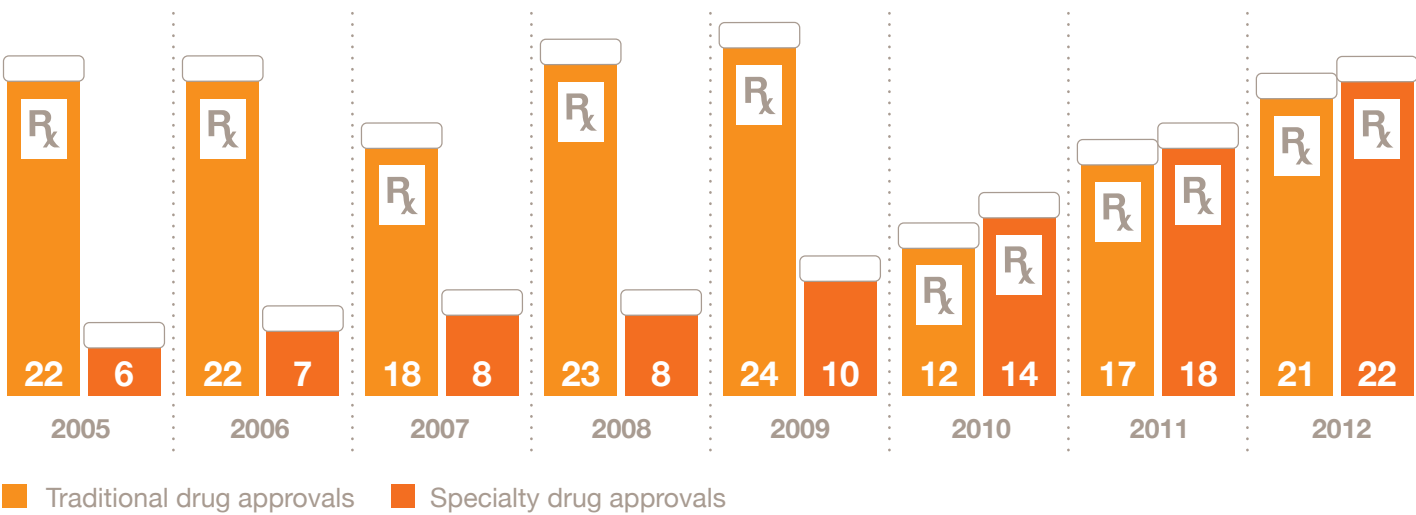
Greater understanding of the molecular and genetic basis of disease has promoted development of sophisticated new medications for chronic illnesses such as multiple sclerosis, rheumatoid arthritis, and cancer. In 2005, 21% of new drug approvals by the U.S. Food and Drug Administration (FDA) were for specialty medications. By 2012, these therapies accounted for over half of approvals (see Figure 6). The pace is expected to quicken in 2014, with specialty drugs poised to account for up to 60% of new approvals and seven of the top 10 best-selling therapies.<sup>36</sup>

The numbers illustrate why prescription spending is poised to nudge medical cost trend up. Specialty drugs—biologics made from living organisms—are more complex than many traditional therapies and have a much higher average cost. Spending on specialty drugs increased 18% in 2012 and is expected to rise by 22% in 2014.<sup>37</sup> The drugs are projected to hit 45% of US prescription sales volume by 2017.<sup>38</sup>

Figure 6. FDA approvals of specialty drugs rising rapidly

**Specialty drug costs cancel out generic drug savings**

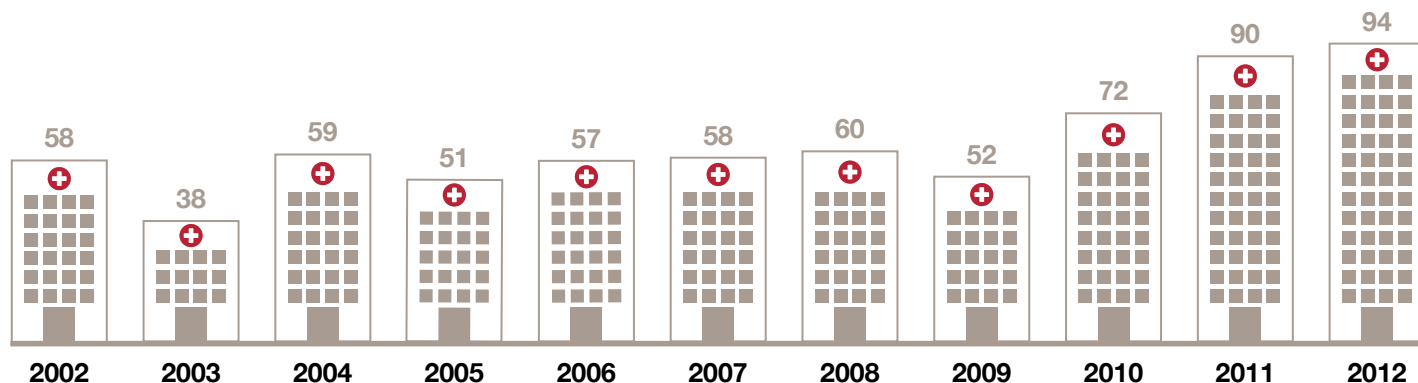
2010 was the first year specialty drug FDA approvals were higher than traditional drug approvals. This trend is expected to continue into 2014, with specialty drugs poised to account for up to 60% of new approvals.



Source: FDA, PwC Health Research Institute

Figure 7. Hospital deals on the rise

## Industry consolidation can lead to higher prices



Source: Irving Levin Associates

### Industry consolidation can lead to higher prices

Hospital merger and acquisition activity has increased nearly 50 % since 2009, reaching its highest point in the last 10 years—even surpassing the number of deals seen at the height of the 1990's merger craze (see Figure 7). The activity shows no sign of abating in 2014. Over half of hospitals plan to acquire physician practices in 2014, compared to 44% in 2012, according to one industry survey.<sup>39</sup> And the data understate the volume of activity happening through affiliations and joint ventures.

With consolidation, higher prices often follow. Studies have shown that hospital mergers in concentrated markets can increase prices by more than 20%.<sup>40</sup> Insurance companies contract with hospitals for services, and they are often the first to experience price changes.

Despite the economies of scale that consolidation offers, many insurance companies report an immediate increase in hospital rates. Often the new entity adopts the higher payment rates of the two. Some smaller, independent hospitals have used the mere specter of consolidation with a larger hospital to negotiate better payment.

Physician employment can also increase prices. When physician groups join a hospital system, a “facility fee” is typically added for procedures performed in a hospital or surgery center. The result—overall costs are greater than if the same procedure were conducted in the physician’s office.

Higher prices associated with hospital consolidation can trigger increased government action. In Massachusetts, one-third of hospitals have merged, acquired, or partnered with another

system in the past three years, and prices have remained among the highest in the nation.<sup>41</sup> In response, the legislature has enacted laws that peg health spending to economic growth and increased price transparency.

The promise of provider consolidation is that it can improve efficiency by both eliminating duplication and by delivering integrated care supported by a larger organization with more resources. But it also can lead to increased market power and higher prices. “They aren’t taking the waste out of these systems fast enough,” Darling, of the National Business Group on Health, told HRI.

## ***Early hints of promise from accountable care organizations***

Some ideas need time to mature. Accountable care organizations (ACOs) have big ambitions—to lift quality, hold down costs, and create happy customers. Hopes are high that these new groups can curb healthcare spending too, though it may be years until the evidence is in. Although some say they resemble HMOs from the 1980's, they are different because they are physician- and hospital-led.

Hundreds of hospitals, physician groups, and insurers are assembling into ACOs, trying to capture savings generated by better—and better-coordinated—care. Providers such as Baylor Health Care System and Advocate Health Care are developing their own ACOs, as are insurers such as Highmark and Aetna. Cigna has committed to forming 100 ACOs by the end of 2014.

The Centers for Medicare and Medicaid Services (CMS) has approved more than 250 Medicare ACOs, serving more than 4 million beneficiaries. During a U.S. Senate Finance Committee hearing this spring, CMS chief Marilyn Tavenner called the programs “one of the Affordable Care Act’s key reforms to improve delivery of care.”

Early data from a federal pilot program of Medicare patients point to modest savings. The pilot, formally known as the Physician Group Practice Demonstration, saved \$137 million over five years across 10 participating physician groups, an average of \$114 per year per beneficiary.<sup>42</sup> Similarly, in 2009 spending grew about 2% less per quarter for enrollees in Blue Cross Blue Shield of Massachusetts’ ACO-like program compared to its traditional programs.<sup>43</sup> Blue Cross Blue Shield reported that 2010 savings were even higher.

Cigna believes its ACOs can bring costs down and is aiming for 1 million members in its ACOs by the end of 2014. “Our per patient annual cost growth is 50% lower for members in our ACO than members covered by traditional fee-for-service,” said Cigna Healthcare national medical officer Dr. Ozzie Khan.

Emergency room visits fell 7% across the system, while quality indicators for procedures such as mammograms and cervical cancer screenings are up about 5%, Khan said. To achieve these results Cigna encourages primary care physicians to refer patients to specialists with proven quality. Khan adds that, “we share specialist quality data with our ACO physicians so they can make an informed decision about who they send their patients to.”

Yet some healthcare executives interviewed by HRI remain skeptical and stressed that savings from ACOs will likely take a few years before influencing overall U.S. health spending. Some said that ACOs may even push costs higher in the beginning as systems invest in infrastructure and technology such as electronic medical records. “There are promising signs of cost savings, but it’s still a little too early to tell how extensive and sustainable they are,” said Mary Grealy, president of the Healthcare Leadership Council.



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## Conclusion

In short, 2014 will be one of the most complex years the health sector has faced as it takes on major uncertainty in an environment of constrained resources.

The numbers are encouraging. Medical inflation has slowed—from an unsustainable 11% in 1990 to 3.9% in 2011, according to the most recent government data available.<sup>44</sup> Annual Medicare spending rose just 1.7% per beneficiary from 2010 to 2012, compared to 6% per year in the previous two decades. The slower trend has been welcome news for healthcare purchasers and federal budget writers, but poses difficulties for healthcare organizations.

Initially, the slowdown was attributed primarily to cuts in payments to doctors, hospitals, and drug makers. Over time, however, the industry has begun to refashion itself, and for the second year in a row, HRI's annual report on medical cost trend identifies structural changes that are altering how and where care is provided. In the case of some changes, such as accountable care organizations,

it is still too early to know whether the savings will be significant and long term.

Employers and consumers are also impacting medical cost trend as they comparison shop for healthcare—whether it is a business sending complex cases to a “center of excellence” hundreds of miles away or a family enrolling in a wellness program to reduce its insurance premiums.

Millions of new customers are on the way because of coverage expansions in the ACA. Much will depend on the health risk profile of the newly insured and how the industry manages them. HRI demographic analysis projects the group as a whole is relatively young (median age 33).<sup>45</sup> On average, these potential new customers also consider themselves to be in good health, are less educated, poorer, and may not speak English as its first language. Few have navigated the formal health system, presenting challenges around education, outreach, and enrollment.

It appears the cost curve is starting to bend—now the question is whether the health industry can continue on the path to full transformation.



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### ***What this means for your business***

Employer engagement and individual consumers are powerful and growing forces in the health ecosystem. To succeed, healthcare organizations should fashion strategies around new demands for value.

### What are they doing now?

Employers remain concerned about their long-term ability to provide comprehensive health benefits. Despite a slowdown in medical inflation, costs continue to rise faster than GDP. In answer to the rising costs, businesses continue to shift more of the financial burden onto workers, are reducing retiree benefits and pursuing more aggressive strategies to promote measurable health outcomes.

Employers still describe health insurance as a valuable tool for recruitment and retention, and tax advantages are expected to keep employer coverage at high levels in 2014. In Massachusetts, employer-sponsored coverage has risen since the state enacted its healthcare overhaul seven years ago, even as employer coverage declined nationally.<sup>46</sup>

Employers are self-insuring more than ever before. Over 80% of large employers and a third of small employers are providing their own coverage. The ACA exempts self-insured employers from a new industry tax on commercial insurance plans.<sup>47</sup> Some employers are evaluating a move to private insurance exchanges, in which employees choose from a range of benefits packages. Other employers are considering paying a penalty in lieu of providing coverage.

### Things to consider

- *Explore high-performance networks even if they are not local.* Employee travel expenses may be well worth the cost if employees have better outcomes at lower prices. Employers should find health plans that offer a high-performance network for medical care or contract directly with these health systems.
- *Encourage use of new care venues.* Onsite work clinics, retail clinics, and mobile health options are convenient and typically less expensive than traditionally delivered care. Round-the-clock care centers reduce time spent away from work.
- *Educate employees and families about their options and responsibilities.* As high-deductible plans become more of the norm, employers should ensure that employees understand their benefits and responsibilities. Studies have shown that some people in high-deductible plans forgo preventive care that is fully covered by the plan.<sup>48</sup> “Health navigator” programs that guide employee decision-making can be a worthwhile investment for businesses.
- *Embrace the data.* Employers need to evaluate program results to determine what works and then continuously modify strategies to improve the value of the programs they offer and the care that their employees receive.

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## Providers

### *What are they doing now?*

Reducing costs has been the focus for hospitals for the past few years. Many have addressed simple reductions in labor force and supply chain management. Now other factors are coming into play. As the federal government continues to shrink reimbursement, hospitals and doctors are focused on full-scale transformation that shifts incentives away from fee-for-service medicine toward outcomes-based payment. Additionally, hospitals have been forming partnerships with urgent care centers and retail clinics that offer less expensive and more convenient options and that also expand their referral network for complex cases.

### Things to consider

- *Apply predictive analytics to target high-cost patients.* After years of preparing to meet the government's "meaningful use" requirements, hospitals can now use EHR data to target high-risk/high-cost patients. Health information technology will be critical to achieve care integration and to reduce costs associated with redundant testing and delays in follow-up care.
- *Forge new alliances.* As accountable care and readmission penalties become the norm, hospitals should partner with long-term and home care to ensure sustainable results. Hospitals may also need to build on their current information technology capabilities by partnering with insurers to access data beyond their systems.
- *Invest in the human side of HIT.* Hospitals should not only continue to focus on building their technology infrastructure, they should also develop the resources necessary to implement and run these systems. Two-thirds of healthcare providers are experiencing IT staff shortages, according to HRI research.<sup>49</sup>
- *Align individual incentives with organizational incentives.* As organizations switch to different payment models, clinicians and staff need incentives such as performance metrics that link compensation to quality.

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## Health insurers

### *What are they doing now?*

Preparing for the uncertainty of 2014 has been a major challenge for insurers. The health insurance business model is fundamentally shifting from a wholesale approach primarily focused on group insurance to a retail approach focused on serving the growing individual market. New rules related to the ACA have prompted insurers to develop plans to meet the requirements for operating in health insurance exchanges, which will serve the 27 million individuals expected to gain coverage over the next decade.

Health insurers face intense scrutiny regarding premiums. The ACA requires a review of rate hikes of 10% or more by state insurance commissioners or the U.S. Department of Health and Human Services. Insurers are struggling with how to price new products when the risk profile of the newly insured is largely unknown. Early premium pricing in state exchanges has already prompted some payers to lower their prices under the spotlight of transparency.

### Things to consider

- *Form strong partnerships with providers.* As health insurers shift to payment models rewarding quality and efficiency, they should work closely with providers to hit ambitious new targets. Insurers should share data that helps hospitals and physicians manage the highest cost population segment with multiple chronic conditions.
- *Empower consumers to make cost-efficient choices.* Team up with employers to give employees information on lower-cost options. Encourage the transparency of quality measures, and provide information comparing different treatment options.
- *Focus on high-cost specialty drugs.* A top concern of government and private purchasers is the growing use of expensive specialty drugs. Insurers can help push for data to manage this growing cost.
- *Provide access to high-performance networks.* Offer companies new solutions to bend the cost curve. Identify and promote high-performing hospitals for complicated and costly procedures. Help companies understand that poor quality compounds the total cost of treatment.

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## Pharmaceutical and life sciences

### *What are they doing now?*

Pharmaceutical and life sciences companies have been realigning business strategies to address the new environment of constrained growth. One recent HRI survey found that 35% of life sciences companies have revamped their R&D models in the past three years. Those models are now focused more on partnerships, alliances, and even outsourcing.<sup>50</sup> The need to demonstrate cost-effectiveness has prompted companies to invest in clinical informatics and health economics analytics teams.

Biologics have become an increasing focus for many drug makers. They offer long term market protection from generic competition as high start-up costs are a barrier to market entry for biosimilar manufacturers. However, pressure to address the rising costs of specialty drugs is a top priority for employers and insurers, and may create challenges to the growth and profitability of these drugs. Pharmaceutical companies are addressing cost pressures by investing in companion diagnostics that use evaluation tools to ensure these expensive drugs are targeted at the right patients.

### Things to consider

- *Get closer to insurers and providers.* Collaborative relationships that demonstrate effective outcomes enable drug makers to address challenges early in the development process and adapt drug design and payment methods to make them attractive to purchasers.
- *Follow pharmacy benefit decisions.* Which drugs are covered will vary significantly from state to state and plan to plan. Drug makers will need to assess how the pharmacy benefit differs in each exchange and develop an appropriate strategy to get their products covered.
- *Evaluate data and apply to R&D processes.* The push for cost-effective medications continues. Drug makers must continually demonstrate the value of their products with compelling cost and quality studies.
- *Understand how companion diagnostics affect drug treatment decisions.* Companion diagnostics offer the promise of targeted therapies and reduced spending on treatments that may not be effective for certain individuals. Insurance companies hope to use companion diagnostics to shrink total costs through more effective treatment.

- 1 Good news on innovation and healthcare, White House Blog, Secretary Kathleen Sebelius, May 28, 2013, <http://www.whitehouse.gov/blog/2013/05/28/good-news-innovation-and-health-care>.
- 2 Irving Levin Associates.
- 3 Robert Wood Johnson Foundation, "The impact of hospital consolidation—Update", June 2012.
- 4 All numbers are national estimates. Cost trends may vary from market to market depending on the level of provider and health plan competition as well as the regional economy. In addition these numbers will vary by employer based on the benefit plan design and impact of their specific health and productivity efforts.
- 5 Kutscher B, "Feeling the outpatient pinch." *Modern Healthcare*. 27 April 2013.
- 6 IMS InMedica study: Telehealth—An Analysis of Demand Dynamics—2012 Edition.
- 7 Courneya PT, Palattao KJ, Gallagher JM, "HealthPartners' Online Clinic For Simple Conditions Delivers Savings of \$88 per Episode and High Patient Approval", *Health Affairs*, 32 No 2 (2013).
- 8 Prices are based on publicly available data for a patient with or without insurance. Actual co-pays may differ based on type of insurance. The prices do not include other factors such as cost sharing or rebates and may not reflect the true costs. Prices include only physician visit services and do not include lab diagnostics or other specialized procedures. Prices from 2008-2013 were gathered from publicly available sources such as websites for specific retail clinics, urgent care centers, and e-visits. Prices for physician office and emergency room visits were obtained from published articles and publicly available data from sources such as the American Hospital Association. (e-visits n=3, retail n=9, urgent n=4, physician n=3, emergency room n=4).
- 9 Campbell-Scherer D, "Multimorbidity: A Challenge for Evidence-Based Medicine," *Evidence-Based Med* 2010;15(6):165-66.
- 10 Institute of Medicine, "Living Well with Chronic Illness: A Call for Public Health Action," National Academic Press 2012 and National Health Expenditures Data 2011.
- 11 Meyer H, "Return of narrow network," *Managed Healthcare Executive*, 1 July 2012. <http://managed-healthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/return-narrow-network>
- 12 Page L, "7 Points About Cleveland Clinic's Bundled Payment Program for Lowe's Employees," *Beckers Hospital Review*, 11 October 2010.
- 13 Gamble M, "Cleveland Clinic Strikes Bundled Payment Deal With Boeing", *Beckers Hospital Review*, 19 October 2012.
- 14 "Companies Search for Fixed Rate Surgeries," *Medical Tourism Magazine*, 14 January 2013.
- 15 Johns Hopkins Medicine News, "PepsiCo Agreement Makes a Splash," 1 February 2012.
- 16 "Diabetes Integrated Practice Unite Pilot Project: Collaboration of Michelin, Bon Secours, United Healthcare, Medco, and Porter/Teisberg/Wallace."
- 17 Terhune C, "Companies Go Surgery Shopping," *Los Angeles Times*, 17 Nov 2012.
- 18 Silverman R, "Peeling Off a Service Line How Hoag Reinvented Orthopedics," *ImagingBiz*, 3 March 2012.
- 19 Terhune C. "Companies Go Surgery Shopping," *Los Angeles Times*, 17 Nov 2012.
- 20 Kroger Presentation, National Business Group on Health, May 2013.
- 21 A publication analysis search was done using a key word search for hospital readmissions through Factiva. Publications include all licensed Factiva sources.
- 22 Ladermann M, Loehrer S, McCarthy D, "The Effect of Medicare Readmissions Penalties on Hospitals' Efforts to Reduce Readmissions: Perspectives from the Field," *The Commonwealth Fund*. 26 Feb 2013.
- 23 Robert Wood Johnson Foundation, "The Revolving Door: A Report on U.S. Hospital Readmissions", February 2013.
- 24 CMS, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," April 2010. [http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA\\_2010-04-22.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf)
- 25 Healthcare Intelligence Network, Reducing Hospital Readmissions in 2012 Survey
- 26 <http://www.medicare.gov/HospitalCompare/About/HOSInfo/Survey-Patients-Experience.aspx>
- 27 <http://www.qualitynet.org/dcs/>
- 28 <http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnet-Tier4&cid=1228695492636>
- 29 <http://www.consumerreports.org/cro/magazine/2012/08/how-safe-is-your-hospital/index.htm>
- 30 <http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2013/02/interactive-map-the-revolving-door-syndrome.html>
- 31 "Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care", RAND Health, 2012.

- 32 Haviland AM, Marquis MS, McDevitt RD, Sood N. "Growth of Consumer-Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save \$57 Billion Annually", *Health Affairs*, 31 No 5 (2012).
- 33 "Health Insurance Exchanges: Long on options, short on time," PwC Health Research Institute, October 2012.
- 34 First-time generic drugs are those drug products that have never been approved before as generic drug products and are new generic products to the marketplace. These may include multiple versions of an equivalent drug from different manufacturers.
- 35 Specialty medications include injectable and noninjectable drugs that are typically used to treat chronic, complex conditions and may have one or more of the following qualities: frequent dosing adjustments or intensive clinical monitoring; intensive patient training and compliance assistance; limited distribution; and specialized handling or administration.
- 36 EvaluatePharma. <http://www.gabionline.net/Biosimilars/Research/Biologicals-boom>
- 37 Express Scripts 2011 and 2012 Drug Trend Report. Pharmacy benefit spend which does not include the roughly 47% specialty drugs used for medical benefit (drugs delivered in outpatient physician settings).
- 38 Hernandez A, "Strategic Approaches for the Distribution of Specialty Pharmaceuticals" *Specialty Pharmacy Times*, 20 Dec 2012.
- 39 Jackson Healthcare, Trend Watch: Physician Practice Acquisitions 2012-2013. <http://www.jacksonhealthcare.com/media-room/surveys/trend-watch-physician-practice-acquisitions-2012-2013.aspx>
- 40 Robert Wood Johnson Foundation, "The impact of hospital consolidation—Update", June 2012.
- 41 The Massachusetts Experience: Employer-sponsored health insurance post reform, PwC Health Research Institute, May 2013.
- 42 Colla et al, "Spending differences associated with medicare physician group practice demonstration." *JAMA*, Vol 308, No. 10, 12 September 2012.
- 43 Song et al, "Health care spending and quality in year 1 of the alternative quality contract," *NEJM*, vol. 10, 8 September 2011.
- 44 Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census; data obtained in April 2013.
- 45 Health Insurance Exchanges: Long on options, short on time, PwC Health Research Institute, October 2012.
- 46 The Massachusetts Experience: New wave of consolidation for health sector post reform, PwC Health Research Institute, May 2013.
- 47 PwC 2013 Health and Well-Being Touchstone Survey (large employer > 1,000 employees, small employer <1,000 employees).
- 48 Beeuwkes Buntin M, Haviland AM, McDevitt R, and Sood N, "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans," *American Journal of Managed Care*, Vol. 17, No. 3, March 2011.
- 49 "Solving the talent equation for health IT," PwC Health Research Institute, March 2013.
- 50 "New Chemistry: Getting the biopharmaceutical talent formula right," PwC Health Research Institute, February 2013.

## Acknowledgements

Helen Darling  
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National Business Group on Health

Mary Grealy  
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Mark D. Birdwhistell  
Vice President, Administration and  
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## About this research

Each year, PwC's Health Research Institute provides estimates on the growth of private medical costs over the next year and what the leading drivers of the trend are expected to be. Insurance companies use medical cost trend to help set premiums by estimating what the same health plan this year would cost the following year. In turn, employers use the information to make adjustments in benefit plan design to help offset cost increases. The report identifies and explains what it refers to as "inflators" and "deflators" to describe why and how medical cost trend is impacted.

This forward-looking report is based on the best available information through May 2013. HRI conducted interviews in March and April 2013 with 10 health plan officials (whose companies cover a combined 95 million people) about their estimates for 2014 and the factors driving those trends. Findings from PwC's Health and Well-Being Touchstone Survey of 1,047 employers from over 35 industries are also included. HRI also examined government data sources, journal articles, and conference proceedings in determining medical cost trend.

*Behind the Numbers 2014* is our eighth report in this series.

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