The US Supreme Court ruling upholding the 2010 healthcare law reinjects a sense of urgency into the transformation of an industry that represents nearly one-fifth of the US economy. Across the health sector and beyond, implementation deadlines that once seemed far off now rapidly approach, putting fresh pressure on health organizations to devise innovative ways of delivering high-quality, affordable care.

The Court ruled that a core provision of the Affordable Care Act—the requirement that every American carry health insurance—is a tax and as such, is constitutional. The ruling also permits the federal government to pursue a broad expansion of the Medicaid health program for the poor, but gives states maximum flexibility on whether to do so.

As a result, incentives for collaboration are quickening the convergence of hospitals, insurers, drugmakers, physicians, and technology companies. Creation of new state and private insurance exchanges, greater pricing transparency, mobile technology, and nontraditional competitors are turning the health business into a retail operation.

At the same time, we are entering an era of megapayers—the federal government, large employers, and state exchanges empowered to direct business based on health outcomes. Economic uncertainty and federal budget reductions add muscle to efforts to improve efficiency, eliminate waste, and constrain overall cost growth. Coordinated, integrated care, powered by richer data, continues its spread across the healthcare landscape.

The ACA could still be repealed, revised or defunded by Congress or a new administration. Despite the political uncertainty, private-sector initiatives—accentuated and accelerated by the law—are moving forward. The crucial question now is: Will health reform define your organization, or will your organization define the post reform landscape?
Insurers

The 2010 law accelerated changes already underway in the US health system by expanding and enforcing payment models that revolve around performance quality. Under the ACA, about 30 million more Americans are projected to secure insurance coverage by 2021, while insurers are obligated to operate under tighter controls and constraints.1

The law aims to refashion core elements of the health insurance business. Prior to the ACA, insurers mitigated risk by underwriting policies at the individual and the small group market levels. Under the law, risk mitigation becomes a population-level exercise. At the core of the law, the individual subsidies and individual mandate mitigate the risk of adverse selection by encouraging a mix of healthy and less-healthy populations to enroll in the individual market and state exchanges.

When 50 state insurance exchanges open enrollment in 2013, along with private exchanges, payers must decide whether they will compete in all or only certain exchanges and, if so, with what plan offerings. Insurers with plans in place and ready to go by 2014 will be in the best position to compete and gain market share early on.

The market for individual policies is expected to explode with customers who could determine how health insurance is sold in the future. By 2021, the individual and small business exchange market is projected to grow to about $205 billion in premiums and $148 billion in exchange subsidies and related spending.2

Insurance companies, especially those focused on the wholesale market of employer-sponsored coverage, will have to devote considerable resources to individual policies sold on the exchanges. While many have experience with direct-to-consumer sales in the retail market through Medicare Advantage plans, PwC’s Health Research Institute (HRI) research shows that the exchanges create huge consumer education challenges regarding eligibility for subsidies, access, benefits, and pricing.3 Some insurance companies have already partnered with retailers and mass-market wholesalers to establish and market outreach programs for new healthcare consumers.

Government review impacts the business model

The ACA grants the US Department of Health and Human Services (HHS) the authority to review health insurance premium increases, and insurers must justify rate hikes of over 10%. HHS publicly announced that premium increases in nine states were unreasonable.4 The Department reports that the review program has led to a drop in proposed double-digit premium increases.5 With the ACA upheld, health plans must be prepared to justify increases in premiums.

Figure 1: Projected medical loss ratio rebates

$377 M Small group market

+ $426 M Direct market purchase

+ $541 M Large group market

$1.3 B in rebates are projected to be paid out to insurance consumers in August 2012.

Source: Kaiser Family Foundation.6
With the medical loss ratio (MLR) provisions still in place, payers must continue balancing benefit administration and management costs with the payout of claims. When MLRs are too low, consumers benefit through rebates. Approximately $1.3 billion in rebates are expected to be paid out in August 2012, with $541 million going to the large group market, $377 million to the small group market, and $426 million to the direct purchase market. Since individual market membership is expected to increase under the new law, insurers should quickly adjust practices to manage MLRs, including accrual, reporting, and distribution of rebates.

The growth of high-deductible health plans underscores consumers’ cost sensitivity and puts increased pressure on insurers for the most cost-effective healthcare options, such as retail clinics, e-visits, and mobile health, which provide convenient primary care services. Expanded coverage will continue to reinforce trend. With physician services already constrained, physician extenders, telehealth, retail clinics, and Federally Qualified Health Centers can play an important role in helping the US healthcare system meet the needs of the newly insured.

**Employer market remains dominant**

Insurance companies should be prepared for strategic conversations with their clients. Small companies may find the Small Employer Health Insurance Plan (SHOP) business exchanges an attractive option for introducing or continuing to offer insurance to their workforces. Four million people are expected to receive employer coverage through the SHOP business exchanges by 2021. Additionally, companies not currently offering health insurance may face pressure to do so since their workers must comply with the individual mandate or make a payment.

Conversely, some businesses may consider the individual exchanges an attractive alternative for their workers. Estimates vary, but small employers and firms with high concentrations of low-wage workers will be the most likely to consider dropping coverage. Overall disruptions to the traditional employer market should be minimal. The nonpartisan Congressional Budget Office (CBO) projects that in 2021, about 4 million fewer people are expected to have employer-sponsored insurance, a 3% reduction.

Payers should start making decisions now about which markets they will pursue, how they will engage and educate new consumers, and how they will operationalize, scale and manage risk. Business as usual will pivot toward satisfying a broader scope of consumers who are faced with more choices.

---

### The path forward—insurers

**Act**

- Be the market leader through differentiated products, services, and consumer experience.
- Start thinking about membership retention and growth through the exchanges. Offer Gold, Silver and/or Bronze plans on the exchange.
- Develop a social media strategy to advance continued education and outreach with consumers. This could be a key differentiator and bring you closer to understanding new consumer product needs and behaviors.
- Collaborate with employers to reinforce the value proposition of employer-provided coverage related to health and productivity.
- Keep a pulse on what is happening in the retail health space.
- Pursue collaboration and partnership opportunities with providers where all parties have skin in the game.
- Leverage Medicare Advantage experience and industry partnerships to build simple and scalable outreach.

**Assess**

- Assess your organization’s readiness to comply with federal and state regulations, MLR, and rate review.
- Understand and manage risk under new exchanges, expanded Medicaid and new provider payment arrangements.
- Assess technology capability and prepare for participation with Exchanges and/or Medicaid.
- Consider your position in the market relative to competitors and retail market trends.
- Assess standardization of benefit design and products to minimize operational variation and complexity that increase administrative costs.
- Reevaluate pricing strategy, and prepare for price transparency. Market-competitive pricing should flatten the cost curve.
- Assess investment in HIE and HIT to facilitate new contracts, payment structures, and other financial arrangements with providers to support movement away from fee-for-service contracting.

**Stop**

- Stop putting off key decisions.
Providers

The long march to a new way of paying for healthcare is being validated under the ACA. Financial pressures and the need to improve quality and access to care were among the top reasons that both public and private purchasers developed pilot programs with new quality and cost requirements. The ACA enables these efforts and accelerates their widespread use through financial incentives and penalties tied to Medicare reimbursement.

Increased access

The ACA is expected to give providers access to about 20 million newly insured individuals in 2015, rising to 30 million by 2021. About 11 million of those newly insured (those below 133% Federal Poverty Level) are expected to receive coverage through an expanded Medicaid program. But under the Court’s ruling, it is likely some states will expand their Medicaid programs in 2014 while others may not. Overall these coverage expansions will reduce uncompensated care for hospitals, but there will also be reductions in some Medicare and Medicaid payments, including the Disproportionate Share Hospital (DSH) payment adjustments.

Providers should respond by coordinating the delivery of care, measuring quality-based outcomes, and maximizing reimbursement through participation in new commercial and government payment models such as accountable care. An accountable care organization (ACO) is an approach that ties reimbursement of a medical team to outcomes and the total cost of care.

Figure 2: Different providers, different outcomes

The challenges and strategic response to the ACA will vary by organization.

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Revenue trend</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average hospital:</strong> Hospital with a typical payer mix relative to national average</td>
<td>▲</td>
<td>New revenues from better coverage, which offset loss from reduced Medicare payments and DSH cuts. Some gains may also be tempered for hospitals located in states that do not expand Medicaid coverage</td>
</tr>
<tr>
<td><strong>Academic medical center:</strong> Draws seriously ill and those who want high-tech care; despite a healthy mix of all payers, higher-than-average Medicaid and uninsured</td>
<td>▲</td>
<td>Medicare cuts balanced by increase in newly insured; other sources of funding, such as grants, at risk from federal budget cuts and commercial payers moving toward narrow networks excluding higher-cost AMCs. Additional risk if serving a large uninsured population in a state that does not expand Medicaid</td>
</tr>
<tr>
<td><strong>Suburban hospital:</strong> Satellite facility with few uninsured and higher-than-average private and Medicare patients; draws some uninsured young people not eligible for Medicaid</td>
<td>▲</td>
<td>Could benefit from coverage of uninsured; will have to demonstrate high quality and brand image relative to peers in the market in order to attract the newly insured.</td>
</tr>
<tr>
<td><strong>Safety net hospital:</strong> Big hospital in low-income area with large share of Medicaid and uninsured and less-than-average share of privately insured and Medicare</td>
<td>▼</td>
<td>Hospital may benefit from coverage of the uninsured. However, the hospital will likely have to improve quality and brand image relative to peers in the market to attract the newly insured. They may still be serving the remaining uninsured population, which could be significant in some states that choose not to expand their eligibility to Medicaid program</td>
</tr>
<tr>
<td><strong>Integrated delivery system:</strong> Health system with associated provider-owned health plan</td>
<td>▲</td>
<td>Best suited to be first to market to take advantage of new payment mechanisms, such as ACOs, bundled payments, and other population-health-oriented payments. May have fewer uninsured given the mandate</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>▲</td>
<td>Certain specialties fare well, others less so; some primary care may benefit from temporary increase in Medicaid rates, but others may see more uninsured if located in a state that does not expand their Medicaid program. Other benefits include first-dollar coverage for preventive services, and physician-extender initiatives. Specialists dealing primarily with Medicare lose slightly on decreased reimbursement. Overall, large physician groups fare better because of more resources to manage risk and build infrastructure to participate in new reimbursement models</td>
</tr>
<tr>
<td><strong>Long-term care, skilled-nursing facility, home healthcare, rehabilitation</strong></td>
<td>▼</td>
<td>Potential negative effect from Medicare rate cuts; may need to partner with acute care facilities and payers to comply with Medicare initiatives, such as preventing readmissions and dual eligible demonstration projects. Joining population health initiatives will be important, especially if these post-acute-providers offer clinically acceptable and less-expensive care alternatives to hospital beds and emergency departments</td>
</tr>
</tbody>
</table>
Payment innovation

To date, 65 Medicare ACOs are operating and the number is expected to double in the next year. Providers who wait too long to act may not be able to catch up with the infrastructure and experience needed to transition to these approaches. For example, one ACA program will reduce Medicare payment for unnecessarily high hospital readmissions beginning in October 2012. Providers also need to focus on consumerism and the patient experience to maximize reimbursement. Nearly one-third of quality measures in value-based purchasing are based on patient satisfaction, measured through the Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) survey. Meanwhile much of the ACO action will be seen in the private sector, where providers are forging creative new alliances. Consumers are also pushing this trend for integrated health systems. A recent HRI survey found nearly 75% of respondents indicated a preference for healthcare organizations that encompass a wide range of health related activities and services, viewing integration as a boon to quality and cost. This progression will accelerate now that the ACA has been upheld. But these new models require careful integration and planning. HRI analysis shows that Medicare ACOs may not realize a return on investment without sufficient physician alignment.

Physician alignment

New quality-focused delivery models will require better alignment among providers. Physicians have traditionally been independent of hospitals, but according to a recent HRI survey, 46% of doctors said they were interested in employment by hospitals. In fact, physician employment by hospitals increased 32% between 2000 and 2010, and the law is likely to accelerate this trend. Moreover, healthcare organizations will need to develop physician extender programs such as use of mobile, telehealth, and patient engagement.

Data analytics

Success in a world that pays for value instead of volume requires providers to prove their worth. Data and major investments in infrastructure are an important way to do that. At a minimum, these investments will require sophisticated information technology and datasharing systems but may also include partnering with or purchasing payers to gain actuarial services and patient population management systems. Ultimately, changes in reimbursement methodology from ACA coupled with private sector initiatives create more risk and rewards for hospitals and doctors.

The path forward—providers

Act
- Begin communication with state policy makers on options for Medicaid expansion.
- Formulate your day one communication plan on the ruling to employees and customers.
- Compete for newly insured patients by being aware of subtle market and competitors’ changes.
- Understand how to report on new quality measures.
- Use the most effective mix of clinicians to manage cost structure, balancing new Medicaid and privately insured patients.
- Use technology to enable better quality and more efficient care.
- Establish care coordination to hedge against readmission penalties and to better serve your patients.
- Continue physician alignment as a key strategy to improve quality and reduce expenses such as physician preference items.

Assess
- Investigate payer mix and opportunities for enhancement; make sure to model with and without state Medicaid expansion.
- Assess your digital strategy to successfully compete for patients in the new health care retail environment.
- Ensure your capability of managing populations of patients, including risks, to increase revenue.
- Explore partnership opportunities (including acquisitions and alliances) to fill capability gaps.
- Focus on EMR implementation to secure full meaningful use reimbursement.
- Prioritize quality measurement and programs or risk losing direct reimbursement through value-based purchasing (VBP) and/or community reputation.
- Assess your patient access and experience metrics to protect existing patient base.
- Assess your level of integration to meet rising consumer interest in integrated delivery networks.

Stop
- Stop the acute care centric model. Most new reimbursement models reward outcomes, not volume.
- Discontinue the ‘wait and see’ approach. Doing nothing puts you at a competitive disadvantage.
- Stop ignoring variation in clinical practice.
Pharmaceutical and Life Sciences

Among healthcare sectors, the pharmaceutical and life sciences industry will experience the least operational disruption from the law. Still, significant financial implications for the industry are at stake. Branded pharmaceuticals stand to lose about $155 billion over the next decade as a result of discounts in the Medicare Part D doughnut hole, increased Medicaid rebates, industry fees, and the establishment of a biosimilars regulatory approval pathway. Those losses are partially offset by a modest increase in sales from expanded insurance coverage of $15 billion, for a net loss of $140 billion (Figure 3).

The law’s financial implications for pharmaceutical companies vary by product portfolio and customer mix. A large drug company with a diverse portfolio of medications could experience financial losses equal to approximately 5% of US pharmaceutical sales. For medium-sized drugmakers with low government sales, the financial loss is estimated to be 1% of US pharmaceutical sales. Large generic manufacturers stand to gain 2% in revenues because new discount and rebate provisions are largely focused on branded pharmaceuticals. Finally, drugmakers with biologics-heavy portfolios may experience disproportionately negative impacts because of the introduction of biosimilars. The pipeline for biosimilars is building; 126 biosimilars were in development in 2011.

Under the law, eligible health organizations’ ability to receive drug discounts through the 340B program will remain in effect. In addition, eligible organizations can contract with multiple outside pharmacies. Thus, pharmaceutical manufacturers will still need to assess their margin exposure under the 340B program.

Pharmaceutical and medical device companies will have new developments to consider:

Re-evaluation of current product portfolio, pipeline, and development strategies should be considered in light of the newly insured and the projected impact on reimbursement. Companies may choose to fine-tune their marketing and sales approaches, with particular emphasis on the evolving

<table>
<thead>
<tr>
<th>Industry impact 2012–2021</th>
<th>$B</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total branded pharmaceutical revenues (in the absence of the ACA), 2012–2021</td>
<td>$3020</td>
<td></td>
</tr>
<tr>
<td>Less: Discounts in the Medicare Part D coverage gap$^9</td>
<td>($41)</td>
<td>(1.4%)</td>
</tr>
<tr>
<td>Less: Increased Medicaid rebates</td>
<td>($40)</td>
<td>(1.3%)</td>
</tr>
<tr>
<td>Less: Annual Industry fee</td>
<td>($31)</td>
<td>(1.0%)</td>
</tr>
<tr>
<td>Less: Biosimilars pathway</td>
<td>($43)</td>
<td>(1.4%)</td>
</tr>
<tr>
<td>Plus: Increased use from coverage expansion in under 65 population</td>
<td>$15</td>
<td>0.5%</td>
</tr>
<tr>
<td>Financial impact to pharmaceutical companies</td>
<td>($140)</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

Note: Numbers may not sum to total due to rounding

Source: PwC analysis of Congressional Budget Office and Center for Medicare and Medicaid Services reports; Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)
notion of outcomes-based payment and contracting. This will require detailed analytical modelling and a deep understanding of the shifting distribution of customer types and drug consumers’ evolving expectations.

**The 2.3% medical device excise tax**

The tax is expected to generate approximately $25.5 billion in federal revenues between 2012–2021 and significantly impact the financial profitability of smaller medical device firms. Determining the tax base for device products is a complex process. Like any additional cost, manufacturers must compensate through higher prices or efficiencies. The House of Representatives has proposed legislation that would overturn the excise tax.

**Structural changes in delivery of care**

Pharmaceutical firms must adjust their business models to an outcomes-based market, in which products must deliver clear clinical and economic value. For example, in an ACO, providers will be eligible for bonuses if they meet or exceed quality standards and generate cost savings. Insurers, too, are demanding cost- and clinical-effectiveness evidence before adding a medication to preferred formulary tiers.

Medical device and diagnostic makers face similar expectations. Drug manufacturers can be allies in these efforts, helping avoid expensive hospitalizations through the best and proper use of their therapeutic solutions.

**The Patient-Centered Outcomes Research Institute (PCORI)**

As findings from PCORI’s sponsored clinical effectiveness research appear, patients may benefit, while drugmakers, medical device companies, surgeons, and assorted other players must compete. Under the law, the institute will have about $500 million a year to distribute in research grants, adding force to the drive for proven value.

---

### The path forward—pharmaceutical and life sciences

| Act |  
|---|---|
| Monitor states’ decisions about whether to participate in the Medicaid expansion and adjust marketing resources and efforts accordingly. |  
| Quickly adjust your business models to include more concepts of value (cost and clinical effectiveness, ACOs, bundled payment schemes, and value-based purchasing). |  
| Continue annual industry fee payments. |  
| Maintain higher rebates and discounts, however begin to transition them over to outcomes-based payment discounts. |  
| Continue practices of physician payment transparency with increased compliance scrutiny. |  

| Assess |  
|---|---|
| Vigilantly track insurers’ and providers’ progress in implementing ACA. Opportunities abound for disrupting old thinking on the improvement of care quality and coordination. |  
| Develop and pilot data sharing collaborations, novel outcomes contracting, and population health initiatives with payers, pharmacy benefit managers, and providers. |  
| Account for variation in the volume and type of new covered lives at the state level, and focus your marketing and payer contracting resources appropriately in preparation for the increase in covered lives starting in 2014. |  
| Prepare for the start of the medical device excise tax in 2013, and think strategically about market positioning of devices to minimize impact. |  

| Stop |  
|---|---|
| Stop wait-and-see approach. |  

For more information, please refer to www.pwc.com/healthreform | Pharmaceutical and Life Sciences
Two central elements of health reform strongly affect states: health insurance exchanges and Medicaid expansion. The Court’s decision that states cannot be penalized for not participating in Medicaid will put more decisions in the states’ hands. To date, more than $1 billion in grants has been allocated to support state exchange readiness, and the Medicaid expansion is expected to increase the federal deficit by $642 billion from 2012-2022. With 25 million individuals anticipated to buy insurance from the exchanges and 11 million people enrolling in Medicaid by 2021, the two provisions are heightening activity in states. New enrollment in exchanges and Medicaid will generate increased need for insurance market regulation to protect against adverse selection, provide consumers with greater access, and ensure that premium dollars are spent on healthcare.

HRI analysis shows that so far, 31% of states (15 states plus D.C.) have made significant progress toward reform, while 37% (19 states) have made moderate progress. The remaining 31% (16 states) have done less to implement the law. (See Figure 4.)

Figure 4: State progress on ACA-related health reform

Key
High-progress states ▲ Moderate-progress states ▲ Low-progress states ▼

▲*Plans to establish a partnership exchange

Progress was measured by state health insurance exchange establishment, Medicaid and/or waiver coverage of childless adults, and early market reform activity.

Sources: Kaiser Family Foundation, Commonwealth Fund, and PwC Health Research Institute Analysis.
(Updated August 2012)
Defining state responsiveness to reform

HRI has identified three types of states based on their progress under the ACA: high progress, moderate progress, and low progress. Progress was measured by three factors: health insurance exchange establishment, Medicaid coverage of non-disabled childless adults, and early market reform activity.29 State exchange establishment determined the progress level, while Medicaid/waiver coverage and early market reform activity served as differentiators within each level.

Deadlines loom for health insurance exchanges

To meet expectations, states should push for better collaboration and information transfers between states.

High-progress states should continue building their operational infrastructures and determine which rules could help in successful implementation—direct and indirect. Moderate-progress and low-progress states should learn best practices from high-progress states in designing and implementing exchanges. One example of a leading practice is the New England States Collaborative for Insurance Exchange Systems, a Massachusetts-based initiative that provides technology support for New England states and others to operate exchanges.39 Low-progress states must also decide the level of federal involvement in exchange-planning.

Major turnover in Medicaid

Based on the Court’s ruling, states have three main paths to take on Medicaid:

- Choose to expand Medicaid eligibility to 133% of FPL and receive federal matching dollars to cover new lives.
- Forgo expansion without penalty.
- Develop their own Medicaid expansion through waivers.

High-progress and most moderate-progress states will likely move forward with Medicaid expansion. Low-progress states however will carefully evaluate the costs and benefits of an expansion, and some may choose to forgo Medicaid expansion and retain current eligibility levels and federal matching rates.

State snapshots

California was the first state to establish an exchange via legislation after passage of the ACA and started phasing in expanded Medicaid coverage to previously ineligible adults.30,31 The state has passed a number of market reforms, including preexisting condition exclusions and prohibition of lifetime coverage limits.32

Minnesota has made moderate progress. It has expanded Medicaid coverage to childless adults, created a task force to develop a plan for delivery and payment system reforms, and passed some insurance market reforms,35 including dependent coverage to age 26.34 The state has not yet implemented an exchange—and bills to establish an exchange have failed in the legislature. However, a task force has been established to move forward with implementation.35

Alaska has had slower progress in implementing health reform. After the Supreme Court’s ACA ruling, the Governor indicated that Alaska will not implement a state-run exchange. Alaska has neither passed any significant market reforms to date nor expanded Medicaid coverage for childless adults.36,37,38
As the ACA stands, cost sharing and premium subsidies are available to individuals with incomes between 100% and 400% FPL. This ruling creates a potential insurance gap in states where Medicaid eligibility caps are below 100% FPL and they decide not to expand Medicaid. For example, Texas with a 12% FPL and Florida with a 20% FPL limit, could leave millions uninsured if they forgo Medicaid expansion to 133% FPL.

In addition to meeting infrastructure requirements for the 11 million estimated Medicaid enrollees, states need to create environments where consumers and their family members are aware of all eligibility requirements and know how to navigate the system. Assuming all states participate in the Medicaid expansion, about 38% of individuals will move in and out of Medicaid and exchange eligibility four or more times between 2014 and 2018. Only 19% are expected to be continuously eligible. This constant shift, known as churn, could drive up costs and disrupt continuity of care. States can prepare for this. For example, Virginia passed Medicaid reforms that include care coordination expansion, program integrity efforts, electronic health records systems, and eligibility system improvements.

Most states have Medicaid managed care plans. There are two types of plans: (1) the popular, risk-based programs, in which states contract out to managed care organizations, and (2) primary care case management, in which states contract directly with primary care providers. Many states have awarded these contracts to Medicaid-only plans, but commercial insurers are chasing managed care Medicaid contracts too.

Medicaid ACOs, which got their start as pediatric ACO demonstrations, also present an option for states. Colorado—currently the only operational Medicaid ACO—started with 60,000 beneficiaries and had to quickly double that number to increase its ability to produce financial savings. Others, such as Oregon and Utah, expect to open Medicaid ACOs later this year.

### The path forward—states

<table>
<thead>
<tr>
<th>Act</th>
<th>Moderate-progress states</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Decide the level of federal involvement in exchange-planning activities:</td>
</tr>
<tr>
<td></td>
<td>- Apply for federal exchange funding or</td>
</tr>
<tr>
<td></td>
<td>- Gear up to participate in the Federally Facilitated Exchange</td>
</tr>
<tr>
<td>Assess</td>
<td>Low-progress states</td>
</tr>
<tr>
<td></td>
<td>Confirm participation in the Federally Facilitated Exchange, or change course.</td>
</tr>
<tr>
<td>Stop</td>
<td>Moderate- and low-progress states</td>
</tr>
<tr>
<td></td>
<td>Stop taking a wait-and-see approach to health reform implementation.</td>
</tr>
</tbody>
</table>
Employers

One of the fundamental premises of the ACA is that employers should continue to provide healthcare coverage for their employees. Many uninsured Americans will gain coverage through the Medicaid expansion and the state-based exchanges, but the 56% of Americans who are currently covered under employer-sponsored group health plans are expected and encouraged to keep that coverage, with modifications. Employers maintaining group health plans have been adapting to ACA requirements since 2010.

Never before required by the federal government to provide coverage, all but the smallest companies will pay a penalty beginning in 2014 unless they provide affordable minimum coverage for every employee working at least 30 hours a week. In some cases, employers may decide to drop coverage and leave the healthcare market, helping their employees obtain coverage on the exchanges—despite the ACA penalties for doing so. Some may offer coverage but recognize that coverage may not be deemed affordable for all of their employees; they will pay a penalty for any employee who obtains subsidized coverage in the state exchanges. In still other cases, the incentives to establish a plan for the first time may persuade small employers that have never provided healthcare to enter the group health plan market.

For most large employers, however, providing healthcare for their employees and employees’ families will remain one of the largest and most important costs of doing business. Companies that stay in the healthcare market will retain responsibility for managing costs and will deploy strategies that emphasize greater consumerism and more personal responsibility for health and wellness.

Employers that provide coverage face new rules

While dealing with these fundamental questions, plan sponsors must also implement requirements coming due this year and next. For example, plan sponsors must report the value of healthcare on employees’ 2012 W-2 forms, facilitate any insured plan’s MLR rebates, and provide summaries of benefits and coverage for plan years beginning on and after September 23, 2012. Contributions to healthcare flexible spending accounts must be limited to $2,500 next year, and group health plans must pay a per-participant fee for comparative effectiveness research.

Figure 5: ACA compliance timeline

<table>
<thead>
<tr>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer reports value of health benefits on W-2.</td>
<td>$2,500 maximum contribution to Healthcare flexible spending accounts (FSA).</td>
<td>No waiting periods greater than 90 days.</td>
<td>Exchange may be available to large employers (&gt;100 employees; available to small employers in 2014).</td>
<td>40% excise tax on high-cost plans.</td>
</tr>
<tr>
<td>Per-employee fee for comparative effectiveness.</td>
<td>New Medicare surtaxes on highly compensated employees.</td>
<td>Auto-enroll employees in plan (awaiting regulations).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employee notice required regarding availability of exchanges.</td>
<td>Guaranteed issue, no pre-existing condition exclusions, no annual limits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide summary of benefits and coverage to employees; and provide summary of benefits and coverage 60 days in advance.</td>
<td>Individual mandate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No discrimination in insured plans (awaiting regulations).</td>
<td>Employer mandate; penalties for failure to provide coverage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhanced Wellness incentives (e.g., 30% of employee-only premium.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maximum out-of-pocket limits (consistent with HSA-compatible OOP limits) for non-grandfathered plans.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Report plan design, coverage, monthly enrollment.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For more information, please refer to www.pwc.com/healthreform | 11
Other requirements, such as automatic enrollment of new employees and non-discrimination rules, will become effective when regulations have been issued. Companies that provide retiree health insurance are expected to continue exploring ways of mitigating the ACA change in the taxability of the retiree drug subsidy, for example by adopting employer group waiver programs.

**Compliance is key**

In the coming months and years, compliance will be critical for employers that decide to “play,” as well as for those that decide to “pay.” All employers must provide information to the state exchanges so that their employees’ eligibility for subsidized coverage can be documented. All employers will have to notify employees of the existence of the state exchanges and will have to (1) provide summaries of benefits and coverage under any plans they offer, and (2) report the value of such plans on W-2 forms.

<table>
<thead>
<tr>
<th>The path forward—employers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Act</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Assess</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Stop</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Conclusion

Although the Affordable Care Act will certainly face continued challenges, for now it remains the law of the land. The ruling by the Supreme Court provides energy and legal authority to the federal government’s efforts to refashion the US health system. Implementation—from new mandates and taxes, to coverage expansions and purchasing subsidies—continues for the foreseeable future.

Yet the Court ruling and the ACA tell only part of the story. Equally if not more important, are the market-driven changes taking place across the healthcare landscape. Sophisticated data, social media, price transparency and more discerning consumers are fueling the move away from traditional fee-for-service medicine that pays for volume. As a result, industry leaders are promoting value-based approaches that drive improved health outcomes. Like other industries that have undergone dramatic transformation, the healthcare sector will continue to consolidate and see an influx of new players. Some existing businesses will have difficulty adapting; new ones will threaten the status quo.

Even with the fits and starts certain to come, there is great opportunity in a system that consumes one-fifth of the US economy. Fundamentally, change—fast and frenetic—has become routine in American healthcare.

Resources

For additional information on HRI, please refer to the following links:

From courtship to marriage: A two-part series on physician-hospital alignment (www.pwc.com/us/courtshiptomarriage)

Change the channel: Health insurance exchanges expand choice and competition (www.pwc.com/us/HIX)

The future of the academic medical center: Strategies to avoid a margin meltdown (www.pwc.com/us/AMCfuture)

Putting patients into “meaningful use” (www.pwc.com/us/patientsMU)

Unleashing value: The changing payment landscape for the US pharmaceutical industry (www.pwc.com/us/pharmavalue)
PwC Health Research Institute | Implications of the US Supreme Court ruling on healthcare

PwC analysis: This figure represents an updated market number from the Health Research Institute “Change the Channel” publication based on CBO’s 2012 projections. Per capita premium calculations are based on 2011 Kaiser Family Foundation small-firm premiums of $5,328 for single coverage and $14,098 for family coverage. The premiums were combined with the typical single and family proportions and divided by the number of people per plan to produce a small-group per capita premium of $4,475. A growth rate of 6.5% was applied to the 2011 per capita premium of $4,475 to get approximately $8,400 in 2021. Individual per capita premiums are estimated to be $6,720 in 2021. The individual-market per capita premiums are about 20% lower than employer premiums based on CBO projections of the typical cost of an employer family plan in comparison to the second—lowest-cost silver plan on the state exchanges in 2016. These premiums were multiplied by the number of projected CBO enrollees in the business exchange and individual exchange markets to generate the approximate market calculations of $190 billion in 2021. Premium revenues flowing through the exchanges could be larger or smaller than PwC estimates depending on such factors as individual-mandate effectiveness and employer enrollment decisions. Exchange subsidies and related spending includes spending for high-risk pools, premium review activities, loans to co-op plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustment and transitional reinsurance.

End notes

5 Ibid.
9 CBO, “CBO and JCT’s Estimates of the Insurance Coverage Provisions of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance,” March 2012; http://cbo.gov/publication/43082. Accessed June 2012. Workers will be able to obtain subsidies in the exchanges or get coverage from Medicaid, and small firms will not be penalized for not offering coverage.
16 PwC Health Research Institute, Medicare ACOs and Shared Savings Models,” 2011.
17 PwC Health Research Institute, “From Courtship to Marriage,” 2011.
19 Includes increased revenues from closing the Part D doughnut hole.
21 PwC Analysis.
22 PwC analysis of Congressional Budget Office and Center for Medicare and Medicaid Services reports; Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)
41 Ibid.
Implications of the Supreme Court ruling on healthcare is an analysis of the Supreme Court’s decision on the Patient Protection and Affordable Care Act performed by PwC’s Health Research Institute (HRI). HRI interviewed PwC subject matter experts as well as industry and association leaders regarding the implications of the decision for insurers, providers, pharmaceutical and life sciences companies, states, and employers. HRI also performed extensive research of literature regarding the implications of the decision for each of these sectors. HRI performed a financial and demographic analysis of publicly available information including Congressional Budget Office data.

PwC’s Health Research Institute provides new intelligence, perspectives, and analysis on trends affecting all health-related industries. The Health Research Institute helps executive decision makers navigate change through primary research and collaborative exchange. Our views are shaped by a network of professionals with executive and day-to-day experience in the health industry. HRI research is independent and not sponsored by businesses, government or other institutions.

Kelly Barnes
Partner
Health Industries Leader
kelly.a.barnes@us.pwc.com
(214) 754 5172

David Chin, MD
Principal (retired)
david.chin@us.pwc.com
(617) 530 4381

Ceci Connolly
HRI Managing Director
ceci.connolly@us.pwc.com
(202) 312 7910

Sandy Lutz
Managing Editor
sandy.lutz@us.pwc.com
(214) 754 5434

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

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

Christopher Khoury
Senior Manager
christopher.m.khoury@us.pwc.com
(202) 312 7954

Tiffany Bredeson
Manager
tiffany.bredeson@us.pwc.com
(612) 596 6417

Alison Kempa
Research Analyst
alison.kempa@us.pwc.com
(703) 610 7481

Caitlin Sweany
Research Analyst
caitlin.sweany@us.pwc.com
(415) 498 7902

Emily Korval
Research Analyst
emily.b.korval@us.pwc.com
(646) 471 6539

Ingrid Grygiel
Research Analyst
ingrid.k.grygiel@us.pwc.com
(720) 931 7566

Jack Rodgers, PhD
Managing Director, Health Policy Economics
jack.rodders@us.pwc.com
(202) 414 1646

Kristen Soderberg
Manager, Health Policy Economics
kristen.a.soderberg@us.pwc.com
(202) 346 5143

Anne Waidmann
Director, Human Resource Services
birgit.a.waidmann@us.pwc.com
(202) 414 1858

Advisory team
Paula Adler
Roslyn G. Brooks
Peter B. Davidson
Elizabeth Dignan
Robert C. Dondero
Todd D. Evans
Kulleni Gebreyes
Jeffrey Gitlin
James L. Gunsior
Sandra S. Hunt
Adiba Khan
Scott Latimer
Steven J. Luber
Susan Maerki
Gus H. Mutscher
Joseph Palo
Warren H. Skea
Shannon Smith
Ross E. Stromberg
Jason Stromberg
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  
(214) 754 5172

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

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

Michael Swanick  
Partner, Pharmaceutical & Life Sciences Leader  
michael.f.swanick@us.pwc.com  
(267) 330 6060

Michael Thompson  
Principal, Human Resource Services  
michael.thompson@us.pwc.com  
(646) 471 0720

Ceci Connolly  
Managing Director, Health Research Institute  
ceci.connolly@us.pwc.com  
(202) 312 7910