

Top health industry issues of 2013

Picking up the pace on health reform

January 2013

Health Research Institute

At a glance

The pace of transformation in the health industry is certain to quicken in 2013 with the effects of technology, consumerism, budgetary pressures and the Affordable Care Act converging on a sector that represents nearly one-fifth of the economy.

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Introduction

It is almost a cliché to observe that healthcare in America is changing rapidly. Yet the pace of the transformation is certain to quicken in 2013 with the effects of technology, consumerism, budgetary pressures and the Affordable Care Act (ACA) converging on a sector that represents nearly one-fifth of the economy.

An industry that had grown accustomed to uncertainty now has a clearer picture of its future. And that future includes full implementation of the reform law, declining federal reimbursement rates, new taxes, and an influx of tens of millions of new customers who bring dollars—and unique challenges—into a fragmented system of care.

Much of the action in 2013 moves to the states, under pressure to expand their Medicaid programs and ensure that new insurance marketplaces known as exchanges suit their constituents. Employers too face fundamental decisions as many rethink their role in healthcare.

At the center of it all is a customer base that is not only growing in size but in influence. The focus is no longer on patients, but consumers, who are demanding the speed, convenience, transparency and results they get in other service industries.

A consumer survey conducted by PwC's Health Research Institute (HRI) in late 2012 found that over 50% of Americans think the biggest obstacle to improving our health system is politics.¹ Respondents identified cost as the second obstacle.

A separate HRI post-election survey showed that voters think the best way to reduce costs is to trim payments to doctors and hospitals, and reduce investment in health information technology.² Those are warning bells that the push for value is now coming directly from consumers. And even high-value companies need to do a better job of proving and articulating their worth.

For this year's Top Health Industry Issues, HRI polled 1,000 consumers about a range of healthcare topics.³ Key findings include:

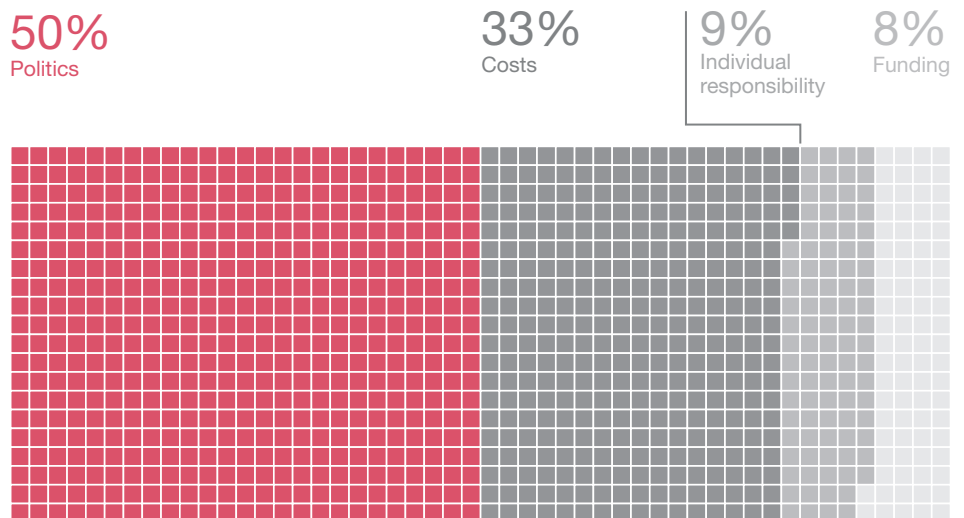
- **Digital communication is gaining traction.** More than a quarter of consumers have had caregivers use email or text messages to communicate with them, with most satisfied with the experience.

- **Concerns about data privacy remain, as access to medical data expands.** Seventy-three percent of customers are either very or somewhat concerned about the privacy of their medical information if providers were able to access it on their mobile devices.
- **There's more evidence on the impact of social media on healthcare.** More than half of consumers read reviews of healthcare providers online, with doctors and hospitals being the most viewed; this is heavily driven by younger consumers.
- **Americans view doctors as the best hope for the nation's health system.** Almost 60% of respondents ranked physicians as first, second or third in terms of their ability to improve the nation's health system—ahead of government, consumer groups, hospitals, insurance companies, employers or pharmaceutical companies.
- **Consumers are warming up to new ways of purchasing insurance.** Individuals are more likely to buy insurance from non-traditional sources such as a retail store than they were in 2011, increasing from 18% to 23%.

- **Knowledge gaps exist about exchanges.** Though health insurance exchanges have been a major topic among industry executives and regulators, one-third of consumers don't know enough about the new marketplaces to assess whether they will make it easier to find and purchase coverage.
- **Skepticism about the value of mergers and acquisitions is rising.** Forty-seven percent of consumers surveyed believe costs would increase if their local hospital was acquired and 56% would expect quality to remain stagnant, up from 31% and 22% respectively in 2011.

For the health sector, 2013 offers enormous opportunities. Providers, insurers and life sciences companies have one year to target and capture a large new market of paying customers. New bonus payments await the innovators, while financial penalties will squeeze other players. Success in 2014 will come to those who use 2013 wisely. This year's Top Issues report—informed by new consumer research and dozens of interviews with policymakers and industry executives—offers a roadmap for navigating the reconfigured business environment.

Figure 1: What is the biggest obstacle to making the US health system better?



Source: PwC Health Research Institute

States on the frontlines of ACA implementation

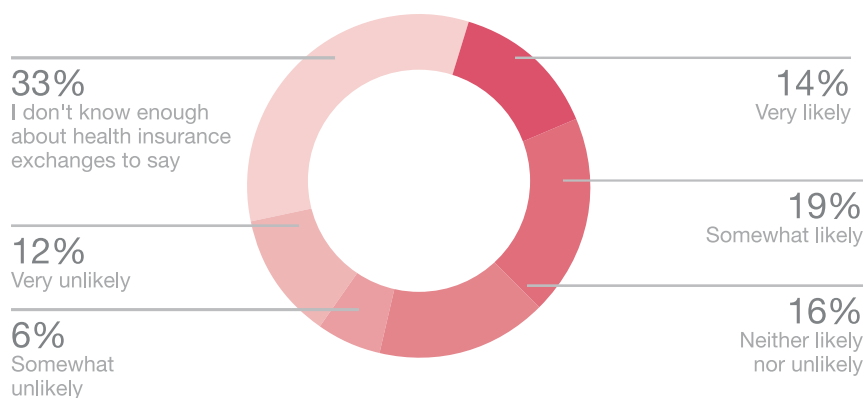
After nearly three years of polarized anticipation, the Affordable Care Act's (ACA) cornerstone healthcare coverage provisions now become reality. In 2013 the spotlight shifts to the states. Building up to 2014, when the major provisions of the law take effect, state officials must make a series of decisions about how—or if—to run their own insurance exchanges, whether to expand Medicaid coverage, and what type of insurance market regulation is needed. Tabling these decisions is not an option; where states are unable to, or choose not to, implement reforms, the federal government will step in.

States were to submit plans for state-based insurance marketplaces, known as exchanges, in December 2012, and blueprints for partnership exchanges are due in February 2013. In October 2013, an open enrollment period will kick-start the exchanges, drawing millions of people who were previously uninsured—and putting pressure on states to aid consumers in selecting coverage and determining subsidy eligibility.

State decisions about whether to expand Medicaid to 138 % of the federal poverty level (FPL), about \$15,400 for an individual, will have a direct impact on the exchanges.¹ In states that choose not to expand, some individuals who would have been eligible for Medicaid will instead receive subsidies to buy insurance through the exchanges (those with income between 100% and 138% of the FPL). Subsidies will boost exchange participation, but states and industry alike know from experience how challenging it can be to enroll new populations.

About 30 million Americans are expected to gain coverage under the ACA through Medicaid, exchanges, and employer-sponsored coverage. However, the newly insured are likely to be significantly poorer, less educated, less likely to be employed full time, and more ethnically diverse than those who are currently insured, according to demographic analysis by PwC's Health Research Institute (HRI).² States and healthcare companies must anticipate the needs of this population and devise strategies to engage and educate them. A recent HRI consumer survey indicates that

Figure 2: Do you think health insurance exchanges will make it easier for you to find and purchase a competitive health insurance plan?



Source: PwC Health Research Institute Consumer Survey, 2012

just a third of consumers believe exchanges will make shopping for coverage easier, while the same number say they don't have enough information (see Figure 2).

Guidance released by the federal government in November 2012 notes that states will oversee risk pools, develop their own effective rate review programs, establish open enrollment periods, and have a hand in certifying qualified health plans.³ States will also have flexibility to define essential community providers.⁴

The biggest challenge facing the states in 2013 is information technology. Many are overhauling their existing Medicaid eligibility systems and designing an exchange infrastructure to create a single, seamless entry point. Even states not expanding Medicaid or running their own exchanges must conduct significant upgrades to existing systems.⁵

Implications

- State exchange leaders should involve stakeholders and conduct thorough research on consumer needs, then design targeted outreach and education programs using many communication channels. For example, Colorado is

partnering with statewide organizations to conduct focus groups and has used social media, including blogging and Twitter, to reach potential participants. Colorado also plans to engage “trusted faces” to educate its citizens about the exchange.⁶

- States should creatively and efficiently build IT capabilities by partnering with other states, using commercial off-the-shelf systems, optimizing existing technical components, and/or engaging contractors with detailed expertise in systems integration. Some are relying, at least temporarily, on the federal government's infrastructure currently under development.
- Healthcare companies should get to know their new customer base and be prepared to deal with distinctive challenges, such as language barriers and frequent movement between exchange plans and Medicaid.
- Healthcare companies should closely monitor how states are interpreting new rules and regulations, and stay in close communication with state officials as they build their regulatory capacity.

Caring for the nation's most vulnerable: dual eligibles

Dual eligibles—individuals who qualify for both Medicare and Medicaid coverage—are among the nation's sickest and poorest. Many have multiple chronic conditions and more than half have annual incomes of less than \$10,000.¹ "Duals" often fall through the cracks of two programs that were not designed to work together. This lack of coordination often leads to poor quality, inefficiency, and avoidable costs.

Cash-strapped state Medicaid programs report that projected long-term costs for this population are not sustainable. Some researchers say shifting dual eligibles to managed care plans or care coordination programs could save up to \$20 billion a year.² But it will be an adjustment for patients accustomed to fee-for-service medicine in the traditional Medicare program.

With the aging of the baby boomers, the number of today's approximately 9 million duals will steadily increase, and so will the cost of caring for them. Spending on duals reached nearly \$320 billion in 2011, accounting for 39% of total Medicaid and 31% of total Medicare spending.^{3,4} Federal spending on duals is projected to reach \$3.7 trillion during the next decade.⁵ To manage the cost, the Centers for Medicare and Medicaid Services (CMS) is seeking health plans willing to take on financial risk through capitated managed care plans. Several states also intend to test a managed fee-for-service financial alignment model.

In the CMS Program of All-Inclusive Care for the Elderly, managed care providers receive capped payments to cover

medical and related services for duals. An interdisciplinary team coordinates care, enabling many duals to receive care at home. In place for over a decade, the program has reduced hospitalization rates and improved care coordination but has yet to demonstrate savings, since capitated payments have exceeded the amount Medicare would have spent on fee-for-service.⁶

In 2011, CMS announced a three-year demonstration project that covers two million duals. Of the 26 state proposals, 18 proposed a capitated model paying a combined, risk-adjusted, per-member, per-month amount.⁷ The first demonstrations begin in April 2013, in Massachusetts with a capitated approach, and in Washington with a managed fee-for-service model.^{8,9}

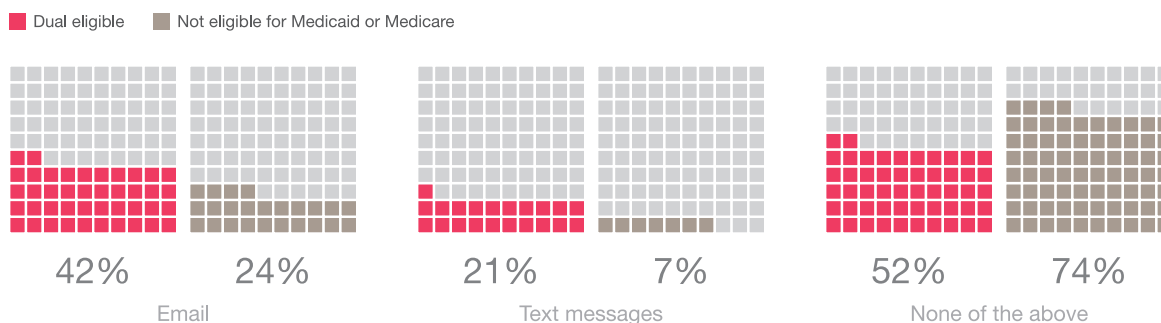
Implications

- In assuming risk for duals, managed care organizations should carefully consider the cost effectiveness of current operations and how they can refashion care delivery to better manage costs.
- While managed care may be familiar to Medicaid beneficiaries, Medicare beneficiaries historically have had freedom of choice in providers. With so many in Medicare fee-for-service, the adjustment to managed care may be difficult.
- Some duals may be receptive to using digital communication for diabetes maintenance, weight management, disease management, and chronic care

programs. A PwC's Health Research Institute (HRI) internet survey of a subset of duals found they are more likely than other consumers to use social media for healthcare purposes (63% compared with 40%). Also, 42% of duals have communicated with a caregiver via email and nearly one-quarter via text (see Figure 3). Twenty percent of duals have healthcare apps on a mobile device, compared with 12% of non-duals.¹⁰

- Plans and providers should fill education and awareness gaps to improve areas such as medication adherence. The HRI survey found that 53% of duals have participated in a prescription assistance program in which they can take advantage of free samples, discount cards, and coupons.
- States and insurers should track progress of demonstrations on reimbursement versus medical cost trends, unique contracting mechanisms between managed care and providers, care management program efficacy, and effective coordination of clinical and non-clinical services such as transportation, meal service, and in-home assistance.
- With long-term care support services accounting for 70% of state Medicaid spending on duals, plans deciding to increase those offerings must determine the most cost effective structure such as in-house coordination and referral services, partnering with state, county, and community organizations, or outsourcing to a specialty provider.¹¹

Figure 3: Have you and a doctor, nurse, or other caregiver ever communicated in the following ways about a health question you had (Dual eligibles vs. all other consumers)?



Source: PwC Health Research Institute Consumer Survey, 2012

Bigger than benefits: employers rethink their role in healthcare

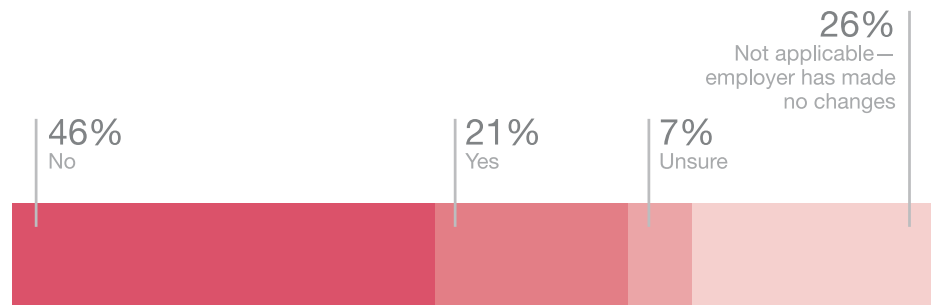
Healthcare and employers—inseparable? Maybe not. With the Supreme Court ruling to uphold the Affordable Care Act (ACA) and the president’s re-election, employers have never had a better opportunity to re-examine their long term role in providing healthcare coverage. The year 2013 will likely be the turning point for the evolution of healthcare benefits over the next decade.

For almost 70 years, employer-based coverage has been a cornerstone of US healthcare. A result of wage-price controls dating back to World War II and favorable tax treatment ever since, healthcare benefits are a core component to attracting and retaining talent. But once seen as a tax-efficient way to reward employees, healthcare costs are now infringing on many corporations’ efforts to compete globally.

Healthcare costs now rank second or third to wage costs. The median employer share of payroll going toward health insurance costs was 12.8% in 2010, up from 8.2% in 1999.¹ Many employers are concerned about the financial impact of new mandates, taxes (including the 40% “Cadillac” excise tax on high cost plans starting in 2018), and administrative challenges brought forth by the ACA. And, with healthcare entitlements center stage in the ongoing budget debates at both the state and federal levels, employers are concerned that cost-shifting from these programs will only accelerate in the future.

Until now, an individual insurance market seen by many as dysfunctional has left employers no choice but to continue offering coverage, even with the rising cost. But a number of provisions of the ACA, such as guaranteed coverage, elimination of pre-existing condition exclusions, and government subsidies for the poor and many in the middle class, have strengthened access and affordability for those without employer-based coverage. Now employers are beginning to consider the new state exchanges as a potential safety net for employees or retirees and are looking at private exchanges as alternatives to the status quo.

Figure 4: Have you changed your behavior as a result of changes your employer made in benefit offerings or wellness programs?



Source: PwC Health Research Institute Consumer Survey, 2012

In 2013, corporate leaders will embark on “pay or play” financial analyses and many will ask tough questions such as why they focus so many resources on something that is not core to the business. Some employers may decide to transition out of healthcare altogether: a recent third-party survey found that only 23% of employers are very confident that their organization will offer healthcare benefits a decade from now, compared with 73% in 2007.²

Others will elect to move toward a defined contribution approach, similar to 401(k) retirement plans, with the exchanges. Still others will double down on their efforts, both individually and collectively, to bend the cost curve through consumer-driven healthcare, wellness programs, and new efforts related to delivery and payment reforms. However, this will not be easy. The PwC Health Research Institute’s consumer survey found that only 21% of consumers have changed their behavior as a result of their employer changing benefit offerings or wellness programs (see Figure 4).³

Implications

- Employers must determine their future role in healthcare and develop a transition strategy to support it, whether they transition out, move to private exchanges with defined contributions, or change their practices for covering certain classes.
- Insurers and providers should anticipate a changing insurance marketplace where employers increasingly participate in and defer to organized health insurance marketplaces, such as public and private exchanges.
- New delivery systems (e.g., accountable care organizations) should engage leading employers and employer coalitions to become partners to deliver improved value and enhance employee population health and productivity.
- Employers should stay in close communication with policy makers as they make technical corrections to the ACA, including the healthcare benefits tax exclusion, and tackle ongoing issues with the federal budget.

Consumer revolution in health coverage

Health insurance is about to witness a consumer revolution. Promises of Amazon-style online experiences for individuals shopping for health insurance will be put to the test in 2013, when 12 million people are expected to enroll in insurance exchanges.¹

In actuality, this revolution is more like an evolution. The 18% rise in high-deductible plans from 2011 to 2012 has pushed more consumers to feel the financial pinch.² Consumers are also demanding a greater say in how they spend their healthcare dollars, and that, along with the development of state insurance exchanges, is prompting the industry to compete differently. Healthcare consumers can expect to see a shift in the marketplace as insurers borrow three key practices from the retail industry.

Convenience

Nearly 40% of consumers surveyed by PwC's Health Research Institute (HRI) said they would purchase insurance at a private insurance company retail store³ (see Figure 5). Insurers such as Florida Blue and Highmark have opened shops to supplement their online presence.^{4,5} From a consumer perspective, buying health insurance—and perhaps participating in wellness programs—at the local shopping center is very convenient. PwC's national Experience Radar survey found that 40% of retail consumers want shopping options, whether it's online, via phone or in stores.⁶

Insurers are also partnering with retailers to bring healthcare products to where the consumer is. Costco, for example, which sells health insurance for small businesses in some states, recently began offering store members a choice of individual health plans through Aetna.⁷

Transparency

Consumers have trouble assigning an accurate value to their insurance; in fact, an HRI consumer survey found that nearly one-third overvalued their individual coverage by more than 65%.⁸ As consumers begin enrolling in the exchanges in October 2013, expect them to demand clear, simple information on prices, provider networks, and quality.

A recent HRI survey found that in addition to an easy-to-use website, 72% of consumers want a cost comparison tool to select insurance and 64% value products that match their needs and preferences.⁹ States are responding to transparency demands with such efforts as Enroll UX 2014, a public-private partnership that has designed a prototype online site for state exchanges.¹⁰

Customer insights

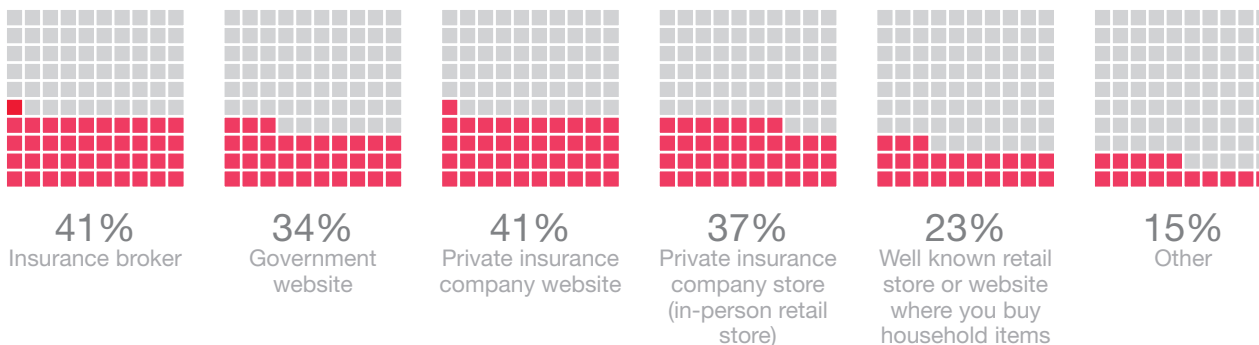
Retailers tap analytics on consumer buying patterns to stock shelves, create targeted advertising and build customer loyalty. Insurers such as Blue Cross and Blue Shield of North Carolina (BCBSNC) are

investing in data analytics to personalize care management through targeted messaging. For example, predictive data will be used to identify the best methods for communicating with members about preventive care options, such as flu shots.¹¹ The data would also allow BCBSNC to identify diabetic members who prefer more self-care resources versus those who want more direct counseling.¹²

Implications

- Consumer expectations for flexibility and transparency should spur insurers and employers to offer intuitive navigation assistance and better comparison shopping tools.
- As the retail convenience of coverage grows, providers can also expect to see a continued increase in the use of retail clinics as consumers seek lower cost options for minor ailments. Consumer use of retail clinics rose from 9.7% in 2007 to 24% in 2012 according to HRI consumer research.
- With price-sensitive customers and a competitive generic drug market, pharmaceutical companies can enhance brand loyalty through patient assistance programs such as drug discount and coupon programs.

Figure 5: How likely are you to buy insurance from the following?



Source: PwC Health Research Institute Consumer Survey, 2012

Customer ratings hit the pocketbooks of healthcare companies

The consumer experience matters to healthcare businesses, especially with its connection to financial penalties and bonuses. Private insurers who cover Medicare members were eligible for more than \$3 billion in bonus payments in 2012 based on quality ratings.¹ The program, known as the Medicare Advantage Five-star Quality Rating system, relies on consumer input for nearly half of its quality measures.²

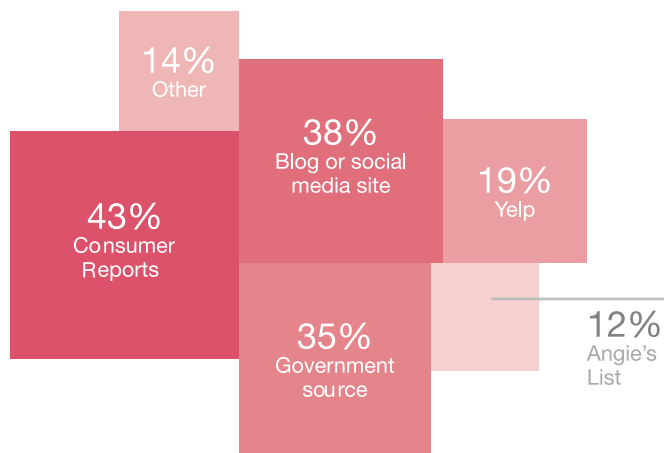
Hospitals and health systems are feeling the pinch as nearly one-third of the federal government's value payment program connects to consumer experience and satisfaction. About \$850 million, or 1% of total reimbursement in 2013, could be held back as a part of the federal government's Hospital Value-based Purchasing program.³

Customers support these effects. About half of consumers surveyed by PwC's Health Research Institute said that customer feedback should affect payments to healthcare organizations. Nearly 70% of consumers have used reviews to make healthcare decisions related to their doctor, hospital, insurance company or pharmacy. And more than 60% said that a hospital's quality of care affects their healthcare decisions.⁴

More consumers have read reviews on Consumer Reports and blogs, but consumers are also discovering government-sponsored websites such as the Centers for Medicare and Medicaid Services and the National Committee for Quality Assurance (see Figure 6).

One way providers are improving the patient experience is through the patient-centered medical home, which uses the primary care physician as a central point of coordination across the care continuum. All 50 states have medical home efforts, with 44 passing 300+ related laws, and more than 38,000 physicians affiliated with medical homes, an eight-fold increase in the past five years.⁵ Patients in medical home practices reported higher satisfaction with care, access to care, interpersonal experience, technical quality and communication.⁶ Success has been attributed to the reduction in bureaucracy, consistency in care, and providing one easy hub for patient health discussions.⁷

Figure 6: Where have you read customer reviews of healthcare companies?



Source: PwC Health Research Institute Consumer Survey, 2011, 2012

Healthcare organizations are already using positive quality scores as marketing tools. Nearly 40% of Medicare Advantage members are currently served by four to five star health plans, which are the highest ratings available under the bonus program, and the plans with high customer satisfaction scores have increased by 20% over the last year.⁸ The industry recognizes the importance of addressing negative customer input as well. Many companies are taking advantage of social media to address a consumer issue either immediately online or via a follow-up phone call. Nearly 70% of consumers surveyed expected a response to complaints within a day, while 40% expected it within a few hours.⁹

Implications

- As healthcare companies develop new ways to raise their quality scores through improved consumer service, they need to consider how consumers use and contribute to the increasing amount of quality data.
- Providers and insurers should educate consumers on quality metrics and how to interpret and use the scores. This can be done by training call center

representatives and posting online messages during customer service inquiries. Healthcare companies should use all consumer touch points where education could be relevant.

- Moving beyond surveys and using consumer research to get a more complete picture of consumers and their health needs will be a differentiator. Safety net hospitals are particularly vulnerable, given their history of lower patient experience scores.¹⁰ (See issue on "Consumer revolution in health coverage" on page 7)
- Establishing a well-integrated and thoughtful consumer program that ties in with business needs will be more important than ever. Insurers and providers have shifted hiring practices to include individuals with the skills and talents to connect with consumers and understand how to collect and use customer data. Chief experience officers have become increasingly popular in the health sector, with one in ten hospitals giving accountability for the customer experience to a senior member of the leadership team.

Goodbye cost reduction, hello transformation

With reimbursement ready to reset under the Affordable Care Act (ACA) and in light of the ongoing federal budget debate, hospitals are scrambling to reduce costs even further. And, with more than 40% of consumers postponing care because of costs, hospitals must be competitive (see Figure 7).¹ The traditional low hanging fruit savings of labor productivity and supply cost reductions have largely been picked over. Healthcare companies must instead embark on full-scale transformation efforts to redesign how they deliver care.

Retooling labor management

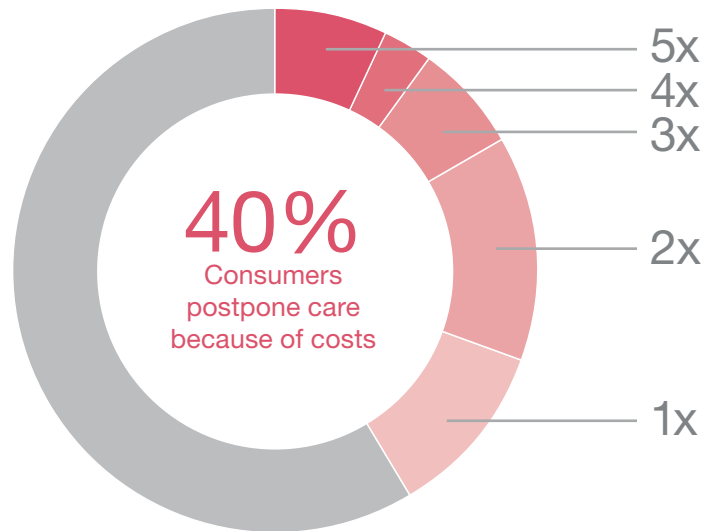
Hospitals and health systems have historically focused their productivity efforts on broad-based staffing benchmarks instead of tackling underlying issues such as workflow. In designing new processes, hospitals now face pressure to use the most appropriate venue for care, which is often lower-cost settings. This may require redeployment of existing staff and investment in continuing education and training.

Successful transformation addresses how and by whom care is delivered. To maintain high quality while implementing sustainable cost reductions, health systems are involving clinicians, staff and even patients in redesigning the delivery of care. The Mayo Clinic created a Center for Innovation that relies on a diverse design research team to connect evidence-based practices with consumer research. The center uses technology that allows it to simulate leading practices and adjust them to fit the clinic's environment. This approach helps Mayo Clinic to understand the needs of its consumer base while developing a positive and cost-effective experience.²

Reining in supply costs

Transforming organizations often requires increased stakeholder involvement and new alliances. Health systems have traditionally focused on standardizing and reducing costs of commodity supplies such as bandages and IVs, through group purchasing contracts while tiptoeing around politically charged issues such as physician preference items and the

Figure 7: How many times have you decided not to seek healthcare in the last year because of how much that care would cost you?



Source: PwC Health Research Institute Insurer Survey, 2012

comparative effectiveness of products. Hospitals are now employing more physicians and have more influence in managing physician preference purchases. Some innovators are building upon group purchasing contracts to create regional supply chain cooperatives with other provider organizations. For example, the Texas Purchasing Coalition, a 27-hospital partnership, expanded and forged a hybrid contract with a national group purchasing organization to not only reduce supply costs but also to standardize distribution and improve decision support. As a “power buyer” with over \$800 million in combined supply costs, the coalition achieved \$54 million in savings in the first 18 months.³

Implications

- Before embarking on full transformations, healthcare companies should first master general cost management, particularly in nonpatient care areas, and assess the effectiveness of management layers in patient care and administrative areas.

- Transformation requires long term, data-driven efforts with a perpetual focus on efficiency. Hospitals may want to create a permanent project management office to lead and sustain these efforts. Chief innovation or transformation officers are emerging to lead the charge and determine which initiatives will have the greatest impact across the enterprise.
- Top leadership must approve which transformation projects move forward, focusing on projects that have broad impact and the ability to be scaled across the organization. Having a formal process, possibly through internal social media, for employees to suggest improvement projects is also critical.
- Hospitals must align individual incentives with organizational incentives which are ultimately aligned with payment incentives. If ACOs or other contracts require organizations to meet quality and efficiency targets, then clinicians and staff need to have similar incentives. Health systems need key performance indicators that measure progress and connect to compensation models.

The building blocks of population health management

Population health management shows promise in the quest for better health at a lower cost by creating an integrated system of care, rather than leaving consumers to fend for themselves. In 2013, expect to see more partnerships as companies build their population health infrastructure to include shared responsibility for patient outcomes and satisfaction, data collection and analysis, member education and engagement, and a focus on at-risk populations.

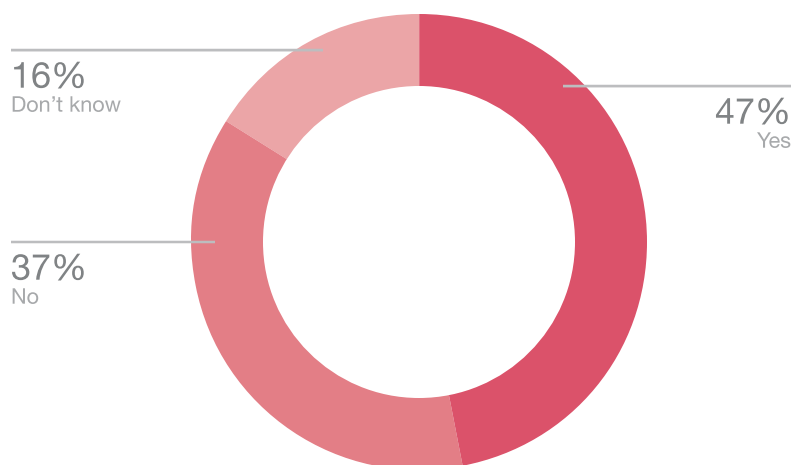
Collaborations can start small, targeting specific chronic diseases or patient groups. Bon Secours St. Francis Health System and Michelin North America collaborate to provide integrated care for Michelin employees and dependents with diabetes. Care ranges from coordination of specialists to buying groceries, providing education, and conducting work-site evaluations. Successes include patients who are able to stop insulin therapy and decreases in blood glucose levels, blood pressure, and weight.¹

Other partnerships allow large organizations to tap remote expertise. The Mayo Clinic Care Network connects nine systems, including Dartmouth-Hitchcock and Chicago's NorthShore University HealthSystem. Patients and practitioners gain from Mayo Clinic expertise through e-consultations and an online database of clinical information. Members may refer complex cases to Mayo Clinic while providing follow-up care locally.²

Population health management sometimes involves co-management, giving physicians a governance role and basing compensation on outcomes. Geisinger Health System in Pennsylvania ties about 20% of physician pay to quality and efficiency and uses a bundled payment arrangement (ProvenCare) for some procedures, such as cardiac bypass surgery, reducing costs through fewer complications and readmissions and improved patient outcomes (see Figure 8).³

But the shift to compensation based on value is only beginning to take hold. Only 47% of hospitals participating in a recent PwC Health Research Institute survey said they have a compensation plan based at least partially on metrics of quality, efficiency, or health outcomes.⁴

Figure 8: Does your hospital have a physician compensation plan that is based at least partially on metrics of quality, efficiency, and/or health outcomes?



Source: PwC Health Research Institute Human Capital Survey, 2012

In some population health approaches, navigators or care managers assess the socioeconomic environment of patients and help remove barriers to improve adherence. A diabetic patient who keeps returning to the hospital might be taking insulin as prescribed but may not have a refrigerator to store it in or electricity to run the refrigerator—and insulin loses its effectiveness when exposed to excessive heat. Only when such underlying problems are identified and addressed will patients improve.

For care management, an Arizona hospital system contracts with Optum (of United Healthcare), providing Optum nurses access to patient electronic health records. The nurses consult with patients by phone, provide instructions, and set expectations for follow-up care. This has resulted in immediate responses to after-hours queries; reduced use of on-call physicians, ER visits, and hospitalizations; and improved patient satisfaction.⁵ Other insurers and providers are following suit.

Kindred Healthcare, a post-acute provider, reduced hospital readmission rates by more than 8% by forming “joint operating committees” with hospitals. One partnership discovered that a significant

number of readmissions involved urinary tract infections acquired in the hospital. More active screening and treatment prior to patient discharge reduced readmissions.⁶

Implications

- Population health management requires major investments over multiple years, and requires trial and error. Convergence and consolidation must accelerate among otherwise disparate players.
- The push for higher quality and value requires standardization of processes and the ability to continually improve or risk losing reimbursement.
- Collaborations need a strong technology foundation, including web-based reporting tools that connect to clinical, financial, and administrative systems. Systems must support analytics across a wide spectrum of inpatient, outpatient, post-acute, and community services.

Bring your own device: convenience at a cost

For many people, mobile devices are an extension of themselves, so it's not surprising that they have found their way into the workplace—including hospitals. Once there, they easily outshine employer-issued desktop computers or laptops, and soon clinicians have switched to their own devices instead. Recognizing the associated risks and admitting that attempts to stop the trend might be futile, many hospitals now permit employees to “bring your own device” (BYOD) to work.

Currently, 85% of hospitals support clinician use of personal devices at work.¹ In 2013, expect a heightened focus on security as more employees “bring their own” and more sensitive data is made available on them.

Of the 502 breaches of protected health information reported to the Department of Health and Human Services Office of Civil Rights since September 2009, 71 involved portable electronic devices.² Loss and theft are the top threats to the information stored on mobile devices. Viruses and other software attacks targeting smart phones and tablets rose by 273% in the first half of 2011 over the first half of 2010.³ Physicians and contractors who work in multiple hospitals might inadvertently spread viruses via their mobile devices among the hospitals they visit. And patients add another wild card: one study revealed that of the 76% of hospitals allowing visitor access to the Internet on their mobile devices, 58% lack password protection for that access, putting hospitals at risk for viruses.⁴

Hospitals must balance the desire for work flexibility with creating an environment secure enough to protect sensitive patient data. According to a recent PwC Health Research Institute survey, half of consumers agree that being able to access electronic health records (EHRs) using a mobile device would help their providers work together more effectively to coordinate their care, and one-third believe that doing so would result in a quicker response to their health questions.⁵ Also, 61% of consumers are willing to communicate with a clinician via email, and 91% who have done that were satisfied with the experience.

Even so, consumers are not enthusiastic about physicians accessing their health information on a personal device, with nearly three-quarters saying they would be concerned about privacy (see Figure 9).

Indeed many hospitals are behind on security. Three-quarters of hospitals permit clinicians to access EHRs on their personal devices,⁶ but PwC's Global Information Security Survey found that 46% have a security strategy governing the use of mobile devices.⁷ More than half of IT professionals say they've experienced employees circumventing or disengaging security features like passwords and key locks.⁸

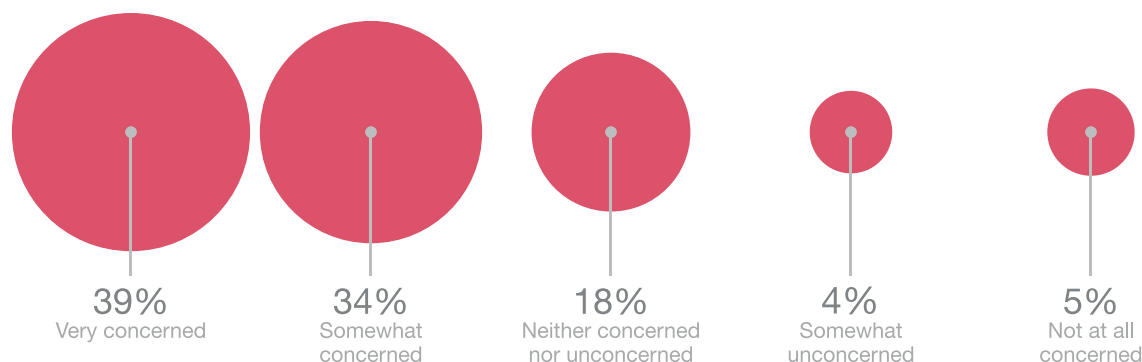
Some hospitals give staff read-only access to sensitive data; others permit interaction with it to enhance work flexibility. The Department of Veterans Affairs' program to make EHR data user-friendly on portable

devices allows providers to access a limited amount of information: demographics, allergies, medications, and lab results. Soon the VA will expand access to more medical applications that require the input of patient data. The VA uses complex pass codes, locks inactive machines, tracks data, has remote wiping, and never stores patient data on the devices.⁹

Implications

- Hospitals need an identity management approach that accounts for patient and employee mobility. This includes a centralized, integrated, and comprehensive view of people, roles, and privileges for more accurate and efficient auditing and reporting and for continuous improvement of policies and controls.
- Stage two of the government's “meaningful use” program calls for the encryption of data on end-user devices. Starting in 2014, failure to comply will mean the loss of incentive payments and, in 2015, penalties.
- Hospitals must continue to communicate privacy and security policies and practices to consumers, especially as the desire to communicate with patients via email and text gains popularity among clinicians.
- The costs of BYOD may outweigh what hospitals save in hardware costs. One study found that supporting employee personal devices can cost companies 33% more.¹⁰

Figure 9: If doctors, nurses and other caregivers were able to access your medical information from a phone/mobile device that they also used for personal use, how concerned would you be about the privacy of your medical information?



Source: PwC Health Research Institute Consumer Survey, 2012

Meeting the new expectations of pharma value

Pharmaceuticals and medical devices play a pivotal role in health outcomes. But the path from lab to bedside is often long, arduous, and expensive. Today, the final hurdle is no longer regulatory approval; it's reimbursement.

Physicians, once the primary arbiters of pharma value, now have less say in payment decisions than insurers and large providers. If purchasers don't see evidence that a new drug fills an unmet need or outperforms similar products at a more reasonable cost, the drug won't receive preferred formulary placement and may not even be covered by insurance. The industry has largely shielded customers from the price of medication, but as costs shift to individuals, drug and device makers will be under greater pressure to prove value.

Memorial Sloan-Kettering Cancer Center recently refused to pay for a new colorectal cancer drug, citing data that it performed no better than a similar medicine at less than half the cost.¹ The manufacturer responded by lowering the price to that of the competing therapy barely two months after launch.²

Outcomes-based contracts help prove the value of drugs and devices. EMD Serono, the biopharmaceutical division of Merck KGaA, has forged separate contracts with insurer Cigna and pharmacy benefits manager Prime Therapeutics to provide adherence-based discounts on Rebif, a multiple sclerosis therapy. Cigna claims data has shown that Rebif helped reduce hospitalizations by 43% the first year of its agreement with EMD Serono.³

Such partnerships could yield substantial savings. A recent study found that medication adherence by diabetics could save between \$4.7 and \$8.3 billion in annual US healthcare costs.⁴ However, only 74% of consumers surveyed by PwC's Health Research Institute (HRI) said they very closely adhere to prescription instructions.⁵

Interest is growing among insurers to partner with pharma to determine unmet medical needs, and improve medication adherence and clinical outcomes. In a recent HRI insurer survey 43% of insurers agreed that they would benefit from a data sharing partnership with pharma companies (see Figure 10).⁶ Drug maker Pfizer and insurer Humana have formed a five-year partnership focused on improving cost, quality and access to appropriate care. They seek to better understand patient care needs by tapping into clinical evidence and comparative effectiveness research. Specifically, they hope to improve the treatment and management of chronic conditions including cardiovascular disease and Alzheimer's disease.⁷

Comparative effectiveness studies can help build pharma's value case. Britain's National Institute for Health and Clinical Excellence (NICE), which makes reimbursement recommendations for England and Wales, initially recommended against a highly touted, FDA-approved melanoma medication because it had not been compared with other drugs used for the same indication.⁸ It recently reversed the decision after the manufacturer offered to discount the drug.⁹

In Germany, if a company cannot demonstrate that a new therapy provides clinical benefit over established treatments, reimbursement starts at the same level as existing clinically equivalent medicines.¹⁰

Collaborating with regulators early in drug development is another approach. For its psoriasis medication, Novartis collaborated with NICE on trial design, product selection for comparative effectiveness, study population, and economic evaluation.¹¹ Following the pilot, NICE established its Scientific Advice program to provide fee-for-service advice to pharma and medtech companies. The agency reviews product development plans to ensure that they produce relevant evidence for submission.

Implications

- The pharmaceutical industry must provide robust and reliable data to purchasers on cost-effectiveness, using mock formulary evidence audits, data-sharing partnerships, and outcomes-dependent contracts.
- Pharma and its partners should monitor costs and outcomes as they aggregate and interpret data. Underused data from electronic health records, patient registries, medical devices, nutrition studies, and social media can often supplement claims and prescription information.
- Drug and device makers can prove value by including a comparative effectiveness component in clinical trials and pairing products with diagnostics targeting patients who can benefit the most.

Figure 10: How much do you agree with the following: our organization would benefit from a data sharing partnership with biopharmaceutical companies?



Source: PwC Health Research Institute Insurer Survey, 2012; 3% did not respond

Medtech industry braces for excise tax impact

Effective January 1, 2013, the 2.3% excise tax on medical devices could prompt consolidation in a \$308 billion global industry consisting mainly of small start-ups with lean product portfolios and fewer than 50 employees.¹ Some could owe more in taxes than they generate in profits, making them less attractive to investors but enticing to larger companies that are better positioned to absorb the tax and looking to expand their portfolio.

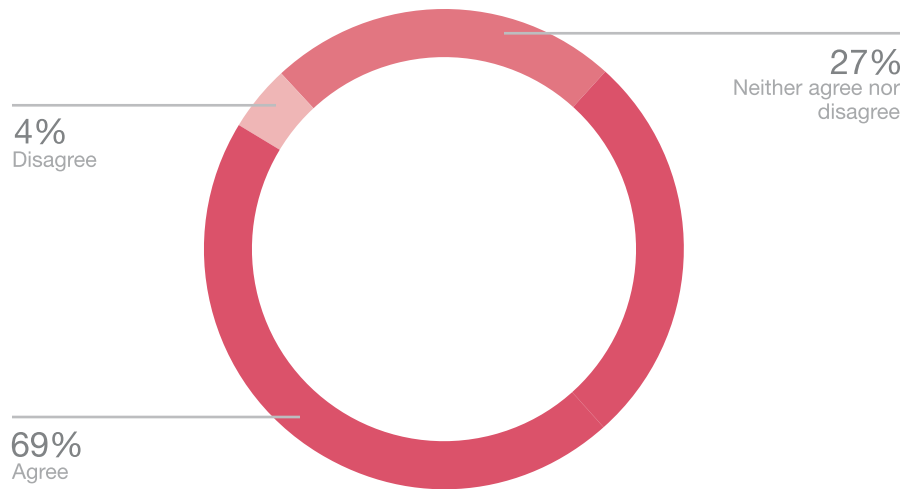
Federal coffers stand to gain \$29.1 billion over the next ten years from this tax, which was included in the Affordable Care Act (ACA).² Much of the industry has labeled the tax a job and innovation killer—predicting nearly 39,000 US job losses.³

Some companies say it's just another cost pressure in an evolving market, but others have already blamed it for shelved domestic expansion plans and layoffs. One company is cutting its workforce by 10% and plans to move some operations overseas.⁴ Medtronic, a large medical device manufacturer, estimates that the tax will increase its annual tax liability by \$125 million to \$175 million, or 1%–2% of US sales.⁵

Medtech companies are unlikely to pass on the tax to customers for several reasons. A group of hospital associations opposes pass-through of the tax and has urged the IRS to prevent them from doing so; and industry analysts predict that companies dealing in commodities, such as coronary stents or tongue depressors, are unable to pass it on because of pricing pressure and competition. Unless companies offer a novel product without direct competition, they will have to bear the cost.

As manufacturers look to shift costs, they must also innovate. Nearly 70% of consumers surveyed by PwC's Health Research Institute say that pharmaceutical and biomedical research is an important contributor to economic health (see Figure 10).⁶ While some companies expect

Figure 11: To what extent do you agree or disagree with the following statement: Pharmaceutical and biomedical research is an important engine for economic growth in this country?



Source: PwC Health Research Institute Consumer Survey, 2012

to absorb the tax and reduce expenses elsewhere, others are recalibrating operations, resources, and investments to spur strategic growth in other areas to offset it. Because the tax applies only to US sales, medical device makers with robust sales abroad should fare better.

Implications

- Manufacturers that have been waiting and hoping for repeal have run out of time. They should have a basic system for calculating tax liability, or they risk overpaying or underpaying the IRS.
- The supply chain may become volatile as manufacturers, contractors, distributors, and other third parties maneuver to avoid responsibility for the tax. Medtech companies should assess the potential for supply chain disruptions before changing pricing policies.

- Medtech companies should consider working with providers on comparative effectiveness studies of products before they are distributed. Doing so may help reduce write-offs on consignment products, demonstrate value to purchasers, and streamline the portfolio.
- Industry consolidation could give medtech companies greater pricing power in negotiations with insurers, providers, and suppliers.

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About this research

This annual report discusses the top issues for healthcare providers, health insurers, pharmaceutical and life sciences companies and employers. In fall 2012 PwC's Health Research Institute commissioned an online survey of 1,000 US adults representing a cross-section of the population in terms of insurance status, age, gender, income, and geography. The survey collected data on consumers' perspectives on the healthcare landscape and preferences related to their healthcare usage.

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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

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

Sarah Haflett
Manager, Health IT Research
sarah.e.haflett@us.pwc.com
267 330 1654

Anjali Saraf
Research Analyst
anjali.saraf@us.pwc.com
213 356 6740

Alena Smalligan
Research Analyst
alena.k.smalligan@us.pwc.com
415 498 5244

Janice Drennan
Manager
janice.s.drennan@us.pwc.com
813 348 7411

Barbara Gabriel
Manager
barbara.a.gabriel@us.pwc.com
813 348 7181

HRI Regulatory Affairs Team

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

Bobby Clark
Senior Manager
robert.j.clark@us.pwc.com
202 312 7947

Matthew DoBias
Senior Manager
matthew.r.dobias@us.pwc.com
202 312 7946

Caitlin Sweany
Senior Manager
caitlin.sweany@us.pwc.com
510 506 8972

Health Research Institute Advisory Team

Joe Albian
Principal
Healthcare Provider Advisory Leader
joe.albian@us.pwc.com
312 298 2018

Reatha Clark
Partner
reatha.clark@us.pwc.com
678 419 1014

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

Daniel Garrett
Principal, National Leader
Health Information Technology
daniel.garrett@us.pwc.com
267 330 8202

Michael Goff
Principal
Pharmaceutical and Life Sciences US
Co-Advisory Leader
mike.goff@us.pwc.com
203 539 4336

Vaughn Kauffman
Principal
Healthcare Payer Advisory Leader
vaughn.a.kauffman@us.pwc.com
216 363 5817

Michael Swanick
Partner
Pharmaceutical and Life Sciences Leader
michael.f.swanick@us.pwc.com
267 330 6060

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

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

Health Industries Marketing

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

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

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

HRI acknowledges the following additional contributors:

Karla Anderson, Amy Bergner, Jeff Cameron, Mick Coady, Gary Dowling, Lewis Fernandez, Nalneesh Gaur, Jeffrey Gitlin, Lawrence Hanrahan, Annette Hastings, Brett Hickman, Sandra Hunt, Gary Jacobs, Joel Jaglin, James Koenig, Katherine Kohatsu, Frank Lemmon, James McNeil, Jack Rodgers, Sean Rutter, Warren Skea, Ross Stromberg, John Wiest

**To have deeper conversations
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 and Life Sciences Leader
michael.f.swanick@us.pwc.com
267 330 6060