

Medical Cost Trend: Behind the Numbers 2015

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Health Research Institute



Table of contents

The heart of the matter

2

The five-year contraction in healthcare spending growth comes to an end next year as the stronger economy releases a pent-up demand for care. Despite some higher utilization and expensive new cures, the rise in the expected growth rate in 2015 is modest compared to prior increases.

An in-depth discussion

4

For 2015, PwC's Health Research Institute (HRI) projects a medical cost trend of 6.8%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI anticipates a net growth rate of 4.8%.

Executive summary

5

Medical cost trend in 2015

6

Factors affecting 2015 spending growth

8

What this means for your business

17

A stronger economy and newly insured Americans mean an uptick in spending growth for healthcare. But the fact that health spending continues to outpace GDP underscores the need for a focus on productivity, efficiency, and better value for purchasers.

Employers

18

Providers

18

Health insurers

19

Pharmaceutical and life sciences

19

The heart of the matter

The notable five-year contraction in healthcare spending growth comes to an end next year as the stronger economy releases a pent-up demand for care and services. Despite some higher utilization and the cost of expensive new cures, the rise in the expected growth rate in 2015 is modest compared to the double-digit annual increases seen throughout the late 1990s and early 2000s.

PwC's Health Research Institute (HRI) projects a 6.8% growth rate for 2015, a slight uptick from the 6.5% projected last year. HRI's analysis measures spending growth in the employer-based market—the foundation of the US health system, covering about 150 million Americans. Fluctuations in the individual market, including new plans sold on public exchanges, are not within the purview of this analysis.

The story of 2015 is a nuanced one. At first glance, the health sector appears to be reverting to historical patterns of bouncing back as the nation recovers from the economic doldrums. Whether spending more freely because of the improved economy or shopping with insurance provided through the Affordable Care Act, consumers triggered the first bump in growth in the first quarter of 2014. We expect that to continue through next year.

But other factors are helping to moderate that growth. The \$2.8 trillion industry is becoming more efficient. Doctors and hospitals are adopting standardized processes that offer the prospect of better value for our health dollar. “At-risk” payment models that hold healthcare providers financially accountable for patient outcomes are beginning to take effect. One tangible sign of shrinkage: growth in healthcare system administrative and clinical employment has declined since 2011.

And major purchasers—namely the federal government and large employers—are tamping down the spending growth rate analyzed in this report, in part by demanding greater value and in part by shifting financial responsibility to consumers.

Eighty-five percent of employers in PwC's 2014 Touchstone Survey have already implemented or are considering an increase in employee cost sharing through plan design changes over the next three years. And 18% of employers now offer a high-deductible health plan as the only insurance option for their employees.

Millions of newly insured Americans accessing care are causing an entirely expected spike in 2015. But the influx also marks a critical juncture in long-term direction: Can the industry build on recent improvements to finally bring medical inflation in line with the overall economy? Or will 2015 represent the start of the next cycle of unsustainable growth?

An in-depth discussion

For 2015, PwC's Health Research Institute (HRI) projects a medical cost trend of 6.8%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI anticipates a net growth rate of 4.8%.

Executive summary

The improving economy demonstrates that structural changes in the health sector have taken the steam out of run-away cost inflation. The challenge for industry executives is to continue to control spending even in the face of countervailing winds such as expensive new innovations, improved consumer confidence, and an aging society that requires more medical care and services.

HRI issues its projection for the coming year's medical cost trend based on activity in the market that serves employer-based insurance—a projection that has become a key ingredient in setting insurance premiums for the past decade.

In compiling data for 2015, HRI interviewed industry executives, health policy experts, and health plan actuaries whose companies cover a combined 93 million members. HRI also analyzed results from PwC's 2014 Touchstone Survey of more than 1,000 employers from 35 industries. In this year's report, we identified:

Four factors that we expect to inflate the spending growth rate in 2015:

- **Economic upswing**—Many have wondered when the economic upswing would kick in and push up the healthcare growth rate. Now, more confident consumers are visiting doctors and the number of people delaying care has notably declined.
- **Specialty drugs**—As exemplified by new high-cost Hepatitis C therapies, drug development continues to play an inflationary

role in the short run. But in some instances, potential long-term savings from these innovative new cures could be substantial.

- **Physician employment**—Once hospitals and health systems acquire in-house physician practices, they have the ability to immediately escalate physician charges to the higher hospital rate, which will likely trigger a rise in spending next year.
- **Information technology investments**—As more health systems go through large-scale mergers and acquisitions, they must make major investments in integrating data and information to capture potential efficiencies of scale. However these investments may increase hospital operating costs by up to 2% during integration before hospitals can realize any savings.

Three factors that we expect to deflate the healthcare growth rate in 2015:

- **“Systemness”**—Understanding that a well-functioning whole is greater than its disparate parts, care teams are seeking to achieve more by working together. Similarly, hospitals within a large system strive to eliminate redundancies and reinforce common goals through administrative and clinical standardization. Reducing redundancies lowers operating costs and should act as a counterbalance on spending growth next year.
- **Healthcare price shopping**—The prevalence of high-deductible health plans is spawning a new

class of healthcare shoppers: price sensitive and willing to consider that less may be more. Families in high-deductible health plans use fewer brand name drugs, pursue lower-cost care venues such as retail clinics and visit doctors less frequently.¹

- **Risk-based payments**—The industry is beginning to realize significant savings by holding physicians and health systems financially responsible for patient outcomes.

What this means for your business

A stronger economy and millions of newly insured Americans mean an uptick in spending growth for healthcare organizations. That may be a welcome respite from recent years of budgetary pressure. But the fact that health spending continues to outpace GDP underscores the need for a renewed focus on productivity, efficiency, and, ultimately, delivering better value for purchasers.

As employers continue to shift financial responsibilities to their employees, the cost-conscious consumer will exert greater influence in the new health economy. Savings that come from standardization can help position health businesses for the value-driven future. But real success and profitability will go to the insurers, drug makers, and healthcare providers that deliver highly personalized customer experiences at a competitive price.

Medical cost trend in 2015

PwC's Health Research Institute (HRI) projects 2015's medical cost trend to be 6.8%— a modest increase over our 2014 projection of 6.5%.² This projection is based on HRI's analysis of medical costs in the large employer insurance market, which covers about 150 million Americans.³ By comparison, Medicare serves 52 million beneficiaries and a little over 8 million Americans enrolled in the public exchanges this year.⁴

The net growth rate in 2015, after accounting for benefit design changes such as higher deductibles and narrow provider networks, is expected to be 4.8%. Benefit design changes typically hold down spending growth by shifting costs to consumers, who often choose less expensive healthcare options.

Five years of historically low growth rates have left many wondering whether healthcare costs were bound to run away again. Next

year's projected uptick is a change in direction from years of significantly slower growth, but it does not guarantee a return to the double-digit increases of the past. In fact, the contained growth is evidence that structural changes aimed at delivering better quality care at lower costs are starting to hold healthcare spending growth in check.

Although total US health spending will likely increase as more people gain insurance under the Affordable Care Act (ACA), it may have little effect on employer health spending. The increase in utilization under the ACA will likely drive up total national health expenditures without changing prices for those with employer coverage.

Pharmacy costs, including specialty drugs, account for 15% of total spending (Figure 1).⁵ And fewer drugs will go off patent next year, which means that fewer low-cost

What is medical cost trend?

Medical cost trend is the projected percentage increase in the cost to treat patients from one year to the next. While it can be defined in several ways, this report estimates the projected increase in per capita costs of medical services that affect commercial insurers and large, self-insured businesses. The projection is used by insurance companies to calculate health plan premiums for the coming year. For example, a 10% trend means that a plan that costs \$10,000 per employee this year will cost \$11,000 next year. The cost trend, or growth rate, is influenced primarily by:

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

Figure 1. Inpatient and professional services account for the largest amount of private health insurance spending

Projected 2015 private health insurance spending by medical category



Source: PwC Health Research Institute estimate based on the 2014 Milliman Medical Index®

drugs—which tend to bring total pharmaceutical costs down—will enter the market. “A large increase in specialty drug costs could be a big deal going from one year to the next when you don’t have as many big blockbuster drugs going off patent,” explained Charles Roehrig, director of Altarum’s Center for Sustainable Health Spending, a health economic think tank based in Ann Arbor, Michigan.

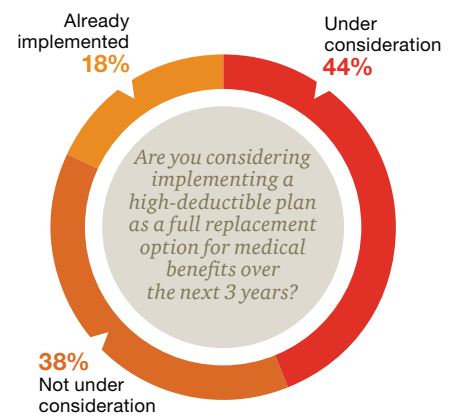
High-deductible plans will continue to tamp down use of services

The popularity of high-deductible health plans continues to rise as employers attempt to manage their benefit costs (Figure 2). According to PwC’s 2014 Touchstone Survey, 44% of employers across all industries are considering high-deductible plans as the only insurance option for their

employees during the next three years (Figure 3). In addition, according to the same survey, 33% of employers are considering moving their active employees to a private exchange in the next three years, and this strategy tends to accelerate employee adoption of higher deductible plans.⁸

Now more than ever, consumers are experiencing increased financial responsibility and are evaluating and rethinking how and when to spend. “High-deductibles will dampen utilization,” said Mary Grealy, president of the Washington DC-based Healthcare Leadership Council, a coalition of healthcare chief executives. According to a recent study, families in consumer-directed plans used fewer brand-name drugs, had fewer visits to specialists, and were hospitalized less.⁹

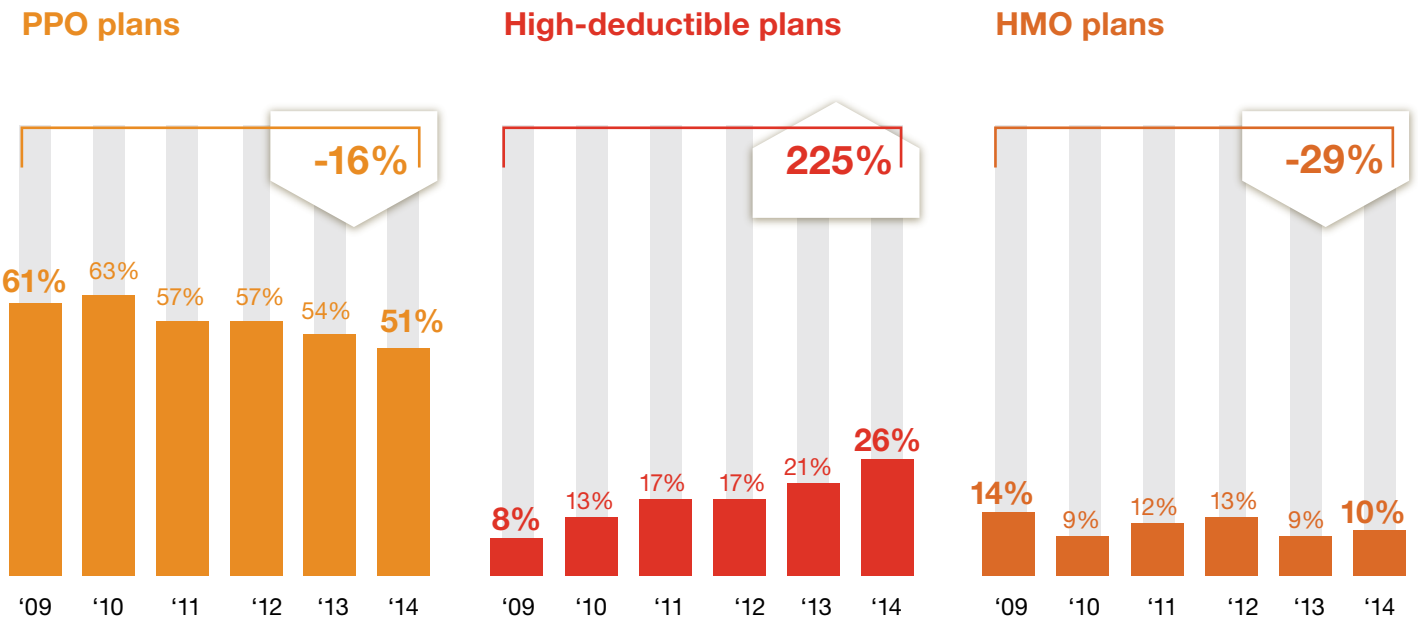
Figure 3. Most employers are considering or already offer a high-deductible plan as the only option for employees



Source: PwC 2014 Touchstone Survey

Figure 2. Enrollment in high-deductible plans has tripled since 2009

Enrollment in employer-sponsored health plans by type of plan, 2009–2014



Source: PwC 2014 Touchstone Survey⁷

Factors affecting 2015 spending growth

The economic upswing, specialty drugs, the shift to hospital-based payments, and IT integration investment will inflate the growth rate

Economic upswing finally reaches healthcare five years post-recession

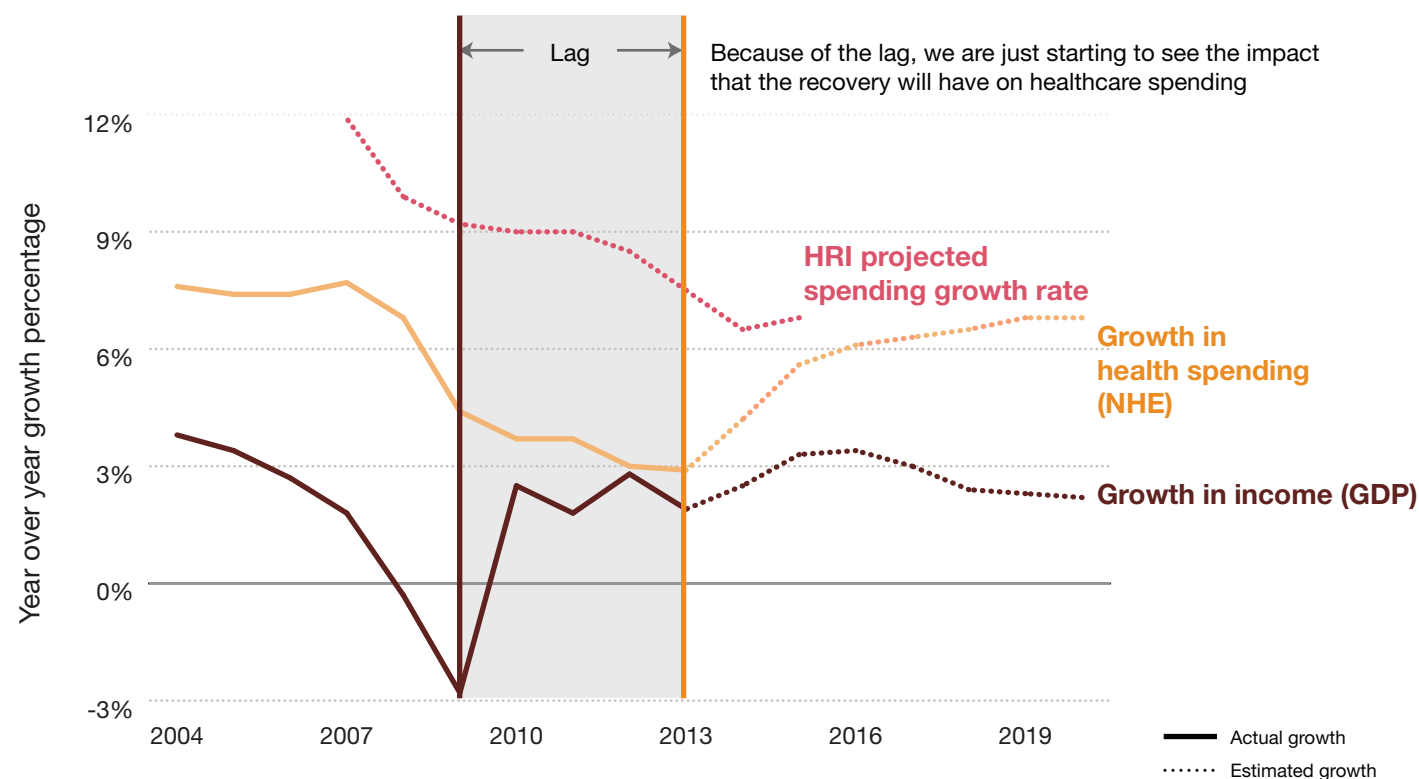
Although the health economy shares a tight connection to the overall economy, its cycle is not always in sync with the larger economic picture. The health economy generally lags behind broader economic fluctuations (Figure 4).¹⁰

“A recession will typically decrease health spending up to five years after it ends, with the greatest impact three to four years post-recession,” Roehrig told HRI. The sluggish recovery from the Great Recession that ended in 2009 played a large role in slowing the medical cost trend over the past few years.

“It is surprising that utilization has remained low the last few years, but as the economy improves, consumers will seek more care,” said Mark Duggan, professor of business economics and public policy at the University

Figure 4. Health spending and income growth track each other but with a lag

Relationship between growth in Gross Domestic Product (GDP) and growth in National Health Expenditures (NHE), 2004–2019



Source: PwC Health Research Institute estimates based on data from the Bureau of Economic Analysis and CMS, and on projections of GDP from the Congressional Budget Office¹¹

of Pennsylvania's Wharton School of Business. The result in 2015 is expected to be a small, but measurable increase in medical spending growth because some of the expected increase will be tempered by deflators as described below.

Low unemployment rates are another indicator of economic health. In 2015, the national unemployment rate is expected to settle in at about 6.5%.¹² As more people become employed, job stability increases a family's discretionary income and allows family members to turn their attention to long-postponed health needs. Between September 2013 and March 2014, 8.2 million people gained coverage from employer-sponsored insurance plans.¹³ Once individuals get coverage, they are more inclined to seek care.

No slowing down for specialty drugs

For years, the budgetary impact of drug spending has been a mixed bag, drawn in sharp relief again in 2015. As blockbuster medications go off patent, the switch to generic drugs brings with it considerable cost reductions for purchasers. But at the same time, the rise of high-priced specialty drugs is sparking anxiety and fierce debate among purchasers over pricing strategies and whether the high cost will be worth it over the long term. One thing is certain: In 2015, several expensive specialty therapies will likely increase the healthcare spending growth rate. (Figure 5).

Only 4% of patients use specialty drugs, but those drugs account for 25% of total US drug spending.¹⁵ Specialty drugs for cancer, respiratory conditions, central nervous system disorders, and inflammatory conditions such as rheumatoid arthritis and psoriasis are expected to increase drug spending growth in 2015.¹⁶

In 2013, 70% of the 27 drugs approved by the FDA were specialty medications, raising the specter of a series of expensive treatment decisions in future years.¹⁷ Nine of these therapies were oncology drugs.¹⁸

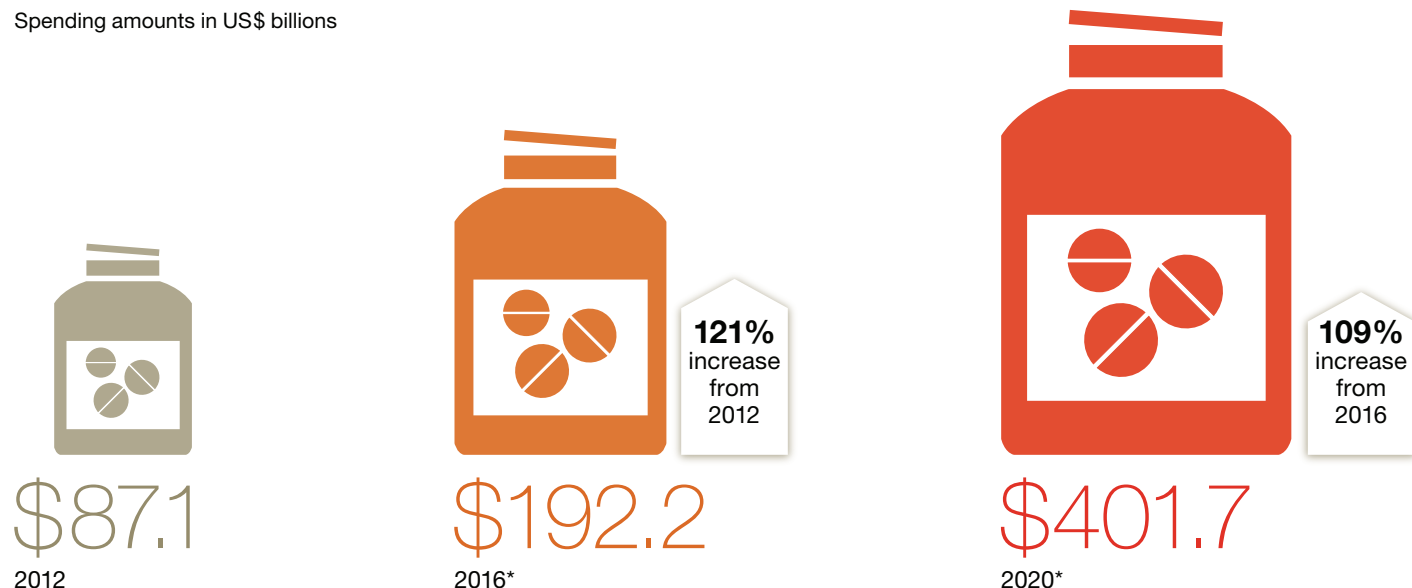
The average cost of branded oncology treatments has doubled over the past decade from \$5,000 to \$10,000 per month.¹⁹ In 2013, two of the first drugs to be approved through the FDA's breakthrough therapy process—an expedited review process for serious or life-threatening conditions—were cancer drugs now on the market for between \$7,000 and \$11,000 a month.²⁰ While treatment costs are high, they can result in extended life span, improved quality of life, and, in some cases, savings over many years.

No drug category has gotten more attention in recent months than the new Hepatitis C therapies, which are expected to increase total Hepatitis C drug spending 209% by 2015.²¹ About 3.2 million Americans have Hepatitis C, a life-threatening viral infection—about a million of those

Figure 5. US specialty drug spending will quadruple by 2020

Projected specialty drug spending from 2012 to 2020

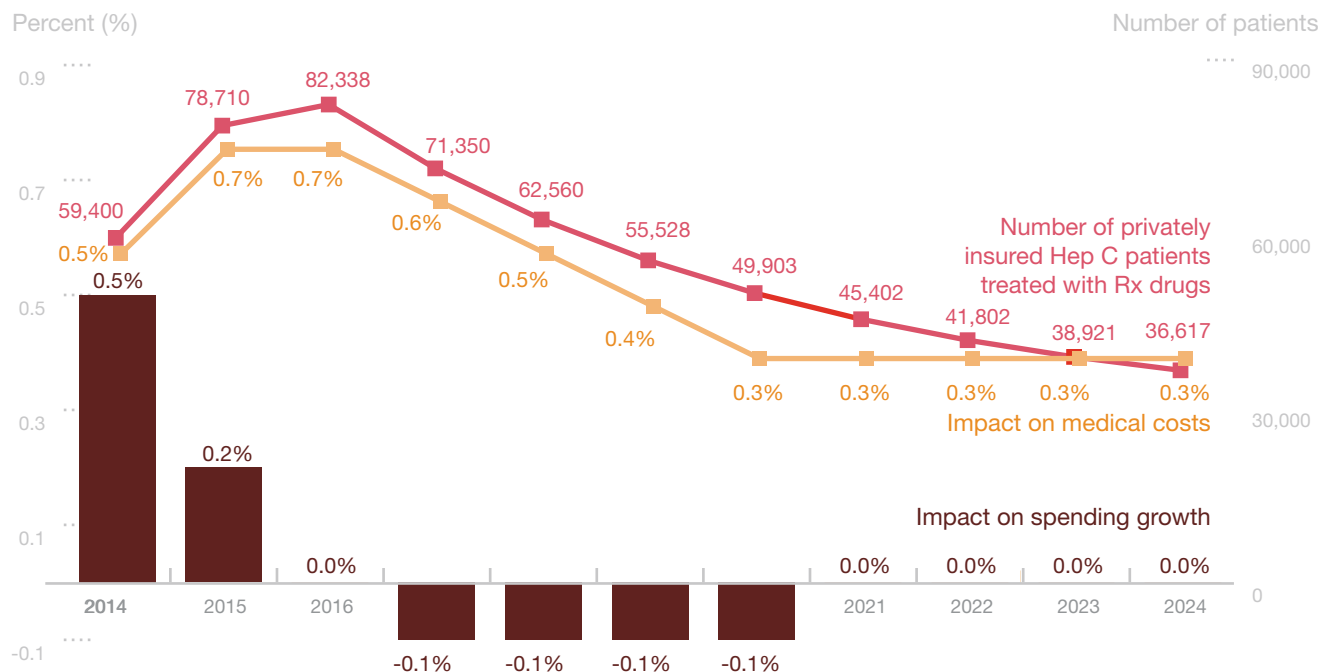
Spending amounts in US\$ billions



Source: PwC Health Research Institute estimates based on data from CVS Caremark¹⁴

Figure 6. The use of new Hepatitis C therapies will increase rapidly, but the greatest financial impact of the new therapies is likely to be in the early years

2015-2016 is the highest cumulative impact on benefit costs for employer plans



Source: PwC Health Research Institute estimate based on National Health and Nutrition Examination Survey and 2012 Truven claims data from employers²³

infected have private insurance.²² Therapies have been available since the early 2000's, but they have unpleasant side effects and must be administered by injection, which can reduce patient compliance. The new therapies represent a significant increase in efficacy, curing Hepatitis C in 80% to 95% of cases, and they have much shorter treatment regimens.²⁴

But at a cost of \$1,000 per pill, the 12-week regimen has insurers deliberating over who to cover, what percentage of the cost to cover, and how to manage timing of treatment.²⁵ Some insurance companies are limiting access only to those who are in "serious" need or are experiencing liver damage from

the virus.²⁶ Potential combination therapies for Hepatitis C that include more than one drug and would likely be even more expensive are pending regulatory approval.

Yet long-term savings for chronic treatments, liver transplants, and lost productivity may ultimately offset the cost of these specialty drugs for the most seriously ill patients.

Compare the average \$86,000 for a course of the new therapy to medical costs for treating those with varying severity of liver disease. For instance, patients with no scarring of the liver can incur average annual costs of \$17,000. Patients with compensated cirrhosis, a scarred but functional

liver, can incur \$270,000 in treatment over a decade. At the most severe side of the spectrum, patients who require a liver transplant could expect to be billed an average of \$580,000.²⁷ According to HRI analysis, about 60,000 commercially insured patients with Hepatitis C will be treated in 2014, rising to over 80,000 in 2016 (Figure 6).²⁸

While Hepatitis C therapies are expected to increase the medical cost trend the most in 2014²⁹, impacting overall health costs by 0.5%, this escalation will continue to affect the overall spending growth rate in 2015 at 0.2%.³⁰ From an insurance perspective, the immediate cost spike should level off as patients are cured.

Offsetting the spike in specialty drugs is about \$17 billion less in spending as big-name branded drugs lose patent protection in 2015.³¹

Physician-based payments become more lucrative hospital-based payments in acquisitions

The rapid acquisition of physician groups by hospitals will likely continue into 2015. Hospitals pursue these acquisitions in search of economies of scale, controlled referrals, bargaining power with suppliers, and more coordinated care. A recent survey by the American Medical Association (AMA) found that 43.6% of multi-specialty physician practices have a business model that includes some type of hospital ownership.³²

Additionally, the share of physicians in a solo practice has decreased 20% during the past 30 years.³⁴

As physician practices are acquired, they may be reclassified as “hospital-outpatient” departments, which allow hospitals to charge a “hospital facility fee” even though services are not performed in a hospital. Hospitals say they charge the fee to cover higher operating costs.

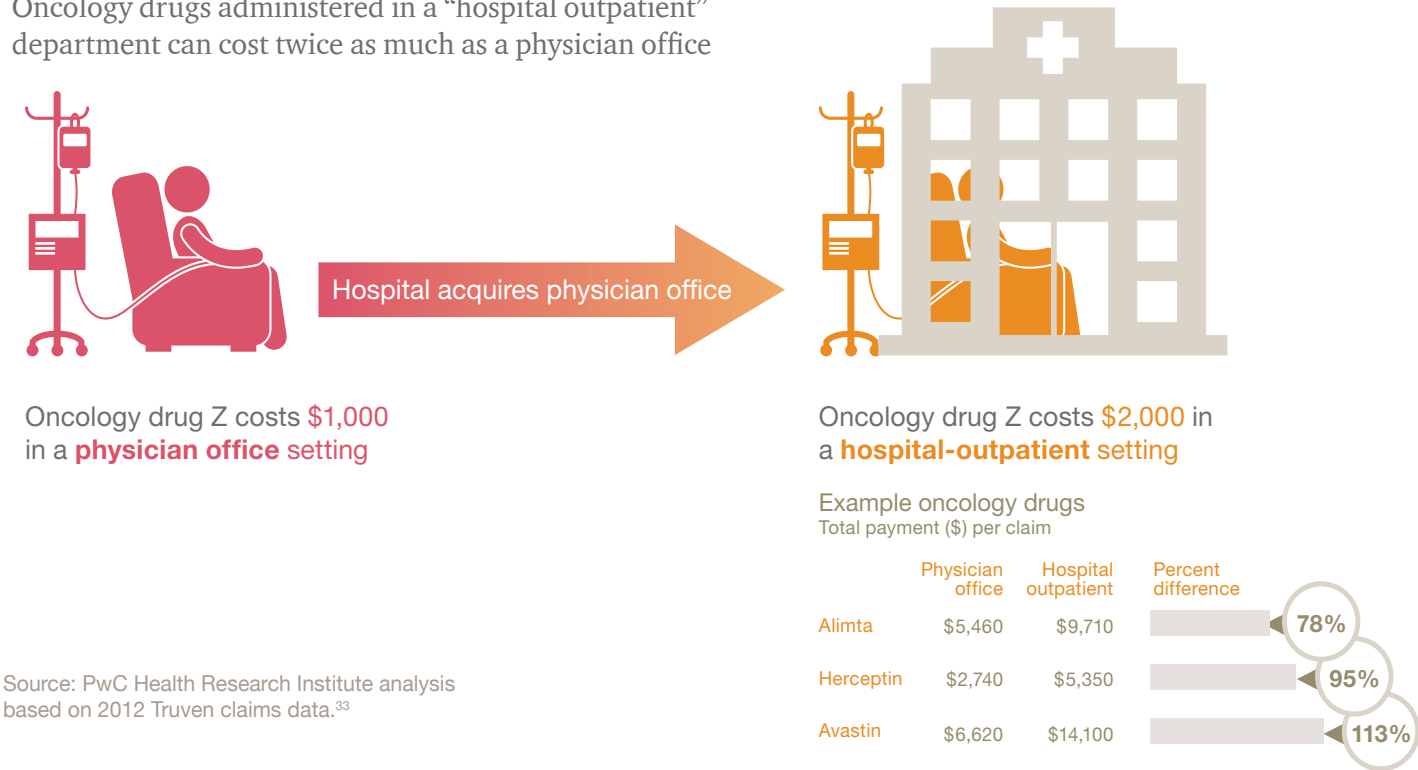
According to a recently published study, this not only affects hospital prices for services and drugs, but can ultimately be passed on to patients who may end up with a higher bill.³⁵ According to a report by the Medicare Payment Advisory Commission, Medicare paid about 80% more per office visit in a hospital outpatient department than at a freestanding physician office.³⁶

This shift has been commonly observed in cancer care. Between 2011 and 2012, the number of oncology practices owned by hospitals increased by 24%.³⁷ The result: hospital oncology outpatient costs were more than double physician office costs during the same time period (Figure 7).³⁸

In April 2014, Highmark, a Pennsylvania-based insurance company, announced that it would no longer reimburse at the hospital-based rate for cancer treatments performed in outpatient offices.³⁹ The insurer believes that it will subsequently reduce claims by \$200 million per year. Other insurance executives told HRI they are watching this trend closely and may renegotiate contracts to pay doctors and hospitals the same regardless of where the drugs are administered.

Figure 7. Oncology drugs cost more when administered in a “hospital-outpatient” department

Oncology drugs administered in a “hospital outpatient” department can cost twice as much as a physician office



Provider consolidation, regulatory changes expose need for IT integration investment

From growing in scale to absorbing the competition, healthcare providers have varying reasons for entering into large-scale merger and acquisition deals. And once they do, the new, larger entity aspires to become a well-oiled machine. For example, being completely integrated and achieving government incentive payments involves making all relevant patient information easily accessible to clinicians.

The ability to share data throughout the system to manage patients, improve outcomes, meet federal “meaningful use” requirements and take on financial risk is a major step toward efficient expansion.

As more providers enter into risk-based contracts (See deflator on page 16: Risk-based contracts are beginning

to reduce costs), success will be measured by their ability to manage patients’ health. A well-integrated technology system is the backbone of population health management. With it, health organizations can better monitor patients, share information among caregivers, report on quality and outcomes, and manage finances.

However, integrating health information technology after a merger is not an easy task. “Finding the least disruptive time to integrate is extremely challenging in a hospital environment that runs 24 hours, 7 days a week, for 365 days of the year,” said John Delano, vice president and CIO of Oklahoma-based Integris Health, which recently integrated two new hospitals into the system.

Technology investments can be daunting for health systems. Vendor selection, hardware costs, and outside support all require significant money and time. According to HRI analysis, the cost for a comprehensive

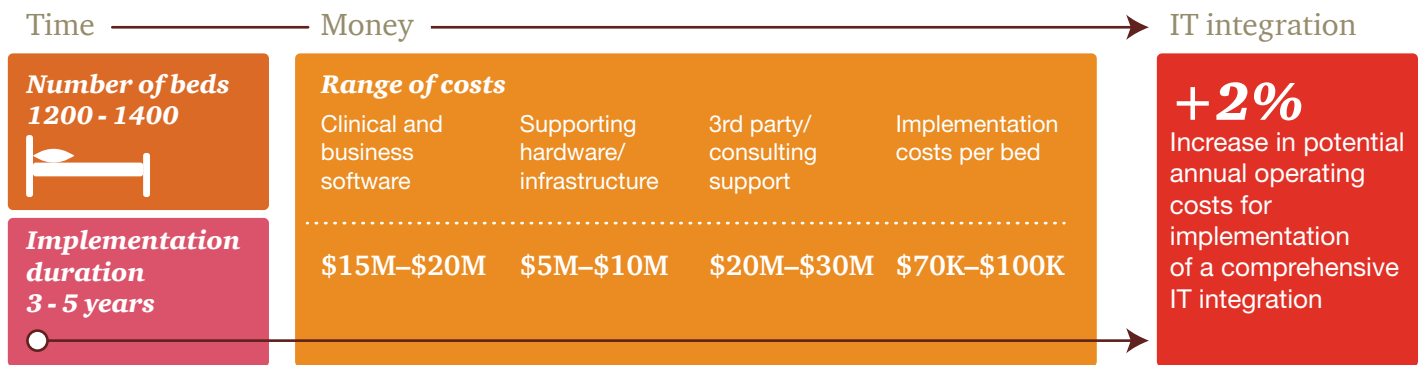
integration for clinical and business systems can run between \$70,000 and \$100,000 per hospital bed (Figure 8). For a 1,500-bed system, that would translate into 2% per year in additional operating costs.

But IT integration is a necessary early investment that can better connect clinical care, business operations, and technology and improve the consumer’s experience.

“Being in a hybrid state after an acquisition, where hospital employees are using two different technology systems, is no fun for anyone. Employees are often confused and patients are frustrated when their health information can’t be accessed,” said Delano. Health systems that defer technology integration are left with incompatible computer systems, which lead to inefficiencies and make it difficult to see a complete portrait of patient data.

Figure 8. Integrating health information technology between two systems requires time and money

Example costs and duration for an end-to-end IT integration



*Does not represent complete range of costs. Numbers are representative.

Source: PwC Health Research Institute analysis of IT cost model based on multiple hospital costs.⁴⁰

Standardization and gaining efficiencies through ‘systemness’, increased consumerism through price shopping, and outcomes focused risk-based contracts will deflate growth rate

Cutting costs through achieving ‘systemness’

As newly merged hospitals standardize and create comprehensive systems, many are shifting their focus away from the immediate work of the merger to the task of realizing efficiencies of scale. For example, duplicative business functions and disparate treatment protocols are often discovered when two entities come together under one umbrella.

“CHRISTUS Health was not acting like an integrated system. We had three different corporate offices and eight different regions each doing their own

accounting, business office, accounts payable, finance, and facilities management,” said Paul Generale, senior vice president and senior financial officer of CHRISTUS Health, a Catholic health system with more than 40 hospitals that has recently completed several acquisitions and consolidation.

To achieve efficiency, hospitals are slimming operations down to the essential components. The main goal is to achieve “systemness,” or the ability to operate as one. Health leaders are focusing specifically on two areas: streamlining administrative activities and consolidating and

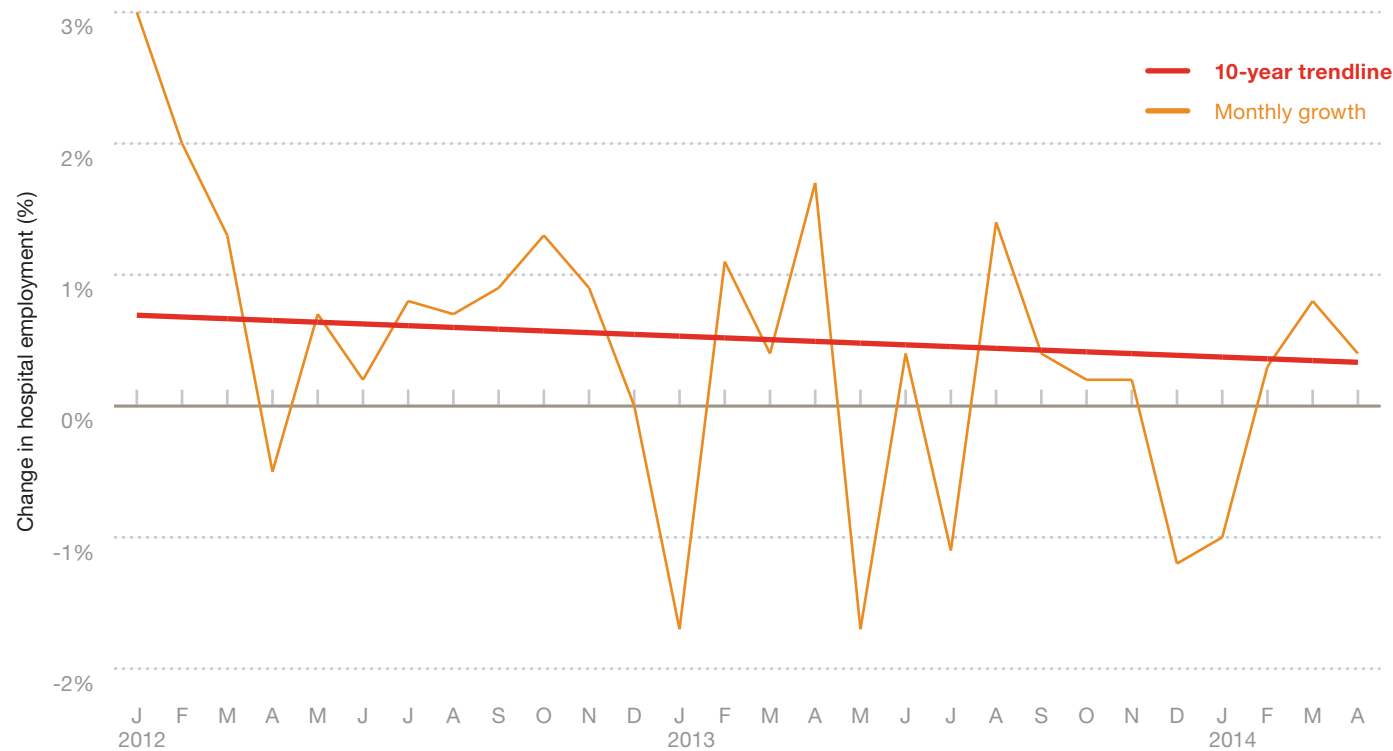
standardizing clinical programs, which can provide better care through consistent processes.

With about 60% of hospital budgets spent on labor, personnel costs are a top priority.⁴¹ Since 2012, hospital employment growth has slowed, and this trend is expected to continue—evidence that providers are achieving efficiency with fewer resources (Figure 9).

When HRI surveyed academic medical center (AMC) leaders in 2012, 59% said that cost reductions via shared service centers are one way their organizations will address future

Figure 9. Hospital employment growth is decreasing

Monthly growth in hospital employment (seasonally adjusted; annualized: January 2012–April 2014)



Source: PwC Health Research Institute analysis based on Bureau of Labor Statistics data⁴²

revenue challenges.⁴³ Now community and regional hospitals are gaining these same savings. The results can be powerful. “By centralizing key support functions, CHRISTUS will be able to save \$20 million over 5 years in facilities management efficiencies, reduce costs to collect payments by 0.35% per transaction, and will project seven-figure savings by centralizing accounting, procurement, and accounts payable,” CHRISTUS Health System’s Generale told HRI.

When hospitals and doctors work together to cut costs and share in savings, the result is reduced supply costs due to greater standardization and improved ability to negotiate prices. Health systems that work closely with doctors can more easily limit the range of implants they must stock to get bulk pricing discounts. For example, the average price paid for femoral knee implants, an implant choice determined by physician preference, decreased 6.6% between 2013 and 2014.⁴⁴ Scottsdale Healthcare saved \$24 million by reducing its number of suppliers.⁴⁵

Standardizing medical practices also yields significant savings. “The term ‘cookbook medicine,’ which used to have a negative connotation, is now leading to better quality and better outcomes,” said Grealy of the Healthcare Leadership Council.

“We have embraced standardized care processes. It is not just paying less for supplies; it is picking a treatment protocol with proven outcomes,” said Mark D. Birdwhistell, VP for administration and external affairs of UK Healthcare system in Kentucky. In 2015, these operational efficiencies will play a role in lowering healthcare spending growth by reducing waste.

Figure 10. Employer survey shows a strong interest in increasing employee cost sharing through plan design changes



Source: PwC 2014 Touchstone Survey

85%

of employers have already implemented or are considering an increase in employee cost sharing through plan design changes over the next 3 years

Consumers become cost-conscious healthcare shoppers

The ongoing growth in high-deductible plans ultimately influences consumer behavior on the number and type of health services purchased. Eighty-five percent of employers in PwC’s 2014 Touchstone Survey have already implemented or are considering an increase in employee cost-sharing through plan design changes over the next three years, and 44% of employers are considering offering high-deductible plans as the only insurance option for their employees over the next three years (Figure 10).

While increased cost sharing and high-deductibles do not affect medical inflation directly, consumer behavior does. Cost remains a top concern for consumers and affects the health choices they make. According to a December 2013 HRI survey, 40% of consumers said that healthcare expenses put a strain on their budget. And a recent study in the journal *Health Affairs* about families with high-deductible health plans observed deliberate changes in those families’ use of health services. Families

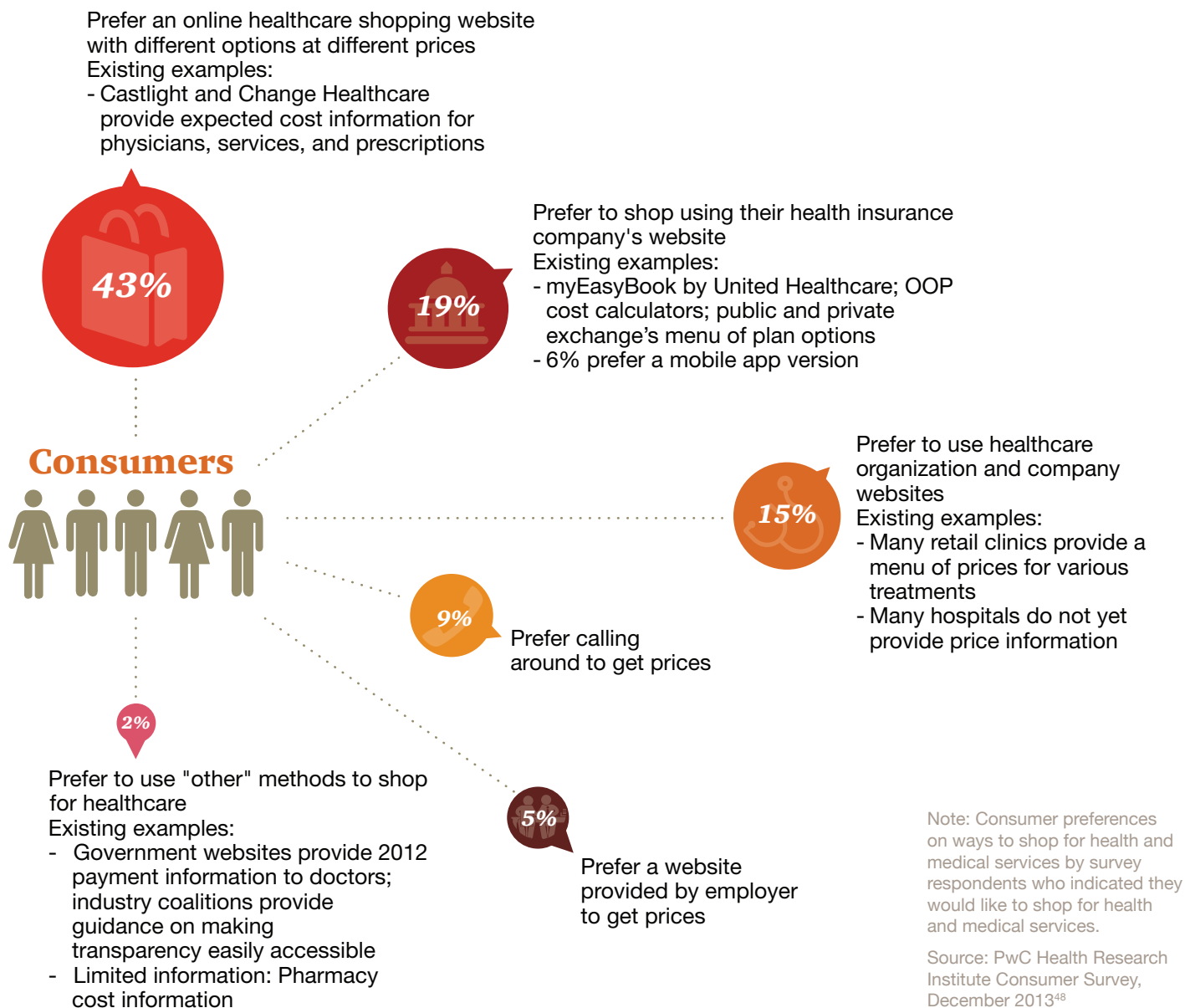
enrolled in high-deductible plans used fewer brand name drugs, had fewer doctor visits, and spent less per visit.⁴⁶

Increased price transparency can also play a role in driving down prices. In 2011, CalPERS, a large California administrator of health and retirement benefits for state employees, demonstrated that consumers shop differently when given cost and quality information and a financial incentive to select wisely. When CalPERS set its reimbursement rate for hip and knee replacements at \$30,000, its members switched to lower-cost providers. In response, other providers dropped their prices to compete, and CalPERS saved \$5.5 million in the first two years.⁴⁷

Consumers are starting to hunt for more pricing information on their own. Based on HRI’s latest consumer survey, 45% of consumers who shopped for medical procedures or health services in 2013 called around to get prices. Many consumers say they want more user-friendly pricing information. According to the same survey, 43% of consumers who would like to shop for health and medical services prefer to use an online

Figure 11. Consumer preferences in healthcare shopping

Percent of consumers who prefer to shop for health and medical services in specific ways



healthcare shopping website that compares different options at different prices (Figure 11).

Consumers may not have to wait much longer for a larger menu of options. "Whether through state governments or the private sector, most purchasers and payers will be offering transparency tools to help consumers shop for care," said David Lansky, president of the Pacific Business Group on Health, a California-based employer association.

After previously releasing hospital payment costs, Medicare recently disclosed details on how it distributed more than \$77 billion of doctor payments.⁴⁹ Although government payment data does not directly allow consumers to price shop, it does provide much more transparency regarding costs. Aetna, Humana, and United Healthcare together with the Health Care Cost Institute, an organization that uses private health insurance claims data to analyze

cost trends, recently announced they will create a consumer website that makes price ranges and average reimbursement for services available for consumer reference.⁵⁰

Private companies such as Castlight Health provide employees with price and quality information, while new care venues such as retail health clinics and teleclinics routinely post their prices. Eighty-six percent of insurers reported having a cost

calculator tool that shows member’s out-of-pocket costs.⁵¹ United Healthcare’s online appointment booking system, myEasyBook, provides cost information based on personalized insurance information, such as the amount of deductible already met, even before booking an appointment.⁵² Users can then pay for their appointment prior to the visit.

More than 40% of employees participating in Aon Hewitt’s Corporate Health Exchange chose a less expensive plan than they had before, suggesting that consumers are willing to “buy down” to less coverage when responsible for more of the costs.⁵³

While the benefit of price transparency has been largely focused on the consumer, a new report finds that the impact can be broader, affecting the decisions of doctors, insurers, employers, and policy makers.⁵⁴ For example, with more readily available price information, physicians may be more likely to consult with patients regarding treatment options. In addition to consumers making smarter decisions, the report estimates that the industry having better access to price information could save \$18 billion over ten years.⁵⁵

Risk-based contracts are beginning to reduce costs

Insurers and employers are increasingly using risk-based payments in their physician and hospital contracts to reduce costs. Risk-based contracts can include quality bonuses and penalties, shared savings programs that encourage physicians to cut costs, and patient-centered medical homes (PCMH), which pay physicians to manage and coordinate care. Most health plan actuaries interviewed by HRI reported that these strategies are starting to reap cost savings.

Government programs such as Medicare Accountable Care Organizations (ACOs) have also shown promise in reducing costs. CMS released results for Medicare and pioneer ACO’s in early 2014 (Figure 12) and reported more than \$380 million in savings.⁵⁶

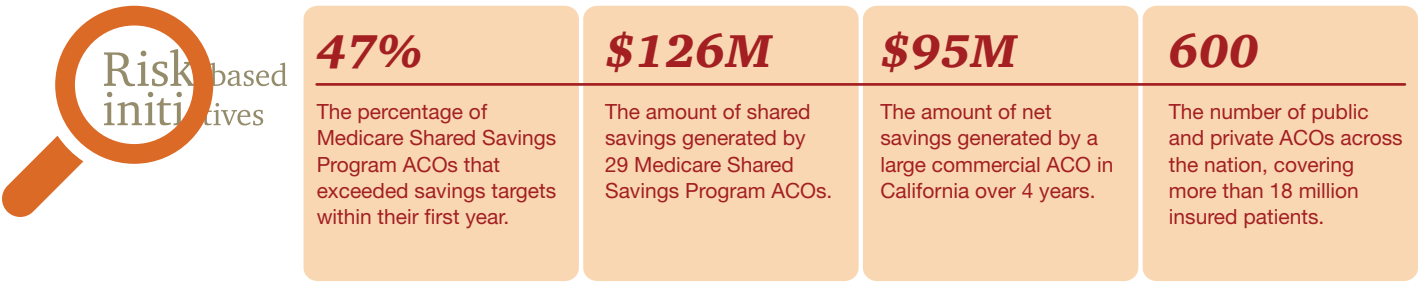
One of the largest and oldest commercial ACO-like programs between Blue Shield of California and CalPERS has recorded \$95 million in net savings over a four-year period since its inception in 2010.⁵⁷ While these savings initially came from

standardizing surgical procedures and reducing inpatient care, the focus has since shifted to PCMH models, shared decision-making, pharmacy costs, and ambulatory care to sustain cost savings.⁵⁸ “Successful ACOs use clinical data to target particular risk groups and develop appropriate treatment algorithms,” Lansky told HRI.

Insurance executives interviewed by HRI also view risk-based contracts as key to controlling costs. Incentivizing doctors to lower costs through shared savings and bonus payments can be effective. But choosing the right incentives is essential to effectively rewarding physicians for achieving good patient outcomes through appropriate use of services.

Fee-for-service medicine, which typically rewards overutilization, is rapidly being replaced by payment models that reward performance, which should continue to slow spending growth into 2015. Within the next two to seven years, a North Shore-LIJ Health System executive estimates that just 25% of its payments will be based on fee-for-service.⁵⁹

Figure 12. Examples of savings from risk-based Accountable Care Organizations



Sources: U.S. Department of Health & Human Services; Health Affairs Blog 2014; and Health Affairs 2013⁶⁰

What this means for your business

A stronger economy and millions of newly insured Americans mean an uptick in spending on healthcare organizations. But the fact that health spending continues to outpace GDP underscores the need for a continued focus on productivity, efficiency, and, ultimately, delivering better value for purchasers.

Employers

What are they doing now?

Employers continue to pursue a range of cost-cutting strategies with a fresh emphasis on shifting more responsibility onto workers. According to PwC's 2014 Touchstone survey, 26% of employers have a high-deductible health plan as their highest enrolled medical plan in 2014—the highest percentage ever.

Controlling costs through high-deductible plans is not the only strategy employers are trying. Offering plans with narrow provider networks, investing in wellness programs, contracting directly with centers of excellence, or even

participating in private exchanges, may save employers money. Consumer behavior is also beginning to impact the spending growth rate.

Things to consider

- *Tailor your pharmacy benefit to control drug spending.* With the arrival of expensive new specialty drugs, more and more employers are looking at their pharmacy benefit with a critical eye. Target cost sharing and pharmacy benefit management strategies that minimize waste and ensure the appropriateness of new expensive specialty drug therapies.

- *Ramp up transparency for your employees.* Consumers are becoming more engaged in making health decisions. Now they need information to make wise choices. Consider playing an active role in educating your employees about cost tradeoffs and providing greater transparency to ensure a healthy workforce.

- *Evaluate private exchanges.* Participating in a private exchange may help to accelerate consumerism-related strategies and help the employer shift towards defined contribution while giving employees greater choice to select programs that suit their personal budget and healthcare needs.

Providers

What are they doing now?

Shrinking margins for providers continue to make cost reductions a necessity. Healthcare providers are taking several approaches. Newly consolidated health systems search for and minimize redundancies. Doctors, hospitals, and health systems ready to take on more financial risk are focusing on population health management to produce better outcomes and lower costs. Some are even becoming their own insurer to take on more responsibility for cost and quality.⁶¹

Things to consider

- *Provide increased price and quality transparency.* Be prepared to deliver easy-to-understand, relevant information, or be prepared to watch patients vote with their feet.
- *Aim for care anywhere.* Adopt the retailer's mindset of convenience to the customer, expanding hours, moving deeper into the community and offering virtual care.
- *Standardize mindfully.* Standardization and streamlining operations is crucial to reducing costs, but avoid eliminating human touch points that enhance the consumer experience.

- *Prepare for post-IT integration maintenance.* Enabling sharing of patient data across an entire organization requires significant upfront costs. Be prepared to account for follow-on costs related to regular maintenance and continuous technology upgrades. Consider joining health information exchange programs to increase data accessibility and transparency for more informed clinical decision making.
- *Embrace innovative care strategies.* The emergence of new entrants such as retail health clinics is creating a wave of new approaches that are attracting patients to lower-cost care settings.⁶² Keep your current patient population with rapid innovations.

Health insurers

What are they doing now?

To keep premiums low and health costs at bay, the role of the insurer is to mitigate surprises. But with so much change in the market, that has been particularly challenging in 2014. The arrival of new Hepatitis C drugs caught many insurers off guard and unprepared to manage the high-cost therapies. Additionally health plans are getting acquainted with millions of new members who arrived via the new healthcare exchanges. With initial successes in using reference pricing and high-performing narrow networks

to steer patients to lower-cost providers, insurers continue to explore opportunities for savings.

Things to consider

- *Prepare for the drug pipeline.* As of May 2014, the FDA's Center for Drug Evaluation and Research had received 62 requests for the expedited breakthrough review process over a 7-month period.⁶³ As more medications fall into this review process, anticipate more approvals for ground-breaking, higher-cost therapies and consider creative new financing models.

- *Emphasize customer engagement with a focus on appropriate utilization.* Help educate consumers on treatment options and medication protocols. Implement utilization management strategies to guide patient choices to cost-effective care to avoid overuse of high-cost services and drugs.
- *Partner with independent price transparency companies.* Nearly half of consumers surveyed by HRI said they prefer to use online healthcare comparison tools to shop for health and medical services.⁶⁴ Consider partnering with respected, independent organizations that consumers trust for clear and accessible information.

Pharmaceutical and life sciences

What are they doing now?

After years of focusing on blockbuster drugs, the science trajectory has shifted to the development of specialty therapies that deliver high-impact treatments to specific populations. In the first quarter of 2014, new therapies, especially for the treatment of Hepatitis C, created headlines and purchaser angst. New pharmaceutical innovations are hitting the market at record-setting prices, leaving purchasers to analyze the short-term cost of treatment and the long-term savings of cures.

The FDA has opened the door to expedited drug approvals by creating the “breakthrough therapy” review process for drugs that treat serious or life-threatening conditions. However medications approved through the expedited process are not automatically widely available to patients. The industry is still left

with the challenge of demonstrating the cost benefit and ultimate value of the therapy to public and private purchasers who play a role in determining the level of cost-sharing for patients.

Things to consider

- *Incorporate value-based outcomes into R&D design.* Whether they are just entering a competitive market or are experienced players with proven products, drug makers will be under growing pressure from purchasers to demonstrate the true value and appropriateness of their goods. Additionally, risk-based providers will start to tap into pharmacy management using value-based outcomes data to extract additional savings.
- *Understand the impact of increased cost-sharing on consumers.* Employers are raising insurance

co-pays and converting to co-insurance. Tighter restrictions from insurers and employers may have consumers looking to manufacturers for financial assistance, or they may forgo treatment altogether.

- *Consider risk-based relationships.* Providers that are under risk-based contracts are hungry for new cost-cutting strategies, including containing drug costs. Determining specific clinical impact and costs per patient are becoming necessary elements in drug evaluation. Pharmaceutical companies should proactively prepare and promote solutions that incorporate comparative effectiveness, price, and utilization.
- *Partner with disease associations.* Drug makers can partner early on with disease associations and patient groups to develop treatment protocols and programs to assist patients in exploring therapy regimens and payment options for new treatments.

Notes

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About this research

Each year, PwC's Health Research Institute (HRI) projects the growth of private medical costs in the coming year and identifies the leading drivers of the trend. Insurance companies use medical cost trend to help set premiums by estimating what the same health plan this year will cost the following year. In turn, employers use the information to make adjustments in benefit plan design to help offset cost increases. The report identifies and explains what it refers to as "inflators" and "deflators" to describe why and how the healthcare spending growth rate is affected.

This forward-looking report is based on the best available information through May 2014. HRI conducted interviews in March and April 2014 with 13 health plan officials (whose companies cover a combined 93 million people) about their estimates for 2015 and the factors driving those trends. Findings from PwC's Health and Well-Being Touchstone Survey of approximately 1,200 employers from 35 industries are also included. Additionally, HRI analyzed the findings of a survey of more than 20 health plans belonging to the Health Plan Alliance. HRI also examined government data sources, journal articles, and conference proceedings in determining the 2015 growth rate.

Behind the Numbers 2015 is our ninth report in this series.

About Health Research Institute

PwC's Health Research Institute (HRI) 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.

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