

Medical Cost Trend: Behind the Numbers **2013**

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Health Research Institute



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The heart of the matter

Medical cost trend in 2013 will surprise the industry with another year of historically low growth. The continued slowdown is the result of a sluggish economy, medical plans with greater cost sharing, and new care models that reward value over volume.

Healthcare spending growth in the United States has slowed considerably over the past three years. And despite expectations that the trend would bounce back up in 2012, it did not. In fact, we see no major change on the horizon for 2013.

Medical cost trend measures spending growth on health services and products—a critical factor in calculating insurance premiums for employers and consumers. For 2013 PwC’s Health Research Institute projects a medical cost trend of 7.5%. Perhaps most notably, the historically large gap between healthcare growth and overall inflation has closed slightly.

As a result, the United States finds itself at a crossroads with respect to medical inflation. History suggests that the current slowdown is merely a dip mirroring broader economic trends and that medical cost growth will return to “normal” when the rest of the economy

recovers fully. Looking even further out, if the Affordable Care Act is fully implemented, tens of millions of newly-insured Americans receiving care for the first time in years could cause a spike in spending in 2014 and beyond.

But across the healthcare landscape behaviors are beginning to change. Employers are pushing wellness programs with real enforcement muscle. Healthcare providers and drug makers are embracing the quest for value. And patients are becoming more cost-conscious medical consumers.

It is always dangerous to predict that medical cost trend could be approaching a more sustainable level. Yet if the structural forces in the industry take hold, the U.S. health system may be entering a “new normal.”

An in-depth discussion

PwC's Health Research Institute projects medical cost trend will remain flat at 7.5 percent in 2013.

Executive summary

The focus on medical cost containment strategies is continuing, aided by the sluggish economy, reforms in the healthcare industry, and efforts by employers to hold down costs.

More than half of the employers surveyed by HRI are considering increasing employees' share of health benefit cost and expanding health and wellness programs in 2013.

In estimating the medical cost trend growth for 2013, HRI relied on multiple sources including interviews with health plan actuaries and industry leaders, a review of available surveys and analyst reports, and PwC's own 2012 Health and Well-Being Touchstone Survey of 1,400 employers from more than 30 industries. In this year's report, we identified:

Four factors that will deflate medical cost trend in 2013:

- Medical supply and equipment costs abate under market pressure. Supplies can account for more than 40% of the cost of certain procedures. Recent hospital consolidation and physician employment are enabling administrators to move away from "physician preference" purchasing and negotiate for significant savings. In addition, insurers are pressuring hospitals to hold down these expenses.

- New methods to deliver primary care gain popularity. One of the slowest areas of cost growth has been in physician services, and this trend is expected to continue in 2013 as consumers choose alternatives to the traditional doctor's office visit. Lower-cost options such as workplace and retail health clinics, telemedicine, and mobile health tools continue to gain market share because employers and consumers view them as cost effective and convenient.

<http://www.minuteclinic.com/>

- Price transparency exerts pressure. As comparative cost information becomes more readily available, purchasers such as employers and individual patients can shop for non-emergency services such as tests and elective procedures. Providers meanwhile are under pressure to justify prices. More than 30 states require some reporting of hospital charges and reimbursement rates. Congress is considering legislation that would prohibit cost confidentiality clauses in insurance and hospital contracting.
- The pharmaceutical patent cliff continues to foster the use of cost-saving generics. Many blockbuster drugs have recently gone off patent, which will have a major effect on lowering drug spending in 2013.

Two factors that will inflate medical cost trend in 2013:

- Uptick in utilization trend is expected in 2013. The recession of 2007–2009 contributed to a significant slowing in healthcare consumption, as many people who lost jobs or were afraid of losing employment delayed care. As the economy continues to strengthen, utilization is expected to rebound.
- Medical and technological advances accelerate growth of higher-cost care. Remarkable new discoveries and technological advances let many in society live much longer—but often at a significantly higher cost. New technologies, such as robotic surgery and positron emission tomography services, have grown rapidly, with 36% of hospitals performing robotic surgery in 2010.¹ Several health plans reported an uptick in high-cost cases, many surpassing the million-dollar mark

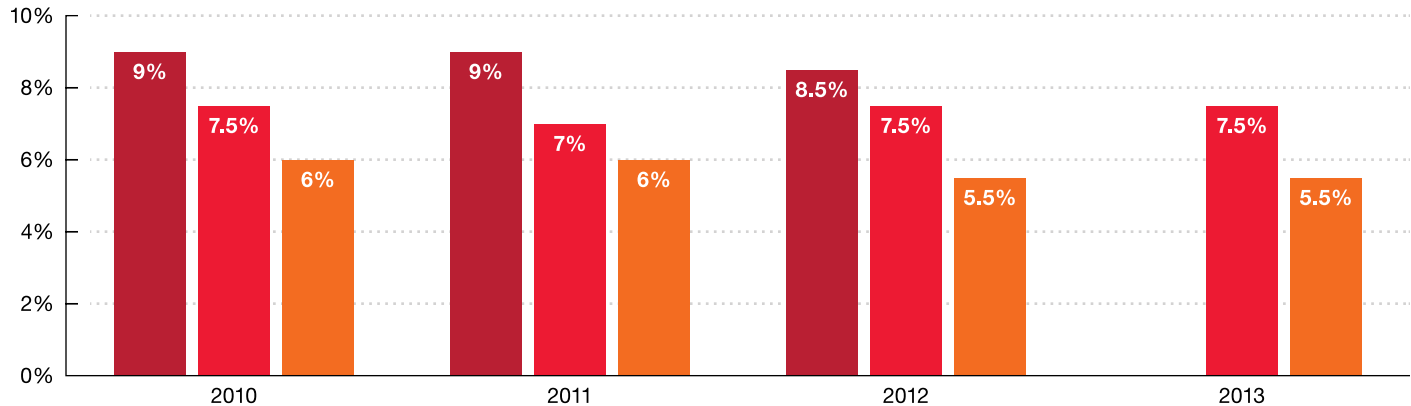
What this means for your business

Employers and insurers will want to capitalize on the recent slowdown, while doctors, hospitals, and pharmaceutical companies will need to retool their business models to succeed in the new environment.

¹ MedPAC, Report to the Congress—Medicare Payment Policy; http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

Figure 1. Medical cost trend, 2010–2013

■ What we predicted ■ Current estimate (before benefit plan design changes) ■ Current estimate (after benefit plan design changes)



Source: PwC Health Research Institute Analysis

Note: “What we predicted” will not available for 2013 until the following year’s look back.

Behind medical cost trend

Medical cost trend could be defined in several ways; for this report, it looks at the projected increase in costs of medical services assumed in setting health insurance premiums. Commercial insurers and large, self-insured businesses use medical cost trend to estimate what the same health

plan would cost in the following year. Medical trend does not take into account **benefit changes**, which were reduced by 1% to 2% over the period reviewed.²

PwC’s Health Research Institute (HRI) estimates the **medical cost trend for 2013 will be 7.5%**. HRI has also recalibrated its trend estimates down for the three previous years as the latest available information indicates

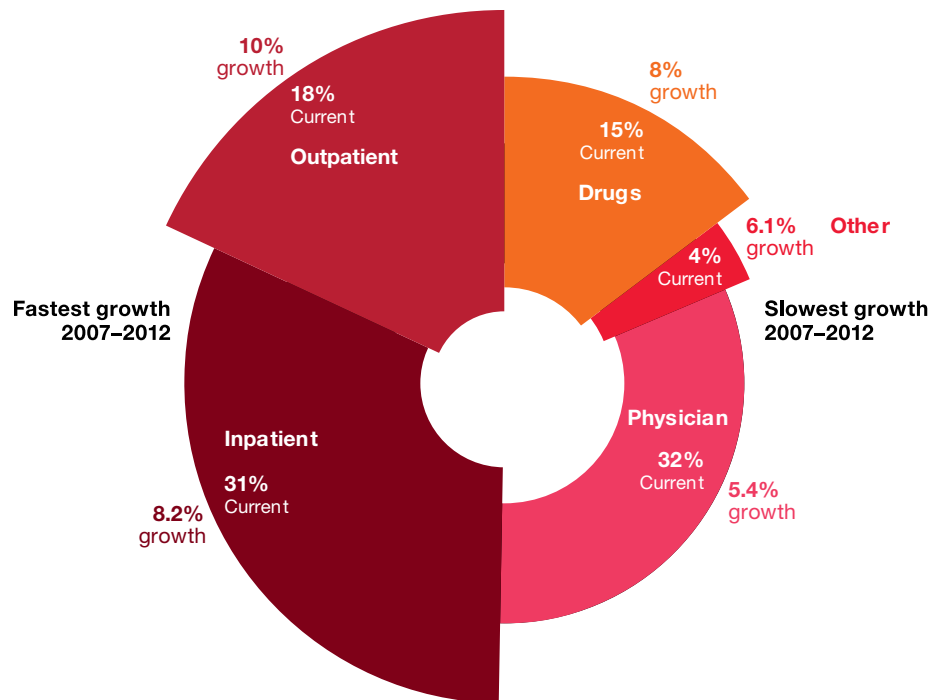
medical costs have come in lower than expected. Taken together, Figure 1 shows the trend is estimated to be in the relatively low range of 7% to 7.5% for the entire period 2010–2013, raising the possibility that we have entered a “new normal.”³

The net cost trend after accounting for changes in plan benefits, such as **higher deductibles and cost sharing**, is also in a narrow range of 5.5% to 6%.

Section 125 POP plan to keep the Employee's contribution tax deductible

² PwC estimates that the wedge between medical cost trend before health plan changes and the net trend after changes is typically 1.5% to 2%, as was estimated in 2010 and 2012, and is expected in 2013. The small adjustment in 2011 is the result of the enactment of the **Affordable Care Act**, which included new benefit requirements (e.g. **removing lifetime limits**), that offset other reductions. Some analysts also argue that low wage increases may have increased resistance to plan changes. By the end of 2013, HRI estimates that the typical relationship between medical trend before and after plan changes will return, yielding a medical trend of 5.5% after accounting for plan changes.

³ HRI’s changes in the 2011 and 2012 estimates were based on this year’s look back including interviews with officials from health plans. Unlike premiums, which are directly observed in the marketplace, the medical cost trend is based on estimates from health plans, large employers, and other analysts.

Figure 2. 2011 Private health insurance benefits by spending category

Source: PwC Health Research Institute analysis of Milliman Medical Index 2007-2012.

Note: "Other" category includes services such as ambulance, home health and durable medical equipment. Growth rates are average annual growth rates between 2007 and 2012.

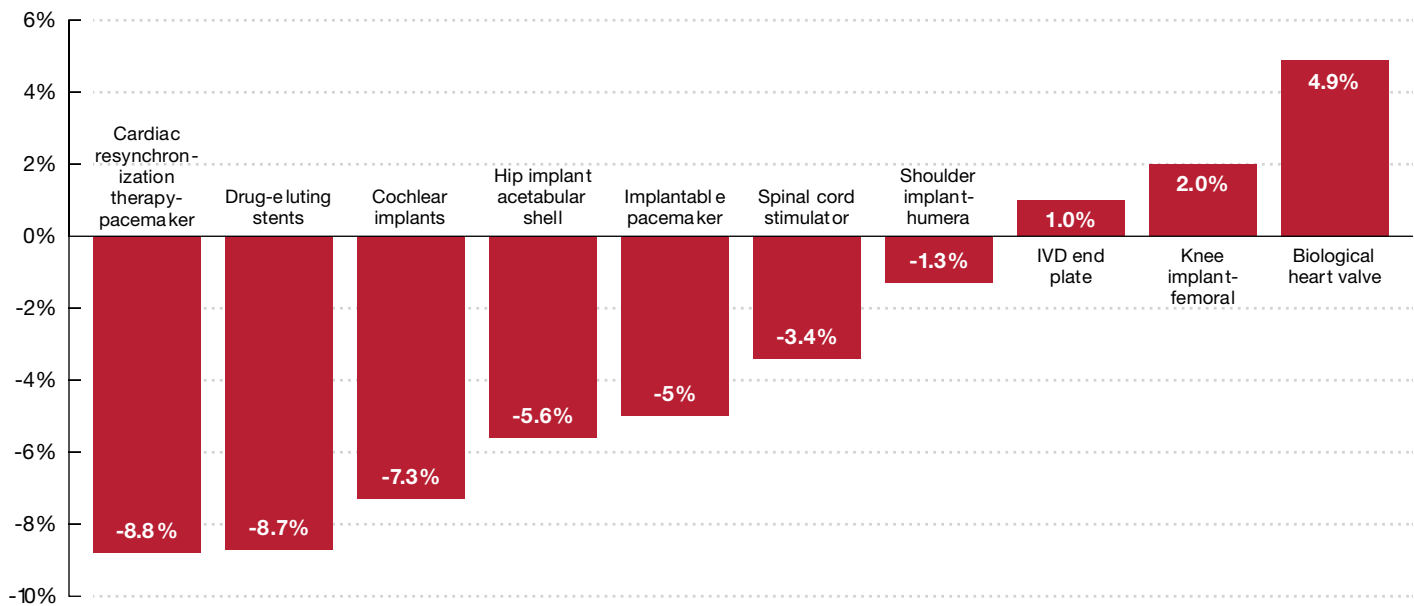
Why medical cost trend matters

Medical cost trend is the **leading factor in setting insurance premiums**. Insurance **actuaries** rely on the medical cost trend, coupled with other factors such as benefit design changes and profitability targets, to set the following year's premium levels.

While anticipating cost trend is important, employers also want to know what's driving it. **Medical cost can be broken down into five broad components: physician care, inpatient, outpatient, drugs, and other**. Figure 2 shows the breakdown of these components for a typical PPO plan.

Physician care, as shown in Figure 2, is the largest component and accounts for one-third of employer benefit costs, with hospital inpatient costs accounting for an additional 31%. The trend is affected not only by the share of each component, but also by how fast it is growing. Outpatient costs grew at an average of 10% from 2007-2012, while physician services, at 5.4%, were the slowest growing of the major categories.

To estimate medical cost trend, HRI conducts research each year to identify new and relevant factors that accelerate cost trend (i.e., "inflators") or reduce cost trend (i.e., "deflators"). Based on interviews with health plans, providers, and employers, as well as a review of financial analyst reports, government spending data, and other published sources, HRI anticipates medical cost **trend in 2013 will remain relatively flat**.

Figure 3. Percentage change in average price of implants December 2010 to February 2012

Source: PwC Health Research Institute analysis of the Modern Healthcare/ECRI Institute Technology Price Index.⁸

Factors affecting 2013 trend

Medical supply and equipment costs, new forms of primary care delivery, price transparency, and generic drugs will “deflate” cost trend

Medical supply and equipment costs are abating under market pressure

Supplies can account for 40% of the cost of certain procedures.⁴ In the past, hospitals have had little leverage

because they purchased a large variety of medical supplies to accommodate **physician preferences**. Physicians have traditionally been independent of hospitals, but according to a recent survey by HRI, 46% of doctors said they were interested in employment by hospitals.⁵ In fact, physician employment by hospitals increased by 32% between 2000 and 2010.⁶ Employment shifts the purchasing control from individual physicians to hospitals.

What’s more, **hospitals’ negotiating power** multiplies as they merge and become larger—another trend in recent years. Once purchased, hospitals are wielding sophisticated inventory management systems with bar codes and radio frequency technology to track and use their most expensive supplies and equipment efficiently. Figure 3 shows the percentage of change in average prices for high-cost medical implants.

Government transparency initiatives may be having an effect as well. The Department of Justice now requires five manufacturers of orthopedic implants to report online the royalty and consulting payments they make to individual physicians.⁷ These companies, representing a large portion of the knee and hip implant market, had **been accused of overpaying orthopedic surgeons for consulting services and providing perks in exchange for the surgeons’ recommendation of their products**. Other payers are creating additional pressures to reduce markups at the point of service for medical supplies and equipment.

4 E.S. Schneller and L. Smeltzer, “Strategic Management of the Health Care Supply Chain,” 2006, San Francisco: Jossey-Bass, as cited in: Premier, “Economic Outlook,” September 2011. Accessed at: <https://www.premierinc.com/costs/economic-outlook/attachments/Public-EO-Fall-2011.pdf>.

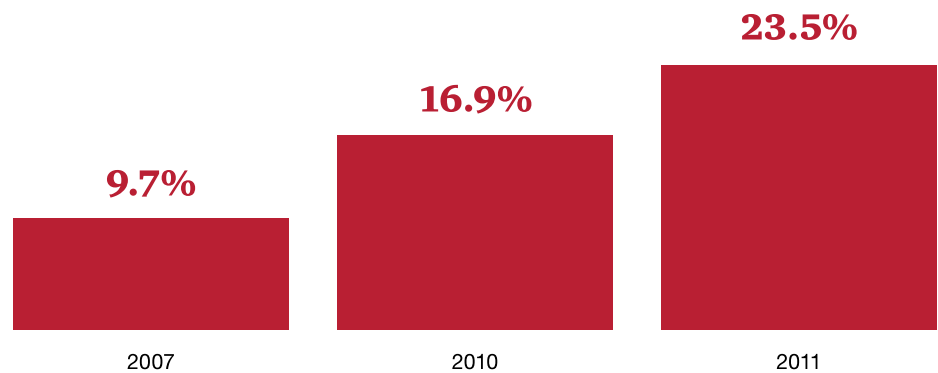
5 HRI, “From Courtship to Marriage,” 2011.

6 Fierce Healthcare: Daily News for Healthcare Executives: <http://www.fiercehealthcare.com/story/hospitals-employing-32-more-physicians/2012-01-09>.

7 American Association of Orthopedic Surgeons, “Orthopedists and industry: Working together at arm’s length,” <http://www.aaos.org/news/aaosnow/oct08/cover2.asp>.

7 American Association of Orthopedic Surgeons, “Orthopedists and industry: Working together at arm’s length,” <http://www.aaos.org/news/aaosnow/oct08/cover2.asp>.

8 <http://www.modernhealthcare.com/section/technology-price-index?Feb-2012#supply>; accessed May 2012.

Figure 4. Percent of survey respondents that have sought treatment in a retail clinic

Source: PwC Health Research Institute Consumer Survey, 2012. N=1,001 respondents, survey data available for only 2007, 2010, and 2011.

<http://www.minuteclinic.com/>

New delivery methods for primary care gain popularity

One of the slowest areas of cost growth has been in physician services, and that's expected to continue as consumers choose alternatives to the traditional office visit. Because so many workers now have deductibles of \$1,000 or more, they are particularly cost sensitive to healthcare purchases. Workplace clinics, retail health clinics, telemedicine, and mobile strategies continue to gain market share because employers and consumers view them as cost effective and convenient.

Retail clinics, which are typically staffed by nurse practitioners, are becoming a standard option for low-cost, high-volume care. As seen in Figure 4, nearly one in four consumers surveyed by HRI said they had sought treatment at a retail clinic in 2011. The United States has more than 1,300 clinics today.⁹

Cost and price transparency are integral for consumers choosing these centers. One study looked at three common conditions and found that retail clinics charged 30% to 40% less than private physician offices—and 80% less than emergency departments.¹⁰ HRI's analysis found that the cost of Tdap, a common childhood vaccine for diphtheria, tetanus, and pertussis, is \$232 in a hospital but advertised by one large retail clinic chain for \$100.¹¹

Technology is also supplanting the traditional office visit. Many activities such as history review, psychiatric evaluations, and ophthalmology assessments can be conducted remotely, producing similar outcomes with lower cost. Almost half of physicians surveyed by HRI said a significant portion of office visits could be eliminated through mobile health, which could also improve access for patients.¹² Insurers such as Aetna, Cigna, UnitedHealthcare, and various Blue Cross Blue Shield plans have begun to pay for electronic consultations, increasing the likelihood of physician participation.¹³

⁹ Merchant Medicine, Retail Clinics in the United States; <http://www.merchantmedicine.com/home.cfm>.

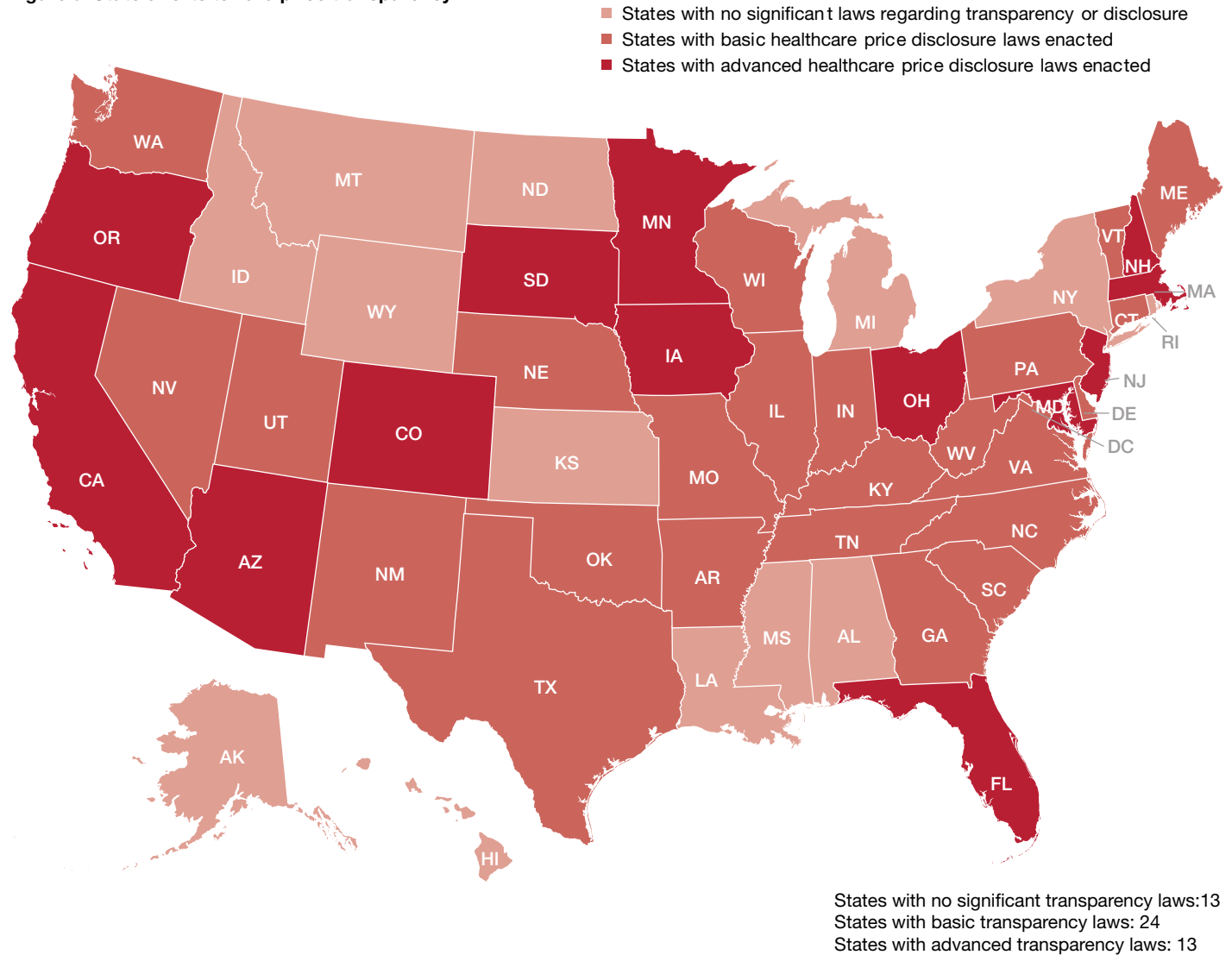
¹⁰ "Comparing Costs and Quality of Care at Retail Clinics With That of Other Medical Settings for Three Common Illnesses," *The Annals of Internal Medicine*, 151, 2009, p. 321-328.

¹¹ HRI analysis of retail clinic advertised prices on April 17, 2012, and 2009 hospital MEDPAR data sets; accessed May 2012.

¹² HRI "Healthcare unwired: New business models delivering care anywhere," 2010.

¹³ *The Wall Street Journal*, "Doctor is in—Online;" <http://online.wsj.com/article/SB124977187174117097.html>.

Figure 5. State efforts toward price transparency



Source: PwC Health Research Institute analysis of National Conference of State Legislatures.¹⁴

Note: State legislation enacted between 1984 and 2010. States with advanced healthcare price disclosure laws enacted have web based information regarding specific prices at the facility level.

¹⁴ National Conference of State Legislatures, State Actions Relating to Transparency and Disclosure of Health and Hospital Charges; <http://www.ncsl.org/issues-research/health/transparency-and-disclosure-health-costs.aspx>.

Several health plans report they are increasingly investing in and collaborating around mobile strategies or mHealth tools that provide care outside of the doctor's office or hospital. Many are partnering with technology companies to help patients virtually manage their weight, analyze physical activity, and report medication intake.

Beginning in October 2012, Medicare will no longer pay for preventable hospital readmissions and will publish readmission rates. Remote monitoring of patients using mobile devices will be especially effective at reducing hospital readmissions and keeping patients out of the hospital altogether.

Price transparency exerts pressure

Americans know the price of almost every major purchase except their medical care. But as more consumers enroll in high-deductible plans, they're more likely to seek out cost information. "Price transparency would be a powerful source of cost control if people knew about it," said Mark Duggan, professor of business and public policy at the Wharton School at the University of Pennsylvania.

It isn't easy to find, but government and health plans are publishing prices more often—and finding wide variation. When accompanied by information on the quality of care, transparent price information may help consumers

make more informed choices about their care, especially for services that can be planned.¹⁵ Knee-replacement surgery at several Colorado hospitals, for example, has ranged in price from \$33,000 to \$101,000, according to a 2011 Government Accountability Office report.¹⁶ Many states now have laws requiring the public posting of charges and prices, which many believe will enable consumer choice (see Figure 5).

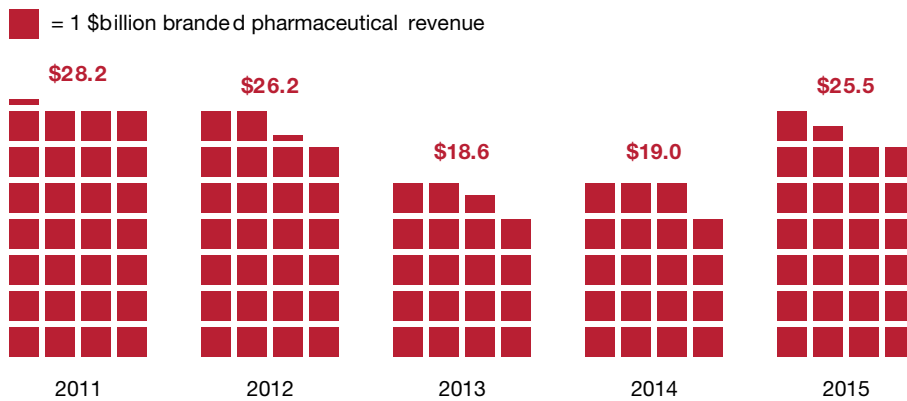
The insurer Cigna unveiled a new feature on its website in March that allows customers to compare prices for 200 common medical procedures. Rather than using broad price ranges or averages, the site provides estimates based on actual claims payments so patients can get a valuation of not only the doctor's fee, but also related services such as diagnostics and anesthesia, as well as hospital or facility costs. "We want to help our customers get the most out of every healthcare dollar," explained Jim Nastri, Cigna's vice president for cost and quality transparency.¹⁷

Publishing prices is affecting the behavior of both consumers and insurers. Several health plans told HRI that price transparency had armed them to negotiate lower prices with providers through reference pricing. For example, an insurer can use a low-cost imaging center in its network as the reference price or benchmark for an MRI. If a patient chooses a provider that charges more, he is responsible for any costs above the reference price.

¹⁵ Paul Ginsburg, "Shopping for Price in Medical Care," *Health Affairs*, vol. 26, no. 2 (2007).

¹⁶ GAO, "Health Care Price Transparency—Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care;" <http://www.gao.gov/new.items/d11791.pdf>.

¹⁷ Cigna, "Cigna Provides Highly Accurate Prices for 200+ Procedures and Health Professional Quality Informatives to its U.S. Customers;" <http://newsroom.cigna.com/NewsReleases/cigna-provides-highly-accurate-prices-for-200+-procedures-and-health-professional-quality-information-to-its-us-customers.htm>.

Figure 6. Branded pharmaceutical sales revenue at risk as a result of patent expiration

Source: PwC Health Research Institute analysis of US Patent and Trademark Office data.
Revenue in 2011 dollars.

The pharma patent cliff continues to increase use of cost-saving generics

In 2011 drugs going off patent represented more than \$28 billion in US pharmaceutical sales.¹⁸ This was followed by an additional \$26 billion worth of pharmaceuticals going off patent in 2012 (see Figure 6). The impact of those two years is only now being fully felt as more generics enter the market, making 2012 and 2013 record years for generic drugs supplanting or replacing branded drugs on health plan formularies.

A number of factors combine to move the major impact of a drug going off patent into the next year and beyond. In some cases, a generic

drug's manufacturer can challenge the branded drug's patent(s) well before expiration, gaining six months of generic exclusivity. "Single source" generics are typically closer in price to the original branded drug (about 20% less for the illustrative drug shown in Figure 7). Only after the exclusivity period can other manufacturers offer a generic. As more manufacturers enter the market, prices fall over time (by 60% for the illustrative drug shown in Figure 7).

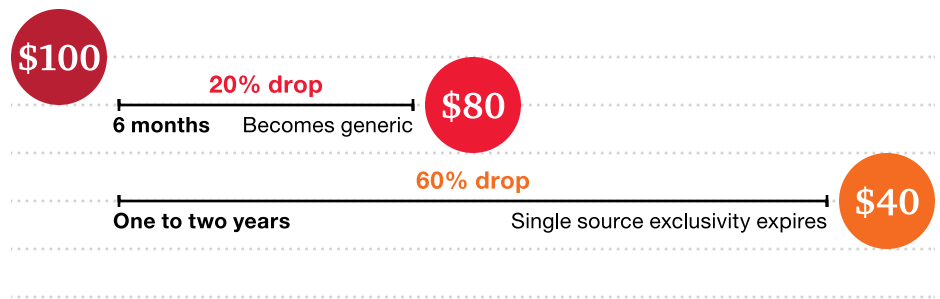
Physician prescribing habits and consumer acceptance of generics are factors in either slowing or accelerating the uptake of a generic equivalent of a branded drug. Generic drugs now account for about 80% of all prescriptions in the US.¹⁹

18 US Patent and Trademark Office; <http://www.uspto.gov/patents/resources/terms/156.jsp>.

19 IMS Institute for Healthcare Informatics, "The Use of Medicines in the United States: Review of 2011;" http://www.imshealth.com/ims/Global/Content/Insights/IMS%20Institute%20for%20Healthcare%20Informatics/IHII_Medicines_in_U.S_Report_2011.pdf.

Figure 7. Generic exclusivity price slope
Impact of the patent cliff for an illustrative drug

A medication that sells for \$100 before patent expiration is sold for \$80 during the first six months that a single company manufactures the generic. However, over the next six to 18 months, as more companies are allowed to produce the generic, the price drops to \$40.



Source: PwC Health Research Institute analysis.

Uptick in utilization and expensive advances push trend up

Medical utilization typically tracks economic growth

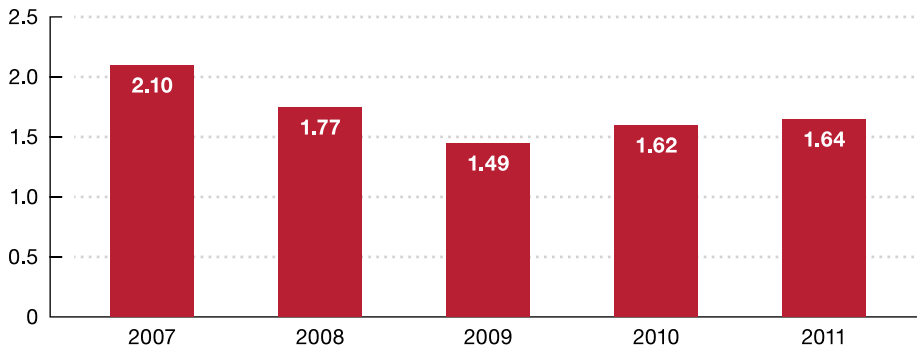
The recent recession and subsequent slow recovery have been characterized by a surprising slowdown in the growth in utilization of most medical services and products. Some health sectors even experienced a drop in utilization. Doctor office visits, for instance, decreased by 4.2% in 2010 and 4.7% in 2011.²⁰

Historically consumption has risen as the economy recovers. The theory, as Helen Darling, president and CEO of the National Business Group on Health, put it, is that “healthcare is a consumer good, and more money in the pockets of consumers equals more healthcare utilization.” In a stronger economy employees feel more secure in taking off work for medical appointments, which boosts utilization, she added. If the US economy continues to recover as forecast, an uptick in utilization would be expected.

As they did last year, several of the industry executives interviewed for this report expect utilization to rebound in the coming year. Some pointed to a slight uptick in acute care at hospitals for late 2011 and early

²⁰ IMS Institute for Healthcare Informatics, “The Use of Medicines in the United States: Review of 2011,” http://www.imshealth.com/ims/Global/Content/Insights/IMS%20Institute%20for%20Healthcare%20Informatics/IHII_Medicines_in_U.S_Report_2011.pdf.

Figure 8. Surgical cosmetic procedures in US
(Procedures in millions)



Source: American Society for Aesthetic Plastic Surgery.²¹

2012 as proof that trends are picking up. **Cosmetic surgery** could also be an early indicator of utilization rebound. Figure 8 shows that cosmetic surgeries fell during the recession, but are now on the rise and increased by 10% from the low in 2009. **Since cosmetic surgery is not generally covered by insurance, it is typically more sensitive to economic fluctuations,** and the recent uptick may foreshadow a utilization rebound in the rest of the healthcare industry. However, it will take a large increase in cosmetic surgeries to return to pre-recession levels.

Utilization of **laboratory services** appears to be increasing as well. First-quarter 2012 financial results for the testing firm Quest Diagnostics indicate a 3.4% increase in volume of clinical testing orders.²² A recent survey by the Joint Commission, a not-for-profit accreditation group, found that 51% of laboratory representatives expect an increase in demand for services in the next three to five years, driven by factors such as an **aging population,** new test development, and a push toward **personalized medicine based on genetic makeup.**²³

Medical advances drive growth in high-cost care and catastrophic claims

Continuing advances in **high-cost medical technology** combined with the **low cost to insured patients** have been a major inflator of US medical cost trend over the decades. New technologies, such as **robotic surgery and positron emission tomography (PET)** services, have grown rapidly, with 36% of hospitals performing robotic surgery in 2010.²⁴ Signs are that even in this slow-growth environment, high-cost treatments are pushing up the medical cost trend. Medical advances are leading to cures, albeit at a higher cost.

At the same time, executives at several health plans said they have experienced a higher-than-normal rate of catastrophic claims. Claims surpassing the \$500,000 and million-dollar marks rose steadily between 2004 and 2008, and there's **no end in sight as Americans live longer with increasingly complex medical conditions** (see Figure 9).²⁵

²¹ The American Society for Aesthetic Plastic Surgery, Statistics; <http://www.surgery.org/media/statistics>.

²² Quest Diagnostics, Press Release—Quest Diagnostics Reports First Quarter 2012 Financial Results; <http://ir.questdiagnostics.com/phoenix.zhtml?c=82068&p=irol-newsArticle&ID=1684292&highlight=/investor>.

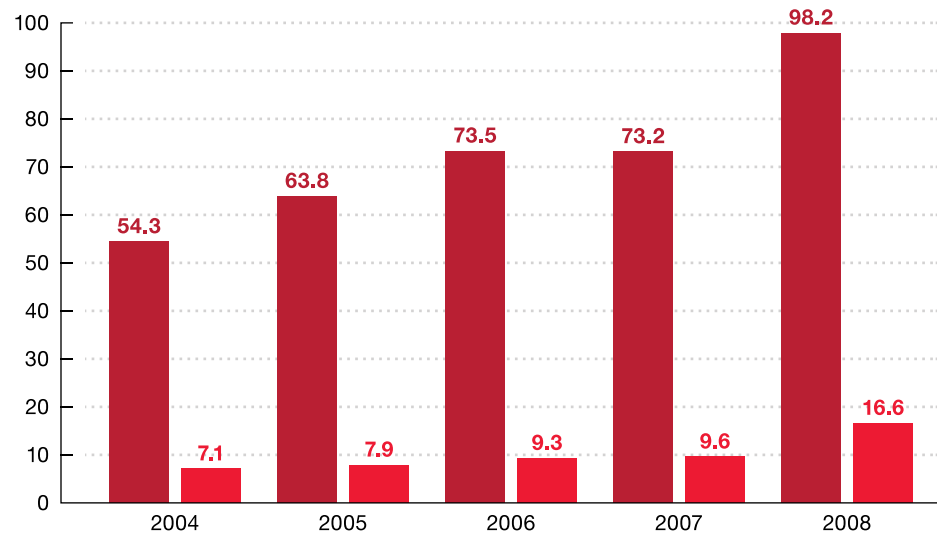
²³ The Joint Commission Lab Focus; http://www.jointcommission.org/assets/1/18/Lab_Focus_1_2012.pdf.

²⁴ Medpac, Report to the Congress—Medicare Payment Policy; http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

²⁵ The number of high-cost claims has not been adjusted to reflect rising medical costs. Some of the increase in catastrophic cases reflects the fact that \$500,000 in 2008 is not what it was in 2004. This distortion is limited by the relatively short period under consideration.

Figure 9. Increase in high-cost insurance claims
(Number of claims per million)

■ Claims greater than \$500,000 ■ Claims greater than \$1 million



Source: Munich Re America HealthCare Newsletter, Summer 2009.²⁶

In Northern California, hospital stays over \$1 million rose sevenfold over the past decade, according to data from the California Office of Statewide Health Planning and Development. Cumulatively, these charges came to \$5.2 billion in 2010, or roughly 7% of all statewide hospital charges.²⁷

One of the most expensive medical procedures is organ transplantation, which can range from \$200,000 to \$1.7 million for multi-organ transplants. The demand for transplantation is expected to rise sharply as the population ages and scientific advances allow more people to benefit from transplants. Higher rates of chronic disease leading to higher rates of organ failure are also fueling demand. Intestine transplants, the most expensive single organ transplant at \$1.2 million, have increased from 52 cases in 2004 to 77 in 2011,²⁸ while most transplants are expected to increase 1% to 6% over the next year alone.²⁹

Life-saving pediatric care can be extremely expensive as well. One health plan interviewed by HRI recently paid its single largest pediatric claim at \$8 million and has seen a rise in \$1 million-plus claims. Neonatal intensive care units, with average daily costs of \$3,000,³⁰ are used more often because more babies—1 in 8—are born premature and require round-the-clock care, temperature-controlled beds, special feedings, or interventions for complications.³¹

While generics decrease the cost of pharmaceuticals, new specialty drugs act as a counterbalance. Soliris, a medication that treats a rare, potentially life-threatening form of anemia, made headlines when Forbes magazine called it “the world’s most expensive drug.”³² Annual treatment is about \$400,000. Several specialty drugs targeting rare diseases have average annual costs up to \$300,000 year.³³

27 The Sacramento Bee, “Million-Dollar Hospital Bills Rise Sharply in Northern California;” <http://www.sacbee.com/2012/03/11/4328036/million-dollar-hospital-bills.html>. Sacramento Bee analysis of California OSHPD data.

28 Milliman Research Report, US Organ and Tissue Transplant Cost Estimates and Discussion; <http://publications.milliman.com/research/health-rr/pdfs/2011-us-organ-tissue.pdf>.

29 HRI analysis of Milliman’s 2011 Organ and Tissue Transplant Cost Estimates and Discussion finds that most transplant rates are projected to increase between 1% and 6% based on past rate increases.

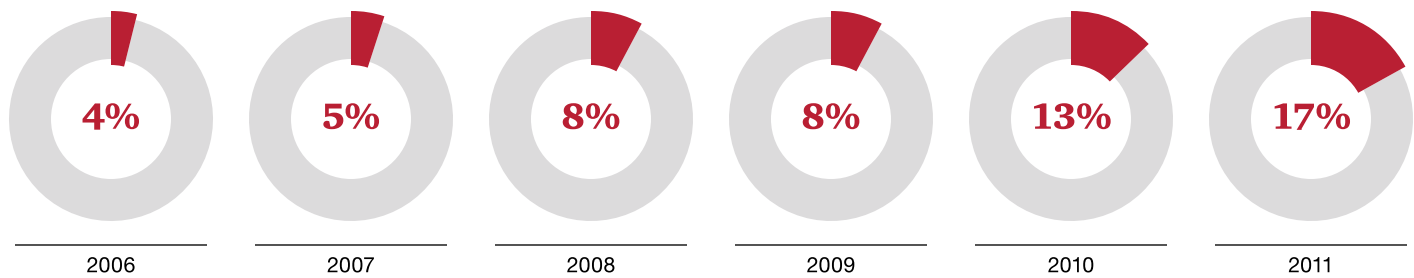
30 Managed Care, “How Plans Can Improve Outcomes and Cut Costs for Preterm Infant Care;” <http://www.managedcaremag.com/archives/1001/1001/preterm.html>.

31 March of Dimes, Mission; www.marchofdimes.com/mission.

32 Forbes, “The World’s Most Expensive Drug;” <http://www.forbes.com/2010/02/19/expensive-drugs-cost-business-healthcare-rare-diseases.html>.

33 Genzyme, “The Cost of Enzyme Replacement Therapy;” www.genzyme.com/commitment/patients/costof_treatment.asp.

26 Munich Re America, Newsletter Summer 2009; http://www.mrahc.com/newsletter/MRAHC_Newsletter_Summer_09.pdf.

Figure 10. Percentage of individuals with employer-sponsored coverage enrolled in a high-deductible plan with a savings option

Source: The Kaiser Family Foundation and Health Research and Educational Trust.³⁴

More on HSA's - Health Savings Accounts

The 'new normal?'

Overall health spending in the US grew more slowly in 2009 and 2010 than in any of the previous 51 years the federal government has been tracking health expenditures. And instead of increasing, the percentage of **US GDP** being spent on healthcare leveled off in 2010 at **17.9%**.³⁵

In years past, medical cost trend was relatively immune to recessionary effects and any slowdown in healthcare growth historically bounced back with the economy. Many experts interviewed by HRI anticipate a similar pattern.

But others observe that the most recent recession—and slow recovery—has created a new dynamic in the health industry. “I don’t see this economy bouncing back as quickly as it should—people are not aware how long it will take to get jobs back,” said Mary Greal,

president of the Healthcare Leadership Council, a coalition of chief executives across the healthcare system. “This recession is different than before.”

In 2013 the unemployment rate is expected to remain above 8%, and it will not fall to the natural rate of near 5.5% until the end of 2017, according to projections by the nonpartisan Congressional Budget Office.³⁶

Unemployment and the overall economic environment have had a direct connection to the health industry.

Between 2005 and 2010, more than 9 million Americans lost employer-sponsored coverage,³⁷ and many other businesses have shifted more costs to employees. For example, average **emergency room copays** have increased and are now **\$125** or more, according to the latest PwC Health and Well-Being Touchstone Survey.

³⁴ The Kaiser Family Foundation and HRET, Employer Health Benefits 2011 Annual Survey; <http://ehbs.kff.org/pdf/2011/8225.pdf>.

³⁵ Anne B. Martin, David Lasman, Benjamin Washington, Aaron Catlin, and the National Health Expenditures Account Team, Growth in US Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged From 2009, Health Affairs, 31, no. 1 (2012): 208-219. Note: US health spending is a broader measure than medical cost trend and includes all government expenditures, private spending, medical costs and administrative costs.

³⁶ Congressional Budget Office, “The Budget and Economic Outlook: Fiscal Years 2012–2022,” www.cbo.gov/publication/42905.

³⁷ Census Bureau, “Table HIB-4. Health Insurance Coverage Status and Type of Coverage by State All People: 1999 to 2010,” Current Population Survey, 2011 March Supplement.

Figure 11. Percentage of consumers delaying care because of cost

Source: 2011 PwC Health Research Institute Consumer Survey. N=1,000 respondents.³⁸

Overall deductible amounts have also crept up. Twenty-two percent of employers said their **most common plan had an in-network deductible of \$1,000 or greater** in 2012—a 14 percentage point rise since 2008. More employers said their out-of-network deductible had crossed the \$1,000 threshold—43% of employers in 2012, up from 21% in 2008. Half of the employers in PwC’s survey are considering increasing cost sharing through plan design, and an additional 34% said they had already done so.³⁹

High-deductible plans, which typically include a **tax-preferred savings account**, have grown significantly in recent years. Seventeen percent of individuals with employer-sponsored coverage are currently enrolled in such a plan, up from only 4% in 2006 (see Figure 10).

This shift is changing behavior and ultimately utilization; some employees are learning to shop around for needed care, while others forego elective

procedures or possibly delay care. A recent HRI survey found that 46% of consumers had delayed care at least once in the previous year, and 10% had delayed care five or more times (see Figure 11).⁴⁰

The sluggish economic recovery may be complementing efforts to constrain medical cost trend. Stakeholders across the healthcare landscape, forced to do more with less, have begun embracing new strategies and habits that have the potential to be longer lasting. Hospitals are using sophisticated technology to create “just-in-time” staffing models and new relationships with physicians to pressure suppliers for lower prices. Employers and insurers are encouraging comparison shopping by patients, coordinated care that pays for better health outcomes, and promotion of **healthier lifestyles**. If these efforts spread widely, the United States may be entering a “new normal.”

³⁸ HRI, “Top health industry issues of 2012: Connecting in uncertainty,” 2011.

³⁹ PwC 2012 Health and Well-Being Touchstone Survey.

⁴⁰ HRI, “Top health industry issues of 2012: Connecting in uncertainty,” 2011.

What this means for your business

Employers and insurers will want to capitalize on the recent slowdown, while doctors, hospitals, and pharmaceutical companies will need to retool their business models to succeed in the new environment.

Employers

What they are doing now

Employers continue to wrestle with how many and what kind of cost-shifting strategies are most effective. The appropriate blend of incentives, cost shifting, and wellness programs can motivate employees to stay healthy and productive. Yet **the science of what works best isn't getting the attention it needs**. If labor markets tighten—and they are already in some industries—this will become critical. More than half of employers surveyed by PwC spend more than 1% of total medical costs on wellness programs, but 88% of these say they either do not measure or have insufficient data to measure a return on the investment.

While many employers have learned to drive participation with financial incentives (e.g., cash, gift cards, raffles), those with significant wellness program experience are emphasizing outcomes rather than just participation. And a select few employers are looking beyond traditional incentives and are **offering discounts on health insurance premiums for employees who show progress on basic health measures such as body mass index**. Some employers have recently **made news** by refusing to hire obese job applicants, or banning smokers from their payroll entirely.

Things to consider

- Collect, analyze, and act on healthcare program data. Take the time to assess your investment—is your workforce getting healthier?
- Communicate, educate, and facilitate wellness. Personalize the message and leverage mobile technology to provide real-time support.
- Promote value by tapping low-cost options such as workplace clinics and telehealth. Employer-sponsored clinics have shown they can improve the overall health of an employee population, with the added benefit of increasing productivity and reducing absenteeism.
- Deploy value-based distinctions in benefit design. Value-based benefit designs rely on incentives to use services more wisely, and they increase the likelihood that patients will comply with treatment plans and engage in healthy behaviors. Value-based designs are primarily intended to stretch healthcare dollars, but they may not necessarily decrease actual costs.

I'm not sure if this is allowed under Health Care Reform?

Providers

What they are doing now

As the largest and fastest-growing segment of medical costs, hospital reimbursement is being aggressively targeted for savings by government and commercial insurers. Even as hospital systems push for rate increases, they know that what insurers really want is to avoid the hospital altogether.

Under every scenario, hospitals and physicians are increasingly accountable for the cost and quality of healthcare they provide.

Things to consider

- Prepare for increased scrutiny and accountability. Conduct in-depth reviews to ensure pricing is defensible. Competitive services such as lab tests, imaging, and outpatient therapies should take into account any local free-standing competitors and be priced accordingly.
- Change care models to reflect new reimbursement models. The overall agenda of accountable care is for delivery of service and patient engagement to be seamlessly working toward improved health and prevention. To meet these goals, it is essential to maximize information exchange among different care providers. Alignment with physician groups can benefit providers on several fronts, whether acquiring a physician practice or focusing on enhanced integration of existing groups.
- Develop a culture of collaboration. Teamwork will be especially critical in achieving lower Medicare readmission rates set to take effect in October 2012. Simple efforts to improve the discharge process such as proactively scheduling follow-up appointments, educating patients and their caregivers, and initiating pill reminders will decrease chances these patients return. Collaboration should also extend to engaging patients in their own care.
- Predictive modeling can help identify patients at higher risk for readmission. These models can be added to electronic medical records, elevating them from mere record keeper to intelligence tool that can help provide better care.

Health insurers

What they are doing now

As health insurers brace for an anticipated rebound in utilization, they also need to closely monitor market perceptions that influence employers and policymakers. Rate hikes are now front-page news as insurers must disclose more information to the public and regulators in justifying large rate increases. Over the past year, some states have stepped up their examination of rate hike proposals, knocking back a majority of requests and putting millions of dollars back in consumers' pockets.

As of March 2012, the justifications and analysis of 186 double-digit rate increases for plans covering 1.3 million people have been posted at HealthCare.gov, resulting in a decline in rate increases.⁴¹ New medical loss ratio rebates are also getting press, as recent projections estimate insurers will owe employers and consumers \$1.3 billion in rebates in 2012.⁴²

In addition to managing reputational risk around future rate increases, health insurers can take an active role in health system transformation by sustaining the lower cost trend. Insurers will want to accelerate efforts to promote transparency, support wellness and realign provider roles and incentives to help support a “new normal” environment.

Things to consider

- Align incentives and empower consumers. If the 2010 health reform law is fully implemented, insurers will look for increased market share in the new age of health insurance exchanges, subsidies, and mandates. Health plans will have to educate consumers, build plan awareness, and distinguish themselves by creating meaningful connections with members. This may include bundling complementary products with insurance or financial institutions or reaching consumers in the places people frequent—hospitals, clinics, grocery stores, and retail outlets.
- Build trusted relationships. According to HRI research, 11% of consumers will purchase insurance through state-based exchanges, and few of them expect to purchase their insurance without help.⁴³ Building trust with consumers will be a large factor in influencing purchasing decisions. One way to build trust is to meet their expectations around mobile and digital communication and engagement. For an in-depth discussion on how social media is changing the nature of healthcare in the United States, see *Social media likes healthcare*. (<http://www.pwc.com/us/healthsocialmedia>)
- Collaborate with stakeholders. Insurers should work with employers to improve value-based design, influence behaviors, and enhance consumer engagement. Coordinating and analyzing healthcare information will be key to working with providers, as insurers hold vast amounts of patient data that could improve care coordination and allow hospitals and physicians to participate in new government payment systems such as accountable care organizations.

CA Rate Regulation

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⁴¹ HealthCare.gov; <http://www.healthcare.gov/law/resources/reports/rate-review03222012a.html>.

⁴² Kaiser Family Foundation, “Kaiser Analysis: Estimated Health Insurance Rebates Under the Health Reform Law Total \$1.3 Billion in 2012;” <http://www.kff.org/healthreform/hr042612nr.cfm>.

⁴³ PwC Health Research Institute, “Change the Channel,” 2011.

Pharmaceutical and life sciences

What they are doing now

To retain its share of medical revenues in an era of constrained growth, the pharmaceutical industry must pursue strategies that highlight the **additional value a drug contributes to care**. Emphasis will be on drugs that demonstrate cost effectiveness, such as helping people avoid additional doctor's visits or minimizing adverse effects. For an in-depth discussion on pharma, see *Unleashing value: The changing landscape for the US pharmaceutical industry*. (<http://www.pwc.com/us/pharmavalue>)

Two ways pharmaceutical companies are accomplishing this are by investing more in clinical informatics for clinical trials and post-marketing studies, and creating comparative effectiveness or health economics analytics teams.

As the only segment with promising growth, biologics (and their off-patent equivalent, biosimilars), have become an increasing share of yearly FDA approvals and R&D pipelines. Drug manufacturers are increasingly joining forces with small biotech companies and research institutions to create these more targeted medicines, but will be under greater scrutiny to demonstrate value as drug pricing shifts from volume to clinical outcomes.

Private and government payers are also investing more in comparative effectiveness research, pushing drug makers to justify new treatments with meaningful differentiation over existing treatment options. New drugs must demonstrate additional clinical and cost benefits in the new era. For example, a drug that can show a reduction in additional doctor appointments, or reduce emergency room visits, will be viewed favorably.

Things to consider

- Strengthen internal capabilities to conduct health economic studies, pragmatic or “real-world” clinical trials, and better partnerships with diagnostics technologies to improve the pharmaceutical contribution to health system performance.
- Team with providers and purchasers. Demonstrating outcomes requires collaboration on drug design and payment methodology.
- Drug makers will need to continuously apply data and findings back to R&D processes, and evolve their evidence-gathering and product launch strategy to emphasize education, adherence, and population health.

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About this research

The “Behind the Numbers” report includes findings from PwC’s Health and Well-Being Touchstone **Survey of more than 1,400 employers** from 30 industries, as well as interviews with health plan actuaries and other executives whose companies provide health insurance for 47 million American workers and their families.

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

“Behind the Numbers 2013” is our seventh report in this series.

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