

Quick thinking

Four key findings from health reform



While it might be overly dramatic to say that everything has changed with the passage of Patient Protection and Affordable Care Act (PPACA), it can certainly be said that the health system of tomorrow will not be the same as today's:

- Much of the “patchwork quilt” that paid for the uninsured will largely be replaced by public or private insurance coverage.
- A stronger focus will be placed on paying hospitals and physicians for quality.
- Insurers will be highly regulated but have access to new customers through new online exchanges.
- Pharmaceutical companies will see increased pricing pressures through discounts and fees even as they see new customers.
- Individuals and businesses will face the choice of providing and paying for health insurance or paying penalties.

This publication brings together research on health reform from PwC's Health Research Institute (HRI). HRI's research is done through in-depth, first-person interviews as well surveys of consumers and health executives. It also includes economic analysis by our Washington National Tax Service. HRI research is independent and not sponsored by businesses, government, or other institutions.

In this publication, PwC provides a condensed version of HRI reports, providing the industry with some “quick thinking” about how health reform will change the business of healthcare. We explore four key findings around health IT, physician-hospital alignment, mobile health, and the health insurance exchanges.

Overview of timeline and sector implications for health reform

In short, health reform is big and comprehensive, and it will affect nearly all parts of the health system. The changes extend for the next decade, but unfold in three major tranches.

How health reform unfolds

Regulation and coverage (2010-2013)

- Elimination of pre-existing coverage exclusions for children and lifetime coverage limits and rescissions; dependent coverage through age 26
- MLR minimums for non-grandfathered plans
- Medicare Part D gap narrows, Medicare Advantage rates frozen, bonuses available, beneficiary rebates, free preventive care
- Temporary high risk pools
- Fee on brand -name pharmaceutical manufacturers
- Community Living and Support Services Act (CLASS Act)

Major expansion of coverage (2014)

- Mandates for individuals
- Employer penalties for those that do not provide coverage
- Health insurance exchanges
- Small employer and individual subsidies
- Health insurer industry fee
- Guaranteed issue, rating bands, and risk adjustment
- Medicaid expansion
- Disproportionate share payment reductions to hospitals

Bending the cost curve (2015-2020)

- Penalty for not adopting electronic medical records
- Independent Payment Advisory Board (IPAB)
- High-cost plan excise tax
- Medicare Part D “Doughnut Hole” closes
- Reduced payment for hospital-acquired conditions

All sectors of the industry are affected in regulatory, financial and operational terms. Major impacts by sector:

Providers

- New reimbursement models favor hospital and physician alignment, including physician employment, over the traditional private practice model. Bundled payments, accountable care organizations, medical homes, reduced readmissions, and quality-based reimbursement require hospitals and physicians to become partners in payment.
- Low performers will be penalized by Medicare. Beginning in 2015, a 300-bed hospital with poor quality metrics could be penalized by more than \$1.3 million per year. Even more important, these hospitals could suffer reputational damage as performance metrics are published online.
- The number of Medicaid recipients will increase by more than 40% from 2010 to 2019, so hospitals must learn to operate on Medicaid rates. Traditionally, Medicaid has been a poor payer so hospitals will need to quickly address their fixed costs.

Health insurers

- Many health plans will have to reduce their administrative expenses to meet the new threshold for medical loss ratio (MLR) of 85% for the large group market and 80% for the small group and individual market. Currently, many individual and small market plans are not meeting the new required MLR, which governs the amount of premiums allocated to paying medical expenses.
- Successful insurers will have to shift their attention from group to individual plans, which are expected to triple between 2010 and 2019. Over the next 10 years, growth in the Medicaid coverage will also increase substantially.
- Health insurers will have to differentiate themselves on price, service, quality, and provider network in the new health insurance exchanges. With regulations requiring four standard benefit packages, essential health benefits, and limits on cost sharing, insurers will have to compete on factors other than benefit design.

Pharmaceutical and Life Sciences

- Health reform changes will cut into expected spending on brand-name drugs by 4.3%. The increased number of insured will be offset by heavier discounts required by Medicare and Medicaid and other new fees on government sales, making it less attractive to sell to government programs.
- The creation of a new regulatory pathway for biologic products dramatically alters the portfolio design process. Mature biologic manufacturers will see a roughly 20% hit on their revenues, while large generic manufacturers may see an increase in sales of roughly 2%.
- The new law greatly accelerates the movement toward outcomes- and quality-based reimbursement in the US market, resulting in a more intense focus on drug efficacy and results. The mission of the Patient-Centered Outcomes Research Institute, the CMS Innovation Center, the Independent Payment Advisory Board, and other new regulators will be to “bend the cost curve” and reward quality.

Cross-sector

In silos, sectors will not be able to prosper in the new healthcare environment. For example, with changes to their reimbursement structure, providers need to partner with payers and the pharmaceutical sector to share data, increase patient adherence, and improve quality care and patient outcomes. Improved quality and outcomes has positive impacts on all sectors. The implementation of exchanges could lead to low-income employees accepting subsidies and leaving their employer plans (as a result of lack of affordability), thus triggering a financial penalty for the employer. Together, these sectors can work together to keep customer satisfaction high so payers do not lose employers in their plans and employers do not lose employees enrolled in their benefits plan.

All sectors must learn to more consumer-centric. More information, such as quality scores, pricing, and drug or device payments to doctors, is going to be readily available. Each sector will need to think in plain language terms to ensure that they are catering to their consumers' needs.

Sectors will have to find their “community” and partner with others in serving it to survive in the post-health reform environment. There are multiple provisions in the bill that focus on community-wide needs assessments and grants to address health needs across the spectrum. Healthcare in the United States is becoming more patient-focused, providing care through collaborative methods such as accountable care organizations (ACOs) and medical homes. For the pharmaceutical industry, disease groups or drug classes will enable the mobilization of compliance through consumer channels.

This is a condensed version of [Health reform: Prospering in a post-health reform world](#). To read the full report, [click here](#).

Finding 1

The US is embarking on its largest investment in health IT ever, but most health systems have left out the voice of the patient.

Last summer, a woman ended up in an Eau Claire, Wisconsin, emergency room—and then a coma—after months of experiencing symptoms that had perplexed several doctors regarding a diagnosis. Fortunately, a family member released to the woman’s doctor the Facebook account where the woman had been tracking her symptoms, conditions, medications, and hospitalizations. The woman had recorded details about how she felt and when she felt that way. After reading her account, physicians became able to piece information together and diagnose and treat her; she has since recovered.

While this woman was fortunate to have been tracking her health somewhere, it’s unfortunate that she did not have a personal health record (PHR) she could share among her caregivers. With a PHR, she might have uncovered trends in her health data that would have prompted her to ask certain questions of her physicians: 40% of today’s PHR users said their PHRs led them to ask their physicians questions they might not have asked before. With a PHR, this woman might have avoided the emergency room—and the coma.

The government has decided that electronic health records (EHRs) form the asphalt of tomorrow’s information health highway, and it has defined meaningful use (MU) as the master plan to ensure that the highway is effective and systematic. The stimulus funding for health IT, which starts in late 2011, is the government’s single biggest investment in health IT. Yet, it’s a small carrot compared to the amount of resources it will take to deploy this technology. Late adopt-

ers will feel the big stick of Medicare penalties if they fail to implement EHRs that meet the criteria for MU beginning in 2015.

A typical 500-bed hospital demonstrating MU by 2011 could receive more than \$6 million in Medicare incentive payments, and individual physicians could receive up to \$44,000, according to PwC analysis.

There are three stages of meaningful use criteria. With each stage, hospitals are responsible for connecting to a broader set of constituents. However, the result improves the experience for providers, patients and families.

Among a number of other requirements, Stage 2 sets higher standards for communicating health information to patients. This represents a big leap from what hospitals and providers have been preparing for over the past year. In Stage 1, eligible hospitals and providers need only provide patients with an electronic copy of their health information—including diagnostic test results, problem lists, medication lists, and medication allergies—upon request, and just 50% of the time.

However, Stage 2, which begins October 2012, may require eligible hospitals to offer 80% of patients the ability to view and download relevant information via a web-based portal within 36 hours of discharge and eligible providers to have at least 20% of their patient populations accessing information that way. Some health systems may be poised to meet the adoption requirement and assist physicians to do the same, but will providing patients with access to health information alone accomplish the job? Not if health systems want to succeed in an increasingly competitive industry where a redesign of healthcare delivery hinges on how health information is communicated and used.

“Meaningful use” Stages 1 and 2 are leading to interoperability. The hope is that interoperability will enable providers to exchange information, with a view to move into emerging delivery models like the patient-centered medical home, health information exchanges, and accountable care organizations (ACOs). (For more information on health information exchanges and ACOs, see *Designing the health IT backbone for ACOs*.)

However, patient awareness of and access to available health IT tools is low; social, expectation, and education hurdles also exist.

Only 14% of patients access their medical records electronically through their doctor’s office or a hospital, according to an HRI survey. Prescriptions are the most common piece of health information accessed electronically, but over 55% of consumers can’t access such information as lab results or physician visit notes. And of the few who do access their health data electronically, only one-third share their EMRs with primary care physicians and specialists. This may be attributed to consumers’ lack of awareness of the technology and its uses and/or their providers’ inability to provide electronic health data. To add to the confusion, the lines between the EHR, the EMR, the PHR, and the patient portal are blurring.

There are also expectations to bridge. One large health system said it relied on an advisory group of patients and physicians to develop a patient portal. The CIO recounted: “At our first meeting, we discussed what would be reasonable turnaround time for making test results available for view in the portal. The physicians first said 45 days, which was completely unreasonable. Then they said two weeks to 30 days. When we asked the patients, they said, ‘How about 30 minutes?’” Forty-five days or 30 minutes? This time gap mirrors the expectations gap between health organizations and consumers.

To encourage patient engagement, here are four steps that clinics and hospitals can take to promote adoption and utilization of PHRs:

Step 1: Make the physician/advanced-practice nurse the face of the PHR.

Step 2: Define expectations for active participation in healthcare.

Step 3: Get family members on board.

Step 4: Design PHRs alongside patients to keep them coming back.

*This is a condensed version of [Putting patients into meaningful use](#). To access the full report, [click here](#). A companion report, *Ready or not: On the road to meaningful use of EHRs and health IT*, can be [downloaded here](#).*

Finding 2

Hospital and physician relationships are moving from courtship to marriage

As US health reform attempts to alter the way health services are paid for and delivered, hospitals and physicians are quickly moving to align more closely. Physicians and hospitals often have had caustic relationships, brimming with competing interests and skepticisms. In the 1990s, hospitals bought and then sold hundreds of physician practices, an integration strategy still remembered as a largely failed experiment. That was followed by years in which physicians opened competing outpatient surgery and imaging centers as well as specialty hospitals. Now, health and payment reforms have put an end to many of those formerly lucrative options for independent physicians and group practices. Further, hospitals have new reasons to bond with physicians to transform how care is delivered, consistent with health reform and market demands.

Trust—never a natural instinct between physicians and hospitals—remains a barrier. When asked whether they trust hospitals, 20% of physicians surveyed by HRI said no, and 57% said sometimes. However, physicians want financial security from their hospital relationships, and money may win out over trust issues. Nearly three-fourths of physicians surveyed by HRI said they're already aligned financially in some way with hospitals. Such relationships include directorships, employment, and joint ventures. In addition, 24% said that they already work primarily in hospital practice settings.

Three key reasons hospitals want to align with physicians:

1. Decreasing payments create the need for cost reduction. With Medicare reimbursement being squeezed, the biggest potential income stream for both hospitals and physicians may reside in sharing savings from payers. To do that, hospitals and physicians must manage care together. Two-thirds of physicians surveyed by PwC indicated that hospitals need physicians to reduce inpatient costs, thereby signifying a need for better collaboration and care management.

Most interested in employment

Cardiology	63%
Psychiatry	61%
Surgery	53%
Pediatrics	51%
Emergency Medicine	50%
OBGYN	50%
Otolaryngology	50%
Rheumatology	50%
Internal Medicine	49%

Interested in employment

Anesthesiology	48%
Family Medicine	46%
Dermatology	45%
Pulmonology	43%
Endocrinology	39%
Oncology	39%
Allergy	38%
Ophthalmology	38%

Least interested in employment

Neurology	31%
Radiology	31%
Nephrology	30%
Gastroenterology	27%
Urology	26%
Orthopedics	25%

2. Better quality will finally pay off for hospitals, but they need physicians to deliver it. An average-sized community hospital could lose more than \$1.4 million annually starting in 2013 due to poor quality scores, according to PwC analysis. Hospital leaders interviewed for this report said they need physicians to improve clinical outcomes and to protect them from or minimize penalties.

- Hospitals need physicians to participate in the new payment systems. Hospital executives we interviewed were bullish on the need to partner with physicians as a means of participating in accountable care organizations (ACOs) and other new payment arrangements. Physicians corroborated that view, with more than 50% citing bundled payments as a motivator for hospital alignment and more than 54% saying that because of ACOs, hospitals and physicians will become more closely aligned over the next five years.

Three key reasons physicians want to align with hospitals:

- Increase their income. Overall, 56% of physicians surveyed by HRI want to more closely align with a hospital in order to increase their income. Another 40% want to align to ensure a more consistent income stream. In-depth interviews with physicians revealed that many physicians fear income loss, citing recent Medicare reductions in cardiology payments as a precursor for other specialties. Cardiology specialists want hospital paychecks. Two-thirds of cardiology specialists surveyed said they're interested in being employed by hospitals. The cardiology specialty—which is among the most lucrative of all physician specialties—has experienced deep cuts in Medicare payments.
- Align incentives. Forty-seven percent of physicians surveyed said there are now better opportunities to align incentives than there were during the integration efforts of the 1990s. Physicians view payer negotiations as a key motivator for hospitals wanting to align. Sixty-eight percent of physicians surveyed identified such consolidation of market power as the primary motivator for hospitals' desire to align with them.
- Reduce overhead. More than one-third of physicians surveyed said hospital alignment would decrease administrative burdens such as health information technology requirements; 63% said alignment could lead to better work-life balance.

Three interlocking issues support successful physician-hospital alignment: shared governance, aligned compensation, and changing physician practice patterns. All are easier said than done.

Shared governance

- More than 90% of physicians surveyed said they should be involved in hospital governance activities, however, hospital leaders said most physicians lack needed leadership and business skills to participate in these activities. Some hospital systems are providing continuing education for physicians to fill in these skills.

- Nearly two-thirds of physicians said they can devote time to leadership and management activities. To make sure physicians have time to fulfill administrative obligations, more providers are paying them for serving on committees and participating in administrative activities.

Aligned compensation

- Physicians said half their compensation should be fixed salary, and the remainder, incentive based. This shows that physicians realize the health system is changing to track and reward performance and that they can influence the quality and cost of care delivery at the institutional level.
- More than 80% of physicians who are considering hospital employment said they expect to be paid the same as or more than they are now. When asked how much more, the average increase was 2.4%. The average range of expected compensation increase spanned from 1% to 4.7%. Less than one in five physicians surveyed said they would accept a pay cut to work for a hospital.

Changing physician practice patterns

- Physicians, who have traditionally been paid to generate volume, may have to adjust practice patterns that emphasize overall system quality and efficiency. Aligned models emphasize effectiveness of the whole system, not its parts. Elements of health reform such as accountable care organizations, bundled payments, and medical homes are designed to redesign the care delivery model with the patient at the center, but they could reduce utilization.
- Hospitals should lean on accepted guidelines as they move forward. Sixty-two percent of physicians surveyed said nationally accepted physician practice guidelines have the most potential to change current physician practice patterns; only 30% preferred locally developed guidelines. Multiple hospitals interviewed as a part of this report detailed partnering with state and national organizations to establish clinical guidelines.

This is a condensed version of two HRI reports on physician-hospital alignment. In *Part I: Why health reform is driving physicians and hospitals closer together*, we profile physicians in terms of their current alignment patterns and future alignment interests. *Part II: How physicians and hospitals are creating sustainable relationships* examines how hospitals and physicians can make alignment work for both sides. To read the full series, [click here](#). In addition, readers might be interested in a related report, *Stalking the ACO Unicorn*.

Finding 3

Mobile health is booming, but business models have been elusive—until health reform.

Mobile technologies hold great promise for keeping people healthy, managing diseases, and lowering healthcare costs. For years, telehealth has provided clinical services for individuals who lacked physical access: farmers in remote communities, soldiers near the battlefield, inmates in prison.

Now, these technologies have demonstrated the ability to benefit almost any individual. Mobile devices are the most personal technology that consumers own. They enable consumers to establish personal preferences for sharing and communicating. They can enable health and wellness to be delivered through mass personalization.

Unfortunately, the payment wires have been crossed. Providers get paid based on volume of services delivered, and mobile health has been shown to reduce the need for hospital admissions and physician office visits. Why would providers adopt technologies that gouge their incomes? An industry that is paid based on volume will not adopt technologies that reduce volume. However, new payment models enveloped in the new health reform law set up a framework to pay providers based on outcome, not volume.

HRI estimates the annual consumer market for remote/mobile monitoring devices to be \$7.7 billion to \$43 billion, based on the range consumers said they would be willing to pay. Real value will need to be demonstrated in order for adoption to occur. And that value begins with understanding two key customers: the individual and the physician.

Health reform is rearranging the incentives, shifting the payment system to one that rewards performance and outcomes rather than volume. In this environment, the greater financial rewards go to organizations that demonstrate savings over traditional health delivery. Mobile health applications can expand access and reduce costs and in some cases, do both at the same time—a twofer that is rare in healthcare.

Understanding how to use such information hinges on applying a business model that marries technology to financial reward and creating new work flows that move from analog to digital health delivery.

HRI categorizes mobile health business models into three main categories: operational / clinical , consumer products and services , and infrastructure .

The operational/clinical business model enables provider, payer, employer, medical device and drug companies as well as nontraditional healthcare organizations to run their business operations better and more efficiently. Key physician survey findings that inform the operational/clinical model were as follows:

- Mobile health can improve the use and the value of physicians' time. One-third of physicians surveyed by HRI said they make decisions based on incomplete information. They believe the greatest benefit of mobile devices will be to help them make decisions faster as they access more accurate data in real-time.
- Forty percent of physicians surveyed said they could eliminate 11% to 30% of office visits through the use of mobile health technologies like remote monitoring, email, or text messaging with patients. Such shifts could rewrite physician supply and shortage forecasts for the next decade and beyond.
- Physicians are interested in different types of applications. Primary care physicians are most interested in prescribing medication wirelessly, and specialists, in accessing electronic medical records (EMRs) wirelessly.
- In-person consultations are still the main method of reimbursement, but physicians are getting limited reimbursement for phone consultations, email consults, telehealth, and text. Payment models that address how mobile health reduces costs are more effective, but require changes in delivery-care processes.
- Providers in search of additional funding should consider marketing mobile health solutions. According to the survey, consumers said hospitals are the preferred

place to buy mobile health products and doctors are overwhelmingly the most trusted in terms of getting health information.

The consumer products and services model enables individuals to understand key health metrics and share that information with those who matter most in their lives. HRI survey findings showed:

- Cell phones are a ubiquitous device to inform and activate consumers. The simple act of texting has picked up momentum, with nearly 80% of Medicaid patients texting regularly, the highest rate of all other insured and uninsured individuals.
- Healthcare could learn from other markets in which consumers pay a premium for instant gratification. The HRI survey showed that individuals who delayed care more than five times in the last year are more willing to pay out-of-pocket for doctor visits, electronic or in-person.
- Only half of consumers surveyed said they would buy mobile technology for their health, so it's important to know who these consumers are. Of those, 20% say they would use it to monitor fitness or wellbeing and 18% want their doctors to monitor their health conditions. While 40% of respondents would be willing to pay for a monthly mobile phone service or device that could send information to their doctor, they would prefer to pay less than \$10 for the monthly mobile phone service and less than \$75 for the device.
- Physicians agree that patient compliance is a major obstacle and 88% would like their patients to be able to monitor their health on their own. Weight and blood sugar topped the list, with vital signs not far behind.
- Markets for mobile health can be counterintuitive. For example, even though surveys show women make most health decisions for the family, the HRI survey showed that men are twice as likely as women to use their cell phone to get health-related reminders.

Infrastructure business models connect, secure and speed up information and services.

- Integration. Health systems are largely ignoring the importance of integrating mobile health into other IT efforts, such as EMRs. Two-thirds of physicians surveyed said they are using their personal devices for mobile health solutions that aren't connected to their practice or hospital IT systems.
- Security. When physicians were asked about barriers to adopting mobile health in the HRI survey, "worried about privacy and security" was the top answer, cited by one-third of PCPs and 41% of specialists.

- Bandwidth. Hospital IT networks are struggling under the need for more bandwidth to support rapidly expanding data transactions and exchanges.

Healthcare organizations may want to consider these steps when identifying and executing on the mobile health opportunity:

1. Customer: Identify the specific market segment for mobile applications.
2. Pain points: Identify the current failure and pain points that mobile solutions can more effectively address for the target market.
3. Work flow: Identify how the current processes, practices and work flow would change by the application of mobile solutions to provide a better outcome.
4. Vision: Create a vivid visualization of the mobile solution and the characteristics of the offering that would create greater value.
5. Value proposition: Create the value proposition that identifies, quantifies and measures the cost, convenience, confidence and compensation from outcome improvements from the mobile solution.
6. Platform: Identify an existing platform or the need to create a new platform upon which the new mobile solution should be launched and the partners required for the platform components.
7. Business model: Create the business model that delivers the value proposition by leveraging existing or creating new payment options.
8. Develop and launch: Develop and launch the mobile offering for the target market through pilots and then full launch based upon realizing metrics and milestones of successful adoption.
9. Data mining: Mine real-time data and information to create increasing value for all stakeholders.
10. Scale: Expand the platform and business model to address the larger and adjacent markets.

This is a condensed version of [Healthcare Unwired: New business models deliver care anywhere](#). To read the full report, [click here](#).

Finding 4

New members and risks await insurers in the \$60-billion health insurance exchange marketplace

Among the most market-changing aspects in PPACA is the insertion of a new marketplace to buy health insurance subsidized by the government.

In 2014, an estimated 12 million consumers will choose health insurers in a new, tightly regulated marketplace where choice will be king. That marketplace will encompass different state health insurance exchanges (HIXs) in which health insurers compete for nearly \$60 billion in premiums. And that's just the start. By 2019, an estimated 28 million Americans will buy health insurance through this new online channel. PwC estimates that by then, the HIXs will have grown to nearly \$200 billion in premium revenue.

Insurers will compete head to head for individuals who will be required to buy their product but be able to comparison shop like never before. This is a far cry from today's world, where nearly all workers—except government employees—have few choices of health plans. Choice tends to be even smaller still for those on the individual market, where nearly three-fourths are shut out because of cost, preexisting conditions, or insufficient coverage to fit their needs.

More than half of insurance executives surveyed by PwC expect to see an increase in their individual business, and nearly half expect growth in their small group business. The exchanges will create an array of new choices for customers in the individual and small group markets. Of those insurance executives who said they plan to compete in the exchanges, 37% said their companies are not in the individual market today and 20% are not in the small group market.

In the race for members, insurers must first understand these new customers. And they need to start now. For example:

- Nearly all (97%) of the consumers in the exchanges in 2014 are expected to be those who were previously uninsured. The remaining 3% are expected to be those who previously had purchased individual coverage.

- Health insurers and the exchanges will face a huge consumer education challenge. For example, 87% of consumers in the individual exchanges are expected to be eligible for the government subsidies because of their incomes. However, in HRI's survey of consumers, 82% of people in that income group didn't know they would qualify for such subsidies.
- Forty-six percent of consumers say it would be easier to shop for insurance if they had someone to talk to at the insurance company; 43% would like a tool that estimates prices for common procedures.

As insurers approach 2014, adverse selection is their top concern, according to the HRI survey, followed by technology integration, such as payment or enrollment transactions. Health insurers' concerns about adverse selection are valid. To sustain the exchange's success, the exchange will need to balance the risk both inside and outside the exchange. In the 1990s, California established a health insurance exchange that failed because of adverse selection issues. This time around, state policymakers are inserting additional mechanisms to prevent this from occurring again.

To alleviate the impact of adverse selection, the health reform law establishes a risk adjustment process that states can implement along with two temporary risk management programs: reinsurance and risk corridor. Those programs will be in place from 2014 through 2016 while the market adjusts to the shift in members and substantiates the risk adjustment process.

- Risk adjustment. At its simplest level, an exchange will charge a fee to health insurers whose members have lower than average risk scores (including enrollees in all plans inside and outside the exchange). Those fees would be paid to health insurers whose members have above average risk scores.
- Reinsurance. Health insurers (including third party administrators on behalf of self-insured plans) will collectively pay \$25 billion over the three-year period for reinsurance. States may collect more to cover the administrative costs. Insurers with high-risk individuals and/or large claim expenses will receive payments from the reinsurance entity based on a pre-defined list of high risk conditions.

- Risk corridor. This will be based on the Medicare Part D risk corridor and is similar to the risk adjustment. Health insurers with costs (minus administrative costs) of less than 97% will be assessed a fee, and those with costs that exceed 103% will receive extra payments.

How health insurers can prepare for the exchanges

The exchanges are scheduled to begin certifying plans around October 2012. While on average, insurance executives surveyed expect to be ready for exchange certification in 15 months, about 40% expect it will take 18 months and about 20% expect it will take 24 to 36 months.

Here are some recommendations:

Prepare for market disruption

Because health insurance exchanges have never before been implemented nationally, the market could see a paradoxical future. The exchanges could lead to either market consolidation or expanded competition.

- Market consolidation: Some insurers have started exiting markets, citing worries about guaranteed issue and new medical loss ratio (MLR) requirements. Because states have so much flexibility in designing their exchanges, insurers may find some states more profitable markets than others. In addition, some insurers with complementary products and services may join forces. And while HIXs present the opportunity for health insurers to enter new markets, the prospect may prove too expensive to undertake without partnering with one another.
- Expanded competition: Health insurance exchanges create new territory for nontraditional health insurance companies to enter the insurance market. With only 36% of the consumers surveyed opposed to purchasing health insurance from nontraditional insurance companies, this presents an attractive market for new entrants. These players can come in the form of new health insurers or of partnerships between existing insurers and retailers or financial institutions. Companies that have the capital, market presence, and superior consumer interaction and service experience are well positioned to tap into this market.

Redefine the sales process

Brokers and internal sales teams are health insurers' primary mechanisms for attracting and retaining customers in today's individual and small group markets. Brokers have direct incentives to sell for insurers, but with HIX membership, that model shifts in 2014. Compensation becomes the responsibility of the exchange, taking away health insurers' ability to influence brokers through financial incentives. Insurers will need to find new ways to influence the influencers by demonstrating how their products benefit consumers

and by making it easy for brokers, navigators, and providers to understand their plans.

Investing in relationships with those who have frequent touchpoints with consumers is critical for understanding what drives plan selection, for attracting customers, and for establishing a solid position in the market. Virtual touchpoints and such channels as social media and mobile applications could play big roles in influencing the sales process. Connecting with populations that rely on those technologies for their social interactions could create more engagement opportunities and help reduce insurers' administrative and medical costs.

Prioritize population management

Insurers will also need to move away from a reliance on risk selection to a focus on population risk management. To improve their chances of success, health insurers should:

- Establish superior data tracking and analytics. Health insurers need to maintain accurate data to feed the exchange's risk adjustment process. Such input will help exchanges determine the appropriate compensation for insurers that enroll a disproportionately sicker population and balance the risk. Data analytics also lead to more effective case management. Health insurers can better deploy nurses and case managers if they understand which members are at greater risk and who will benefit from various interventions. Health insurers will ensure that up-to-date health status profiles exist for their enrollees.
- Predict the new risk. Health insurers need to understand the prevalent illnesses of the uninsured and of those in high-risk pools. Consider developing customized products for chronic diseases. Creating products that function like centers of excellence enable health insurers to market plans and attract members with medical care they are well versed in managing. Attracting select populations also enables health insurers to better predict the risk that will be received and enables those insurers to better price premiums and better manage MLR thresholds.
- Embrace care management. Invest in disease management efforts and develop innovative ways to help members take better control of their healthcare and make educated decisions. This can range from investing in wellness and prevention programs to opening and/or investing in clinics to lower the use of more costly, emergency departments.

This is a condensed version of [Change the channel: Health insurance exchanges expand choice and competition](#). To read the full report, [click here](#). Insurers and employers also may be interested in PwC's analysis of medical cost trends for 2012. That report, [Behind the Numbers](#), can be downloaded [here](#).

Health Research Institute Team

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

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

Sandy Lutz
Managing Director
sandy.lutz@us.pwc.com
214 754 5434

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

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

Sarah Haflett
Manager, Health Information Technology
Research
sarah.haflett@us.pwc.com

PwC Health Industries leadership

Have a question or comment?
Contact us here.

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

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

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

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