Top Nine Health Industry Issues in 2009:

Outside forces will disrupt the industry

PricewaterhouseCoopers' Health Research Institute

External forces will buffet the health industry in 2009, forcing organizations to react and prepare for new financial realities, regulations, and technology. Chief among those forces will be the effects of the economic crisis, a new president and Congress, and financial and technology companies hoping to extend their reach into health.

Heart of the matter

As the economic crisis persists, the health industry will seek ways to deliver value in spite of market conditions. In addition to the economic crisis, the industry will see continued investment from some unusual players. In 2008, industry trade journal Modern Healthcare recognized three industry outsiders at the top of 100 Most Powerful People in Healthcare: Steve Case, co-founder of America Online; Eric Schmidt, chairman and chief executive officer of Google; and Bill Gates, co-founder of the Gates Foundation and board chairman of Microsoft Corp.

As these examples show, new entrants are moving into the health industry and disrupting the old ways. Health leaders in 2009 must navigate these changes while hedging against risk and preparing for disruption.

1 The economic downturn requires a back to basics approach for health organizations

Although the health industry historically has been less vulnerable to economic downturns than other industries,[1] the effects of a financial and credit crisis that began in the fall of 2008 will reverberate throughout 2009. According to media reports in late 2008, about one-third of consumers have either delayed care or skipped a recommended test or treatment during the past year, and hospitals reported some services have dipped slightly.[2] Hospitals have reported that elective surgeries, diagnostic tests and outpatient procedures have decreased by 1% to 2%, versus a 2% to 4% historical growth.[3] In the first eight months of 2008, the number of dispensed pharmaceuticals dropped for the first time in over a decade, and demand for financial assistance with prescription drugs is increasing.[4]

The disrupted economy is expected to affect the industry in a multitude of ways: Hospitals will experience an increase in bad debt. Investment portfolios were affected for most insurers, providers and pharma companies. Payer mix is shifting away from relatively lucrative commercial insurers and toward Medicare, Medicaid, and self-pay. Charitable donations and investment income are down, and improvement projects involving capital outlays for IT, facilities and equipment have been put on hold. Biotech companies have seen their valuations drop, which could affect their access to raise additional capital.

Health organizations may need to find new sources of capital, and to get that capital, they'll have to demonstrate that they're improving their core businesses and improving efficiencies. On the plus side, labor shortages could ease as more workers look to healthcare as one of the most resilient employers around.

Implications:

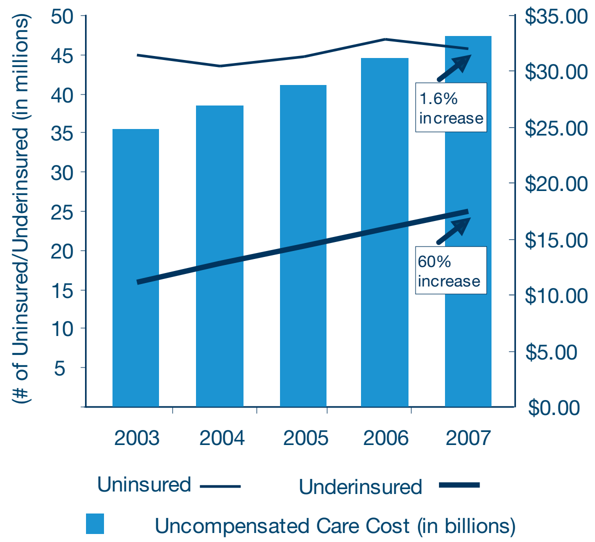
- Higher emphasis on delivering value and service.
- Medicaid programs may become more stingy as state economies are pinched by unemployment and lower tax revenues.
- Financial distress can be an ideal climate for innovation as organizations learn to do more with less.

2 Underinsured surpassing uninsured as providers' headache

The uninsured draw most of the attention from policy makers and the public, but the number of underinsured is growing even faster. The underinsured have some, but not enough, health insurance coverage. When they show up in hospitals, emergency rooms, and doctor's offices, they often can't or won't pay the high deductibles and co-pays for the services they need. In addition, as the number of uninsured and underinsured individuals grows, we can expect more cost shifting to commercial plans and patients delaying and forgoing care. The number of uninsured individuals in the United States increased from 45 million to 45.7 million[5] between 2003 and 2007, an increase of 1.6%. However, an estimated 25 million adults qualify as underinsured, an increase of 60% since 2003, according to the Commonwealth Fund.[6]

The chart below illustrates the growth in uninsured and underinsured patients, which is one factor in the rise in uncompensated hospital care costs.

Exhibit 1: Uninsured and Underinsured Patients and Uncompensated Care Costs



Source: US Census Bureau,[7] The Common Wealth Fund,[8] American Hospital Association[9] and PricewaterhouseCoopers' Health Research Institute.

To mitigate the growth of bad debt, hospitals have begun to prequalify patients, using credit scores and other databases to determine whether they can pay, and how much. Use of consumer credit rating companies allows hospital business offices to sort out patients who can pay and those who may qualify for charity care. Hospital business offices are trying to improve up-front collection practices by using estimation tools. However, many aren't able to provide accurate estimates.

In some markets, hospitals are employing credit card-like swipe machines that verify eligibility, estimate insurance coverage, and access balance information for health savings account balances and health reimbursement arrangements. Other hospitals are using credit cards and extending their own lines of credit.

Implications:

- With growing unemployment during the financial crisis self-pay is becoming a major part of providers' revenue cycle processes.
- Business operations will need to leverage technology and processes from the retail, banking and credit industries to manage self-pay patients and the underinsured.
- Not-for-profit hospitals must tread carefully, as they don't want to be seen as further complicating the credit for uninsured and low-income patients.

3 Big Pharma turns to M&A to build the drug pipeline

Pharmaceutical companies face pressure on three fronts. First, very few new drugs are coming to market. Second, existing drugs are going off patent to generic. Third, sales and marketing channels are starting to be regulated more heavily by government. The result is a steady decrease in revenue. Generics substitution is expected to reduce revenue between 2% and 40% over the next five to six years.[10] The following table shows expected revenue erosion between 2008 and 2015 for some of the top companies in the industry.

With revenue from existing pharmaceuticals slowing down and the decrease of approved new drugs in the pipeline, pharmaceutical companies are focusing on acquisitions of smaller biotech firms to reenergize the drug pipeline.

As the financial markets continue to hit turbulence, cash-rich pharmaceutical companies may be able to find bargains in the mergers and acquisition market.

Even with the weakening credit market, the life sciences industry sector had a 10% increase in venture capital during the third quarter of 2008 as $2.2 billion was invested in 207 deals.[12]

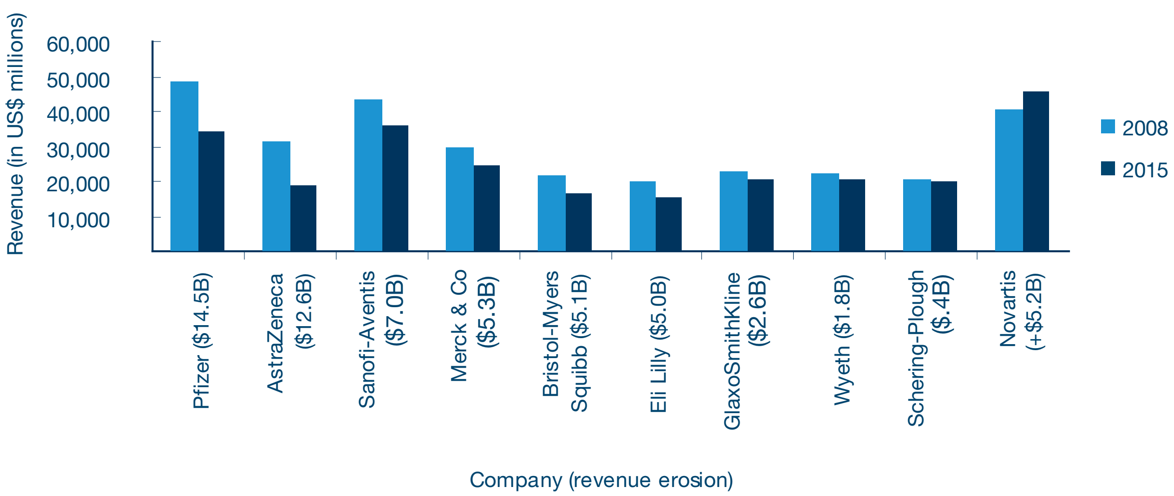
Implications:

- Use of generics will accelerate, and pharmaceutical companies will have to respond by increasing efficiencies in their workforce and production.
- Pharmaceutical companies that can bring technological innovation in the R&D process will realize competitive advantage.
- Pharmaceutical companies will seek out ways to increase revenues by merging with smaller life science companies.

4 From vaccines to regulation, prevention is on the rise

Prevention gets a boost from drug makers and regulators in 2009. While drug makers will see more of their prescription drugs go off patent, vaccines will be a bright spot for their sales. In the US, vaccines such as Prevnar and Gardasil are strong revenue drivers. Globally, vaccines continue to benefit from non-governmental organizations that have placed new emphasis on immunizations, such as the Gates Foundation and Soros Foundation. For example, the Gates Foundation donated $75 million in 2008 to the Global Alliance for Vaccines and Immunizations (GAVI).[13] In addition, vaccine makers are working more closely with regulators earlier in the process to ensure there is greater alignment of the value received in return for the cost of developing the vaccinations.

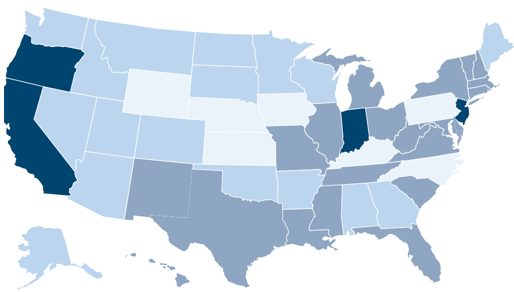
Exhibit 2: The impact of generic erosion on Big Pharma's revenue



Source: Bernstein Research 2008[11]
Note: These figures show each company's "base revenues" from products that are already on the market. They exclude any future pipeline contributions.

On the regulatory side, more state and local governments are regulating health-related behaviors, such as smoking in public areas and serving trans-fats in foods. For example, California recently followed the lead of New York City by banning the use of trans-fats in restaurants. The state also is considering requiring fast-food restaurants to post nutritional information, limiting the locations where cigarettes may be sold, and charging fees for sugary sodas. Massachusetts also has proposed legislation on trans-fats. As shown in Exhibit 3, 35 states ban smoking in public places, four have laws banning trans-fats and 21 states have proposed laws banning trans-fats.

Exhibit 3: States that have enacted laws that limit smoking in public places and laws surrounding the use of trans-fats in restaurants



- No trans-fat or smoking laws
- Smoking ban only, no trans-fat laws
- Trans-fat laws proposed
- Smoking and trans-fat laws enacted

Source: The National Conference of State Legislatures,[14] the Kaiser Family Foundation[15] and PricewaterhouseCoopers' Health Research Institute.

Implications:

- Pharmaceutical and biotechnology companies that can focus research and development on preventive vaccines and immunization will be able to capitalize on these public health trends.
- Increasing regulations on healthy lifestyles could benefit employer and insurer efforts to reduce medical costs through consumer behavior.
- Pressure to spend more government funding on prevention could reduce availability of dollars on treating disease.

5 Genetic testing reaching price point for the masses

The direct-to-consumer (DTC) market for genetic testing will expand as the cost continues to drop. Companies such as 23andMe, which was started with funding from Google co-founder Sergey Brin, are giving consumers unprecedented access to information within their genetic code. Brin used the test to find out he has a mutation in his genes that has been linked to familial Parkinson's disease.[16] DTC marketing of these tests bypasses traditional clinicians, raising questions about how the information affects diagnosis and treatment.

Current DTC genetic testing services cost between $399[17] and $2,500[18] but focus on single letter mutations in the DNA rather than a full genome mapping. This means that the companies perform a scan of the patient's DNA to identify markers associated with specific diseases.

Knome of Cambridge, Mass., is offering a full genome mapping for $350,000.[19] The National Human Genome Research Institute has set $1,000 as the target price for genome sequencing, saying at that price point; genome sequencing will become a routine medical procedure.[20] However, even as prices drop the question remains whether consumers will use discretionary spending for these tests during an economic downturn.

In 2009, providers, payers and regulators must adhere to the Genetic Information Nondiscrimination Act passed in 2008. For example, insurers won't be able to deny coverage or raise premiums to individuals based on their genetic predispositions to developing certain diseases.[21] With that reassurance, more states may consider allowing DTC genetic testing. Currently, 25 states permit DTC genetic testing without limitation.

Implications:

- Physicians will need to anticipate more patients ordering genetic tests and needing guidance regarding the results and potential preventive health strategies.
- Research will focus on how genetics can affect pharmaceuticals and enable personalized medicine.
- Regulations regarding genetics at a state and federal level will continue to develop.

6 Technology is a powerful health extender

Technology will empower patients in new ways during 2009. Patients have more access to health information than ever through laptops, handheld computers, and Internet-enabled cell phones. The increase of patient-to-patient interactions over social networking platforms, often referred to as Health 2.0, is creating a significant buzz among consumers and companies. Websites such as patientslikeme.com and americanwell.com are changing how healthcare is navigated and experienced by consumers. Patientslikeme.com is a networking website that allows patients to share information about and experiences with diseases with other individuals. Americanwell.com has the goal of providing access to healthcare services in the home through technology such as web communications and digital telephony. Biotech companies are looking toward harvesting the collective knowledge within such platforms to improve their product development, enhance innovation, and target their advertising. And in 2009, the Centers for Medicare and Medicaid Services (CMS) will add more patient consultations to the list of reimbursable telehealth services.

CMS is also pushing technology for prescriptions. Starting in 2009, health care providers who used qualified e-prescribing systems can earn incentive payments of up to 2%.[22] Private health plans are also encouraging the move to e-prescriptions. Blue Cross and Blue Shield of Massachusetts announced that it will offer doctors bonus payments for using e-prescription systems starting in 2011.[23]

Electronic health records (EHR) and electronic medical records (EMR) are becoming more commonplace, thanks to large investments by key players. Microsoft Corp. offers HealthVault, and last year, Google launched Google Health. Both products allow users to manage their personal health records and other information online. Wal-Mart, the nation's largest private employer, is offering employees access to personal health records in a partnership with Dossia. The company wants all of its US employees and their family members to have access to EHRs by the end of 2010.[24]

Implications:

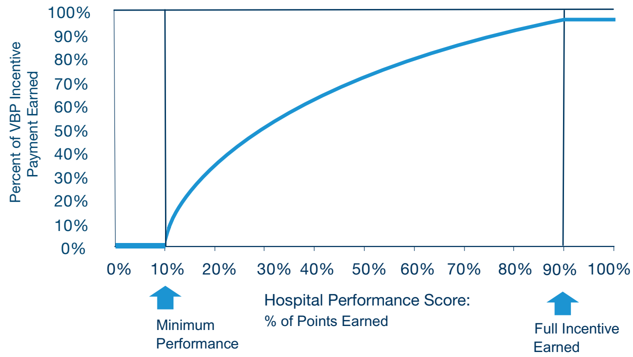
- Technology companies increasingly will connect and intercede between patients and their health records, treatments, and clinicians.
- Consumers will become more knowledgeable and involved in their healthcare as they begin to populate and manage EHRs.
- CMS bonuses for e-prescribing will further e-health progress.

7 Hospitals must perform to get paid

Medicare, Medicaid, and commercial insurance companies are placing additional focus on hospital performance, which could affect reimbursements received by healthcare providers in 2009. Currently, a hospital's MS-DRG payment is adjusted for market factors through the wage index and case mix index. CMS has proposed adding a new index starting in October 2009: the total performance score. It's part of Medicare's move to value-based purchasing (VBP). If Congress approves, CMS would replace the current quality reporting system with one in which Medicare withholds between 2% and 5% of its reimbursements to hospitals. As an example, for a hospital that receives $150 million in Medicare payments, this could be between $3 million and $7.5 million that it would have to earn back through performance and progress on quality metrics.

To improve their scores, hospitals will need to focus on their performance and quality of facility care scores, which are published on the CMS Hospital Compare Web Page. These scores focus on areas including surgical care, heart attack care, pneumonia care, heart failure care and hospital consumer assessment of healthcare providers and systems. Points are awarded based on how a facility's score compares with the scores of other hospitals. If the facility's score is less than or equal to the average score in a specific metric, no points are awarded. Partial points are awarded for those not receiving full performance scores. If the facility's score exceeds the average score, up to 10 points are awarded. Higher points translate to a higher total performance score.

Exhibit 5: Translating Performance Score Into Incentive Payment: Example



Example Source: US Department of Health and Human Services[25] and PricewaterhouseCoopers' Health Research Institute.

This is a lot for hospitals to absorb, particularly on top of Medicare's decision to no longer pay for "never events," which started in October 2008. The "never events" list is expected to grow over the next several years. CMS announced that in 2009 it plans to include ventilator-associated pneumonia and deep vein thrombosis to the list.[26] The goal is not so much to reduce Medicare spending as to reduce unnecessary deaths. With these programs underway, CMS is moving from a passive to an active purchaser of healthcare services.

Implications:

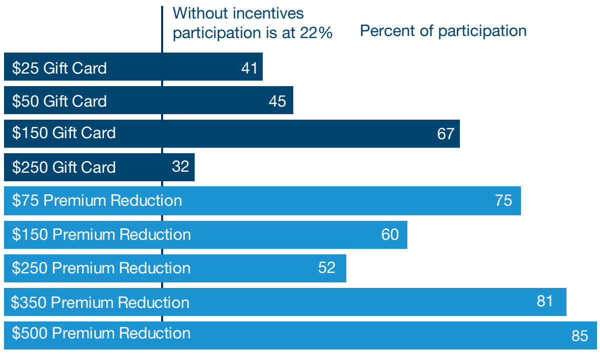
- Healthcare providers will focus on how to improve their performance scores.
- Seeking out process improvements and documenting care will become a priority for healthcare institutions that want to avoid "never events."
- Having an adequately staffed and well-trained clinical workforce will be more important than ever.

8 Payers and employers move the needle on healthy living through incentives

Incentives to encourage responsible health behaviors and participation in wellness and disease management programs are gaining interest among employers. According to a recent PwC Health Research Institute survey, large employers are leading the trend, with more than 60% at least somewhat likely to offer incentives as a health strategy over the next 12 to 24 months. In addition, half of the small employers surveyed are at least somewhat likely to employ the strategy.

Wellness programs don't work if employees don't participate, and most of them don't. Less than 15% of eligible individuals enroll in wellness programs, according to human resources directors surveyed by PwC. However, participation increases when incentives such as cash or gift cards or annual premium savings are used. Employers reported that workers are two to four times more likely to enroll in programs that help them improve their health status if they receive gift cards or other incentives.

Exhibit 7: Percent of employees who complete health-risk questionnaires by type of incentive offered



Source: PricewaterhouseCoopers, Health and Wellness Touchstone

Health plans are in a position to promote wellness and prevention by playing a more active role in plan design, tools, support, and community education. Health plans should advise employers on programs that have been effective at other organizations in terms of gaining participating members and showing positive outcomes. Preventive care has the potential to reduce healthcare costs overall. Therefore, in the best interests of both parties, preventive services should be included in coverage, should be promoted to members, and should be monitored for utilization. Wellness is the most highly valued non-core service offered by health plans. Health plans can start to distinguish themselves among their competitors if they are able to help integrate the most-relevant incentives for an employer population into benefit specifications. Employers are looking for effective wellness programs and increasingly believe—and evidence shows—that incentives matter. There remains much opportunity for innovation on behalf of health plans in this area.

Implications:

- Health plans will begin to play a more active role in plan design, tools, support, and community education.
- Employers will look to health plans to help them increase participation in wellness programs.
- Employers will begin integrating incentives and benefit designs under a single vendor.

9 I see the future in ICD-10

The federal government has finally put a proposal on the table to require healthcare payers and providers to convert to the International Classification of Diseases–version 10 (ICD-10) code sets. With 155,000 codes, ICD-10 offers substantially more detail than the 17,000 codes of ICD-9. Providers and payers will have more information about the care process, not only what is delivered and paid, but also co-morbidity, disease management, prior treatment, post-discharge outcome, and inter- and intra-provider differences.

The transition from ICD-9 to ICD-10 will impact all major provider and payer processes. In addition to clinical process changes, the entire healthcare system—from quality of care, to medical records, to incentive salary systems, to reimbursement—will have to adjust. Transaction and code set upgrades alone represent a huge undertaking; add to that the IT and administrative impact, customer and provider implications, vendor readiness and compatibility, system testing, process testing, and the need to modify or replace service contracts.

When the conversion process is complete, ICD-10 will increase the accuracy of reimbursement and quality management. Overall reporting capabilities will also improve public health reporting and health services research. However, the conversion will no doubt be daunting for the industry during already challenging times. No one can afford the expense of deploying a compliance program that does not also deliver a strategic business value.

Implications:

- Providers and health plans will soon begin the long-term process of implementing ICD-10, although some will put it off hoping for a regulatory delay.
- Healthcare providers and payers can leverage the deployment of ICD-10 by finding ways to use the new, more granular, information to gain additional efficiencies.
- The conversion will likely be costly and disruptive.

Conclusion

During 2009, the health industry may prove to be a source of profitable growth during an economic malaise. As new players continue to enter the healthcare market and new technologies develop, the next frontier in healthcare could be hidden from view. In addition, heightened focus by regulators will need to be monitored carefully as reducing healthcare costs are viewed as a way to stimulate the economy.

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