Healthcare reform:
Five trends to watch as the Affordable Care Act turns five

Health Research Institute
March 2015

At a glance

In its first five years, the Affordable Care Act (ACA) has had a profound, and likely irreversible, impact on the business of healthcare. Industry leaders must rethink strategies to remain relevant in a post-ACA world.

pwc

Table of contents

The heart of the matter

Still the subject of intense debate, the Affordable Care Act of 2010 has already left an indelible mark on the $2.9 trillion health sector. By energizing five fundamental shifts over the past five years, the law has given rise to a New Health Economy predicated on value.

Not since the Telecommunications Act of 1996, *has a piece of legislation sparked such significant changes in a leading sector of the economy.*

Signed into law on March 23, 2010, the Affordable Care Act (ACA) continues to face legal challenges, implementation delays and the re-emergence of cost as a pressing concern. Yet even with those caveats, the law in its first five years has forged a path for major shifts in an industry that represents about 18% of GDP. Not since the Telecommunications Act of 1996, has a piece of legislation sparked such significant changes in a leading sector of the economy.

Though the groundwork was laid in advance of the law's enactment, health industry business models and imperatives will likely never be the same post-ACA. Five trends—both directly and indirectly influenced by the ACA—have ignited this transformation.

1. ***Risk shift:*** Raising the stakes for all healthcare players.
2. ***Primary care:*** Back to basics.
3. ***New entrants:*** Innovators in the New Health Economy.
4. ***Health insurance:*** From wholesale to retail.
5. ***States:*** Reform's pivotal stage.

With a major US Supreme Court case looming and shifts in the balance of political power, there is still the possibility that the ACA could be further revised or defunded. And new taxes and fees add to existing downward pressure on revenues.

Despite the challenges, these key trends—accentuated and accelerated by the law—continue to push forward, building opportunities and risks within the New Health Economy.[1]

Industry leaders must recognize that traditional ways of doing business are rapidly shifting toward a post-ACA system. While many healthcare players are walking the tightrope between old and new, eventually the "new" will become the "norm."

As such, each sector must be forward thinking and flexible. Paramount to remaining relevant is the willingness to innovate: to develop strategies that meet the demands of new healthcare consumers, to pursue alternative business models, to adopt new technologies and to take on new roles and activities.

Five trends igniting healthcare transformation

1

Risk shift: Raising the stakes for all healthcare players.

The ACA added force to new payment models that reward outcomes and penalize poor performance such as high rates of readmission and hospital-acquired conditions. By championing models such as shared savings, bundles and pay for performance, the ACA has accelerated a shift in risk away from traditional insurers and onto providers, pharmaceutical companies and even consumers.

2

Primary care: Back to basics.

Experimentation in new payment models and expansion of insurance coverage are making primary care once again the critical touch point.

3

New entrants: Innovators in the New Health Economy. Over 90 new companies created since 2010.

New entrants are rushing into the market to meet the demand for lower-cost, consumer-oriented care options in the post-ACA era. From data analytics to mobile technology, new businesses—as well as giants from other industries—are inspiring innovation and redefining value based on consumer preferences.

4

Health insurance: From wholesale to retail.

Rapid enrollment in the ACA's public exchanges has demonstrated the potential of retail-style health insurance and spawned renewed interest in private exchanges. In doing more business directly with consumers, insurers are changing their fundamental business model.

5

States: Reform's pivotal stage.

States have emerged as key players in the reconfigured healthcare landscape. From the design of exchanges to the decision over whether to expand Medicaid, states have notable discretion in implementing the law.

Risk shift:
Raising the stakes for all healthcare players

Trend 1

The industry's recognition that the path forward *hinges on being able to demonstrate value has spread.*

The health industry has been spreading and shifting risk—including financial, enterprise, operational and market share—to not only include traditional insurers, but also hospitals, physicians, pharmaceutical companies and consumers. The results of this shift vary in scope, uptake and even location.

While the business strategy varies between sectors, the overarching goal remains the same: learning to compete under an evolving set of rules, limited resources, increased transparency and a focus on value rather than volume.

The ACA fueled this trend. For providers, the law took steps to change how Medicare pays for care by offering financial incentives and penalties that encourage better care coordination, higher-quality outcomes and less fragmentation. Under the ACA, the combined penalties of Medicare's three quality programs—Hospital-Acquired Condition Reduction, Hospital Readmissions Reduction and Hospital Value-Based Purchasing—will put over 5% of Medicare inpatient payments at-risk.[2]

In addition, the administration recently unveiled a framework that would put as much as half of what it spends on Medicare into alternative payment models by 2018.[3] The move quickens the long-anticipated shift from fee-for-service payment that rewards the number of procedures performed to paying for the value or patient outcomes of the care provided.

Cuts to Medicare reimbursement and a focus on value have put cost pressures on hospital systems, challenging them to do more with less. In response, they are aggressively targeting cost structures, scrutinizing operations for reduction opportunities, and developing ways to lower costs and improve efficiency.

The extra force of ACA-championed payment models reverberates across the industry. Pharmaceutical companies have begun to see their influence over product selection and marketing wane.

In 2014, PwC's Health Research Institute (HRI) surveyed senior leaders from a cross-section of pharmaceutical and life sciences companies. The results show a growing willingness by pharmaceutical executives to cede more authority to the US Food and Drug Administration (FDA) to judge new medications based on clinical and economic effectiveness.[4]

The industry's recognition that the path forward hinges on being able to demonstrate value has spread. Hospitals, for instance, are more price sensitive, and some have publicly chosen less expensive drugs over pricier products as a way to tamp down total cost.

The risk shift also changes consumer attitudes. Many health plans sold on insurance exchanges are tethered to a high deductible, requiring consumers to spend more of their own money for medical care. Less insulated from healthcare costs, Americans want a healthcare market that can compete like a more traditional, retail-oriented system.

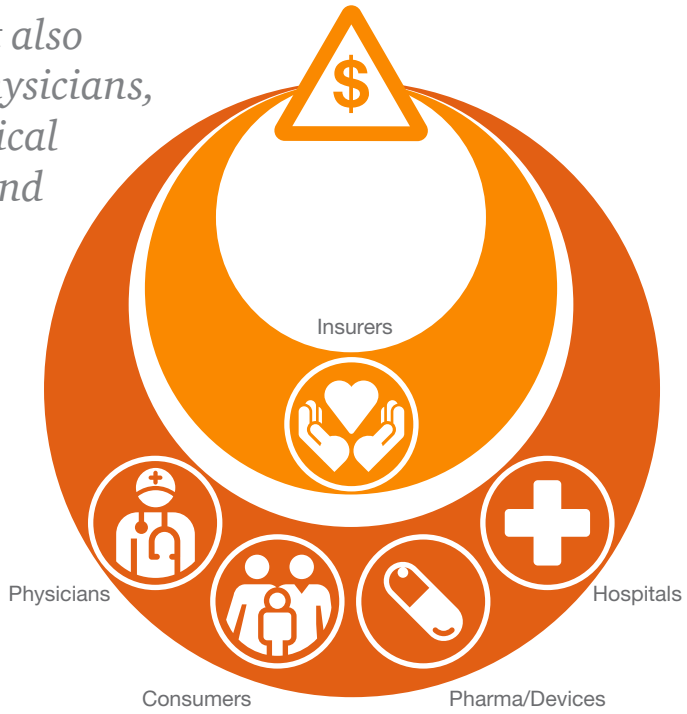
Pharmaceutical companies forge a business-to-business model.

It's not enough for drugmakers to simply satisfy the FDA as their head regulator. Now, forces, such as the creation of Accountable Care Organizations (ACOs) and capped payments, mean pharmaceutical executives must respond to cost pressures by health plans and providers with risk-based demand. This will require teasing out provider definitions of value and demonstrating the impact of outcomes, beyond FDA approval requirements. Outcome evidence creation itself is a pharmaceutical industry challenge. The ACA-created Patient-Centered Outcomes Research Institute (PCORI) has had limited influence to date and is prohibited from considering economic dimensions in its evaluations.

As a result, manufacturers are beginning to engage health systems in new ways, seeking their insights into product development and outcomes research. Just this year, MD Anderson and AstraZeneca announced a collaborative, multiyear research effort that will inform the development and utility of existing and future cancer therapies.[5] In the absence of innovative outcome evidence, undifferentiated products may receive scrutiny from purchasers, which could lead to harsh coverage decisions for products that increase cost with no appreciable gain in clinical performance.

Outlook: As providers take on more risk and continue to grow through consolidation, they should become more aware of the value and effectiveness of certain pharmaceuticals. The planned shift in Medicare payment models will accelerate a change in how pharmaceutical companies develop, price, market and then distribute new products. This becomes a major challenge to consider as healthcare providers currently have little awareness of drug costs.

Risk is spreading to not only include traditional insurers, but also hospitals, physicians, pharmaceutical companies and consumers.



Physicians and hospitals partner for better care coordination.

The Medicare Shared Savings Program and other pilot programs that limit payments further encourage physicians and hospitals to partner in the post-ACA world. Ascension Health and Trinity Health—two major national systems—teamed with Partners HealthCare and Advocate Health Care, as well as insurer Aetna and others, to build new payment models.[6] Other examples abound, as the law fuels the trend toward consolidation and partnerships.

Outlook: The risk-versus-reward calculus created by the ACA has pushed hospitals and health systems outside their comfort zone, to where innovation becomes survival.

Watch these businesses take on riskier strategies with deep cost cuts and an increasingly large share of revenue in value-based contracts. Some providers are starting to take it one step further: effectively becoming insurers themselves. Such moves are largely rooted in the ACA's expectation that health systems must manage patient care across a variety of medical settings, including doctors' offices, hospital outpatient departments, retail clinics and even the patient's home.

North Shore-Long Island Jewish Health System in New York has already seized the opportunity, receiving approval to offer health benefits in 2014.[7] And two Boston-based systems, Tufts Medical Center and Vanguard Health Systems (now Tenet Healthcare), received the go-ahead to sell coverage through the Massachusetts exchange.[8]

Insurers experiment with payment models.

Private insurers tested shared savings programs long before Congress tackled health reform, but the ACA provides teeth. The reason: allowing Medicare and Medicaid to pilot new ways to tie payment to quality improvement encourages commercial insurers to do the same.

Outlook: Insurers face the most immediate upheaval under the ACA, which restricts the types of plans they can sell, creates a competitive environment that puts the spotlight on price and increases industry oversight. But the tradeoff—more paying customers—has proven a boon to insurers.

Exchange enrollment is expected to level-off at about 22 million, while Medicaid enrollment will reach 14 million by 2025 with many enrolled in private managed care organizations.[9] This represents tremendous growth potential for insurers.

Nevertheless, as risk and rewards are passed on to providers, insurers will still need to provide unique services to survive. This will include investing in value-based delivery systems—much like UnitedHealth Group is doing with Optum and Aetna with Accountable Care Solutions. In addition, leveraging brand and distribution to align consumer incentives and reduce the employer healthcare burden will become a differentiator.

Consumers as purchasers.

Over 85% of enrollees in the ACA's health insurance exchanges selected silver or bronze plans in 2014 reflecting an increase in the popularity of high-deductible insurance options.[10]

This coupled with a rise in co-insurance, employer defined-contribution payments and health savings accounts means that Americans who are paying more out-of-pocket must become better purchasers of medical services. And, under the ACA, insurance companies and providers must help them in doing so, making it clear what consumers will pay and then get for their money.

Competition among a variety of health plans—all required to cover specific services—encourages consumer-friendly marketing. The result is a health industry that more closely resembles a retail or service business.

Outlook: As consumers spend more of their own money, they become choosy shoppers and are finding alternatives outside the traditional delivery system. Retail clinics, urgent care centers and even some outpatient departments—all of which typically have more flexible hours, more convenient locations and clearer pricing—have begun siphoning away business from traditional doctor offices and hospitals.

To compete, traditional providers, often with the help of technology, must find ways to give consumers what they want: convenience, alternative settings and remote access to care. For the pharmaceutical industry, this market of consumers—many of whom will struggle to afford expensive therapies—could hamper industry innovation, especially in the branded specialty drug category.

Primary care: Back to basics

Trend 2

*"**Three years ago Accountable Care Organizations** were like fables, often discussed but did not really exist. Now these entities are taking shape, and it appears clear that they will serve an important role in the healthcare marketplace into the foreseeable future."*

—Donald (Trey) Cole, III, M.D., Chief of Family Medicine, Austin Regional Clinic in Texas

If the ACA is a balance between expanding insurance coverage and encouraging non-traditional ways to pay for and deliver medical services, then primary care is its fulcrum. From treating the millions of newly insured Americans to testing novel ways to manage and streamline care, physicians broadly—and primary care clinicians specifically—are integral to virtually every initiative written into the law.

Primary care teams—including physician "extenders"—with their ability to deliver routine medical care while steering sicker patients to specialists, have long been seen as the best value across the US health system. The ACA recognized this, requiring that health plans cover primary and preventive care as essential health benefits, dedicating billions more in payment to keep physicians engaged with Medicare and Medicaid and providing incentives to sway budding doctors to practice primary care.

The ACA infused federally qualified health centers, which provide primary care to underserved areas, with an additional $11 billion for the construction of new sites and expansion of existing ones.[11] It also created the Center for Medicare and Medicaid Innovation which, since 2011, has given out more than $2 billion of its $10 billion budget to fuel exploration of new ways to deliver and pay for quality care, including primary care specifically.[12]

The law also created a new lexicon for doctors. Concepts such as ACOs, bundled payments and population health—ideas that work well on paper if not fully yet in practice—dominate the discussion among industry executives. In addition, greater use of telehealth and extenders—such as nurse practitioners and physician assistants—help to meet the growing demand for care as the number of newly insured continues to rise.

Accountable care becomes more tangible.

ACA-incentivized payment models mean physicians now practice in both the old fee-for-service business model and in a value-driven environment in which care teams are accountable for patient outcomes. New risk-based payment models allow physicians to share in a percentage of the savings generated by more streamlined care. Already, 424 physician practices

participate in the Medicare Shared Savings Program, which serves some 7.8 million seniors. Created under the ACA, the program has generated more than $417 million in savings.[13] Under the recently introduced "Next Generation" accountable care model, hospital and physician groups could have nearly 100% of their Medicare payment in at-risk contracts.[14]

Outlook: While some practices have made modest financial gains under risk-based payment, few have seen revenues on par with fee-for-service, underscoring the need for greater efficiency.

Still, Medicare and other major purchasers, such as private insurers and large businesses, are increasingly putting stock in accountable care arrangements, as demonstrated by the federal government's move to tie half of providers' Medicare reimbursement to alternative payment models by 2018.[15]

The challenge for primary care now is to strike the right balance between old and new, easing the learning curve associated with the inevitable switch to a value-based system without leaving money on the table in a still predominantly fee-for-service world.

Telehealth gets a boost.

The ACA took small but important steps to erase some of the policy issues that have hindered widespread use of telehealth services. But the law's focus on care delivery outside of the traditional Medicare fee-for-service creates one of the best opportunities for widespread adoption. The ACO and bundled payment structures create incentives for providers to tamp down the cost of care, encouraging primary care clinicians to virtually treat patients through video conferencing or simple email responses.

Outlook: Medicare acknowledged the growing popularity of telehealth in 2014 when it expanded payments for patient wellness programs, longer-term outpatient visits and a number of mental health services. It's a start. Medicare likely will need to expand payments to cover more routine care performed remotely. State licensure agreements, which restrict physicians in one state from virtual visits with patients in another state, will loosen to further speed adoption of telehealth services. Other care delivery alternatives—namely, physician extenders—are also being explored as a way to keep costs down and increase access.

The ACA dedicates more than $31 billion to boost primary care.

Community Health Center Fund — $11 billion

$11 billion over a 5-year period for the operation, expansion and construction of federally qualified health centers, which provide primary care to underserved areas.[16]

Center for Medicare and Medicaid Innovation (Innovation Center) — $10 billion

$10 billion over a 10-year period to fuel exploration of new ways to deliver and pay for quality care, including primary care specifically.[17]

Medicaid "pay bump" — $5.6 billion

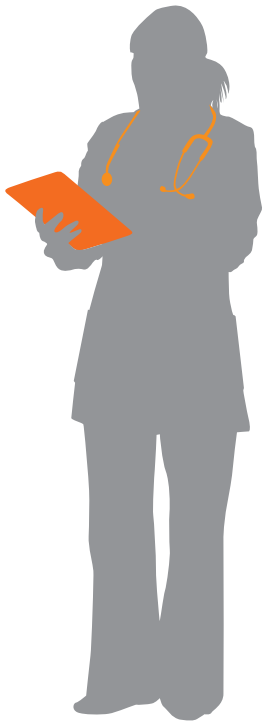
$5.6 billion spent to increase in Medicaid reimbursement for primary care services from 2013 through June 2014.[18]

Medicare bonus payments for primary care — $3.5 billion

About $3.5 billion will be spent between 2011 and 2016 on a 10% Medicare bonus to primary care clinicians.[19]

National Health Service Corps — $1.5 billion

$1.5 billion to incentivize careers in primary care in underserved communities.[20]



New Entrants:
Innovators in the New Health Economy

Trend 3

"Regardless of if you're a health plan, provider or employer, there has been a curiosity to look at innovative solutions because of the ACA."

—Sean Duffy, CEO Omada Health

The Telecommunications Act of 1996 spawned intense competition as new investments in telecom topped $1 trillion, pitting well-established giants like AT&T against newcomers such as Global Crossing and McLeodUSA.[21] A similar trend has emerged two decades later with the ACA, which has set the stage for phenomenal growth from new entrants such as Jiff, Oscar Health, Aledade and Vital Connect. The ACA—by bringing millions more paying customers into the market, promoting transparency, loosening technology regulations and driving changes in how care is delivered and paid for—opens the gates for savvy investors and start-up firms to enter the rapidly expanding $2.9 trillion industry.

Over 90 new companies have been created since 2010, according to HRI analysis. Some of these newcomers—such as Picwell and Omada Health—were conceived in direct response to opportunities and needs borne by the ACA. For Omada, the ACA's funding of disease prevention gave weight to its approach of tackling diabetes, cardiovascular disease and other chronic conditions through behavioral medicine delivered digitally. Now that the Centers for Disease Control and Prevention (CDC) has recognized digital programs to combat diabetes, and intensive behavioral counseling for patients at risk for heart disease will soon be a required preventive benefit for commercial health plans, ACA provisions are helping to fuel the company's growth even further.

In addition to new entities, giants from other industries—Apple and Samsung, for example—are applying decades of retail and financial experience to elbow into the health space. Products and services aimed at improving transparency, wellness and quality come in the form of mobile apps, data analytics and do-it-yourself devices.

Sparking more than just new products, innovation is also igniting partnerships among industry incumbents. Aetna, for example, has teamed up with Inova to create Innovation Health, pairing two historically unlikely candidates in the pursuit of a consumer-centric, tech-supported business model for the 21st century.

Expanding market for upstarts.

Supplementing investments from the federal government through the ACA and, notably, its predecessor the Health Information Technology for Economic and Clinical Health (HITECH) Act, digital health venture funding hit a record-breaking high in 2014, surpassing the $4 billion mark.[22] Technology is seen as critical to delivering on a key aspect of reform: high quality at low cost.

But technology is not the only dynamic force. From growth in retail clinics to heightened data analytics, investors continue to explore the expanding healthcare market.

New sources of venture capital are emerging as well. In September 2014, the University of California's Board

A new cottage industry arises.
More than 90 new health companies created since 2010.

Telehealth — 29 companies

Connecting patients and clinicians via technology

Examples include:
- Alii Healthcare
- CellScope
- MediSafe
- Vivre Health

Consumer education — 15 companies

Increase transparency to inform health-related decision making

Examples include:
- Azumio
- Doctible
- HealthSparq
- Zest Health

Health & wellness benefits — 9 companies

Offer insurance services or individual wellness incentives

Examples include:
- AchieveMint
- EveryMove
- Jiff
- Oscar

Process improvement — 14 companies

Streamline operations to enhance efficiency and patient experience

Examples include:
- Cureatr
- Dabo Health
- Epion Health
- Medisas

Model innovation — 7 companies

Help develop new care delivery and payment models

Examples include:
- Aledade
- Alignment Healthcare
- Iora Health
- Remedy Partners

Connector — 9 companies

Match patients and physicians with treatment and support networks

Examples include:
- Aidin
- Doximity
- Grand Rounds
- Smart Patients

Analytics — 7 companies

Collect and process patient health data

Examples include:
- Artemis
- Flatiron Health
- Human API
- Vheda Health

Source: PwC's Health Research Institute Analysis

of Regents approved the creation of a $250 million venture-capital fund that will target work performed at the university's 10 campuses, five medical centers and three national laboratories.[23]

Outlook: With the market still in flux, opportunities for disruption abound. According to HRI calculations the wellness industry in 2012 represented an additional $267 billion health-related market, with no signs of retreat.[24] Last year, Castlight Health's IPO was valued at over $3 billion, even with little revenue and losses on the books in 2013.[25] However, tepid stock prices post IPO keep investors cautiously optimistic. Though many new entrants will stumble—and at least one new insurance co-operative already has failed—one thing is for certain: shifting frameworks in a consumer-centric sector will continue to inspire disruptive new thinking.

ACA spurs new twists.

Healthcare players explore new business strategies post-ACA.

Providers become insurers

Example: North-Shore LIJ starts its own health plan.

Health players collaborate

Example: MedStar and CVS team-up to improve care coordination.

New players enter health fray

Example: Walmart sells ACA health insurance exchange products.

Source: PwC's Health Research Institute Analysis

Redefining physician-patient interaction.

New health players seek to deliver the same convenience and do-it-yourself flexibility that consumers demand when banking online or booking travel. A 2013 HRI consumer survey shows that middle-aged consumers, and those for whom healthcare expenses had put a strain on finances, are most amenable to exploring convenient alternatives.[26] This will force traditional physician offices to rethink how they operate. Leveraging basic mobile technology, a doctor's visit is no more than a mouse click away.

Outlook: As new entrants continue to shape consumer expectations, traditional providers will need to keep pace, offering flexible hours and exploring telehealth options. Physicians will have to consider replicating how new entrants are engaging with consumers. Enter the likes of One Medical or Doctor on Demand, leading the way in redefining the physician-patient interaction.

Expect the emergence of new technologies to enhance these remote interactions, and more physicians in the mix.

Emerging focus on partnerships.

Not all new entrants are outsiders: established providers are now branching out. Offering a new twist on a trusted brand can strike the right balance between innovation and loyalty, resulting in market disruption from an unlikely contender. Early adopter MedStar, for example, has partnered with CVS's MinuteClinic to improve coordination across the care continuum.[27] Patients can take advantage of the convenience of retail clinical services with the comfort of knowing that information will be shared between CVS' clinicians and their MedStar physician.

Similarly, Walgreens is teaming with both start-up Theranos[28] and telehealth leader MDLIVE[29] giving customers access to convenient, affordable care such as lab tests while they shop. With an eye toward improved patient monitoring, medication adherence and cost control, these partnerships offer an opportunity for greater coordination along the continuum of care.

Outlook: Companies with good brand, consumer identification and user friendly digital platforms will find willing partners in high-quality medical experts. Rather than trying to do it all, health businesses should hone in on their core operations and use outside expertise to fill in the gaps.

Hospitals that were once seen as competitors may make good partners, especially as care shifts from the inpatient setting to clinics, the community and ultimately, home. Partnerships will continue to be forged, and care delivery models that bend the cost curve while catering to consumer needs will prevail.

"The ACA has created massive interest in healthcare investing."

—Derek Newell, CEO Jiff

Health Insurance:
From wholesale to retail

Trend
4

"We're preparing our company for a future where we're going to have a much more consumer-oriented business. [And Aetna wants] a better and more informed work force."

—Aetna Chief Executive Mark T. Bertolini[34]

By establishing health insurance marketplaces and mandating that insurers must sell coverage to all people with no price variation based on health status, the ACA has oiled the emergence of retail-style health insurance. Public exchanges—coupled with the law's "Cadillac" excise tax looming in 2018—have sparked a second look at private exchanges by employers seeking cost-effectiveness, budget certainty and fewer administrative hassles.

With the rise of exchanges, insurers must continue to refine how they deliver this retail experience. The ACA marketplaces have demonstrated that simply providing choice is not enough.

HRI's 2014 Top Issues Consumer Survey found that most consumers who purchase individual policies do not ultimately understand their health benefits.[30] Insurers, as part of their retail strategies, will need to invest resources into educating consumers about the complex world of retail health.

ACA created public exchanges.

The ACA required the development of a health insurance marketplace, mandated that insurers sell coverage to all, removed health status as a pricing component and made subsidies available to those with financial need.

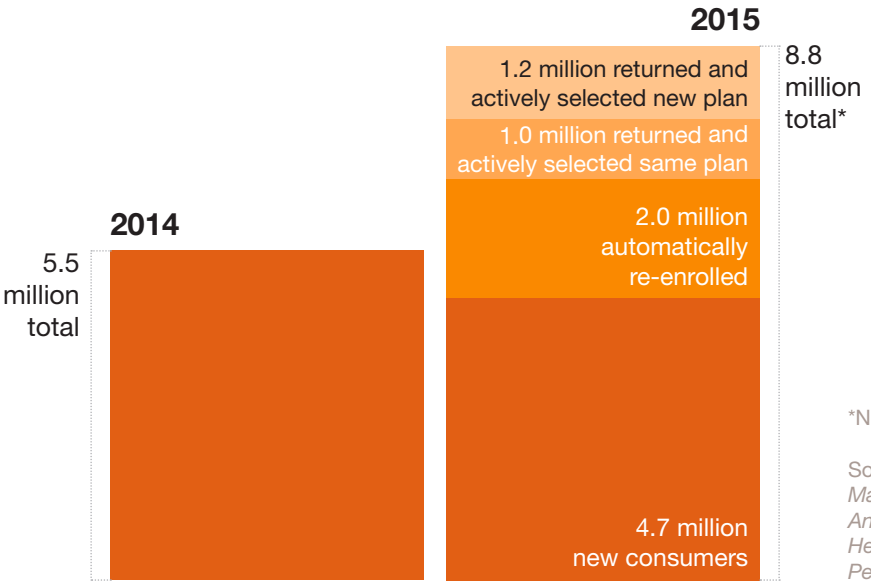
Although punctuated with a problematic launch in 2013 and ongoing glitches, the technology platforms that support the ACA's public exchanges allow, and even encourage, individuals to shop around, comparing coverage options based on price and benefits. In doing so, the exchanges are helping to create a market of active consumers. The second year of open enrollment closed with about 11.7 million people signing up for coverage on the state and federal marketplaces.[31]

Outlook: With average annual enrollment through the exchanges expected to ultimately reach about 22 million,[32] the health insurance industry faces tremendous growth potential. UnitedHealth Group recently announced that it would add hundreds of thousands of new customers because of the ACA—both through the exchanges and Medicaid expansion—helping to drive share prices to record highs.[33] As evidenced by the increase in issuer participation in 2015, insurers are increasingly recognizing public exchanges as a robust market and viable model for selling health insurance.

Public exchanges breathe life into private options.

Private exchanges existed prior to the passage of the ACA but were primarily limited to the individual and small group markets. The rise of the public exchanges—while partially displacing private exchanges in the individual market—has broadened awareness of the exchange concept and its viability to employers and the large group market.

ACA federal exchange enrollment. Creating a market of active consumers.



In 2015, about 11.7 million people enrolled in health insurance coverage through ACA marketplaces. Of the 8.8 million people who signed up on the federal exchange specifically, 2.2 million had returned from 2014 to actively shop around for this year's health plan.

*Numbers may not add due to rounding.

Sources: HHS ASPE, *Addendum to the Health Insurance Marketplace Summary Enrollment Report for the Initial Annual Open Enrollment Period*, May 1, 2014. HHS ASPE, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*, March 10, 2015.

Employer-based coverage remains the core of the US insurance market, but the business model is changing rapidly as employers explore alternatives—including private exchanges—to more cost-effectively deliver benefits that improve consumerism and enhance choice for workers.

According to PwC's 2014 Employer Touchstone Survey, 60% of employers expect the ACA's "Cadillac" tax—which requires employers to pay 40% of an employee's total health insurance costs above $10,200 for individual plans and $27,500 for family plans—to have an impact on their company.[35]

Some employers see moving employees to private exchanges with defined contributions as a viable alternative. In the same survey, 32% of employers acknowledged that they are considering moving their employees to a private exchange in the next three years.[36]

Outlook: Moving forward, employers will need to conduct cost-benefit analyses to determine if a private exchange best suits their needs. Even those that choose not to pursue a private exchange will begin adopting a more employee-centric and integrated benefits design, increasing employee choice and engagement in making benefit selections.

For insurers, the shift from the business-to-business (B2B) model of the 20th century toward a post-ACA business-to-consumer (B2C) model is already underway. Insurers will continue to zero in on this notion of consumer directed health, as plans focus on the consumer experience across all lines of business and not just the individual market. Insurers should tap into their reams of data, pivoting systems to better anticipate consumer needs and manage their choices in order to foster greater consumer engagement from shopping for a plan to seeking care.

According to Jiff CEO Derek Jewell, the ACA's "regulatory barriers" provide helpful parameters to employers as they design benefits packages and give them wide latitude to offer health incentives to employees. For companies like his, "explicitly carving out incentives to move the needle is the foundation of what [they] do."

States: Reform's pivotal stage

Trend 5

***Variation in how states have implemented** the ACA has led to highly diverse, geographically dependent health reform experiences.*

While the ACA broadens the federal government's role and financial responsibility in healthcare, it also confers considerable authority to states for its implementation. As such, states have emerged as key players in the roll-out of health reform. They have gotten to decide if and how they expand their Medicaid programs and to what extent they would have a hand in the administration of health insurance exchanges. In the last five years, some states have elected to take more active roles in the law's administration; other states, less active roles.

States have taken advantage of the latitude the law and US Supreme Court provided, reflecting differences in philosophy about the best way to expand coverage, or whether to participate in the expansion of coverage. Variations in risk tolerance and willingness to adapt systems have driven a multiplicity of health insurance marketplace designs and Medicaid expansion models. As a result, the law's implementation has led to highly diverse, geographically dependent health reform experiences. For health plans specifically, operating in multiple states means they must assess each one individually.

This summer, the US Supreme Court will deliver its verdict on *King v. Burwell*, a case which questions the legality of ACA subsidies made available on the federal marketplace. Depending on the Court's decision, these subsidies—which have been granted to more than 80% of the people enrolled in the plans offered on Healthcare.gov—could be eliminated.[37]

With such legal challenges looming—and the opportunity to waive significant portions of the ACA through state innovation waivers starting in 2017—states stand to take on even more responsibility, catalyzing further divergence in implementation and implications.

To expand or not to expand?

That is the question states face with their Medicaid programs. And, if the answer is yes, then how?

While the ACA extended Medicaid benefits to every American earning less than 138% of the federal poverty level ($16,105 for an individual), the US Supreme Court made this expansion optional in June 2012.

Consequently, expansion has been piecemeal across the country, with about half of states choosing to participate; half not. In addition, because of the flexibility granted under both the ACA and pre-existing Medicaid law, there is significant variation in how states choose to expand.

Some states—such as California—simply expanded their existing Medicaid programs. Others—such as Arkansas and Indiana—pursued alternative models that include

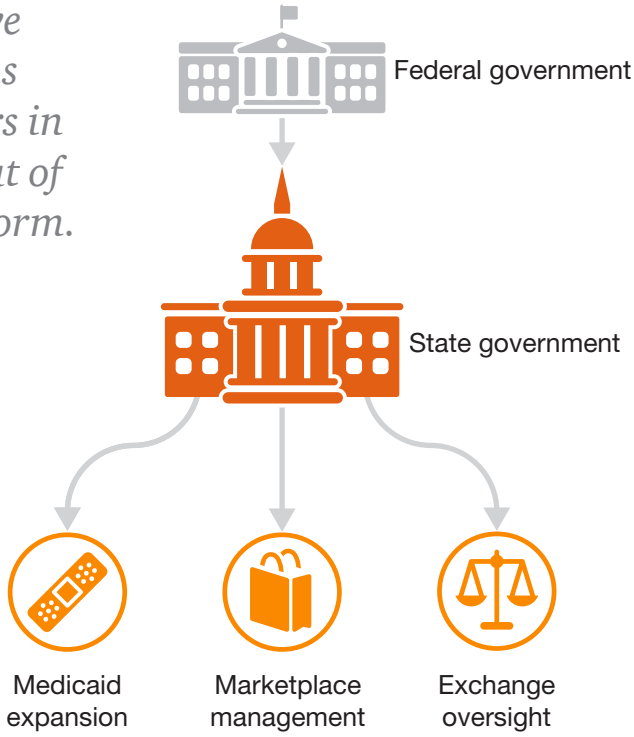
client cost-sharing through co-pays and deductibles. In Indiana, those earning above the federal poverty level can be temporarily locked out of the program if they fail to pay monthly contributions.

In those states that have opted to pursue it, Medicaid expansion has been a boon for health systems, which have seen a dramatic reduction in uncompensated care. Between October 2013—when the ACA health insurance exchanges first opened for business—and December 2014, enrollment in Medicaid and its children's health component grew by 27% compared to average monthly enrollment prior to the ACA changes in expansion states, dwarfing the 7% growth observed in those states that didn't expand.[38]

According to HRI analysis, an increase in Medicaid admissions in expansion states was complemented by a decline in uninsured and self-pay admissions for the country's three largest health systems in the first half of 2014.[39] In the last quarter of the year, Dallas-based Tenet Healthcare, which operates hospitals in 5 states that have expanded Medicaid, specifically saw a 63% decline in uninsured and charity cases, and a 21% increase in Medicaid admissions across those states.[40]

Outlook: With the option to expand Medicaid still on the table, more states may pursue alternative models. These Medicaid "private option" models will create a continuum between Medicaid, the public exchanges and the private market, reducing variation and making benefit design as similar as possible to that available through employers. Providers, recognizing the financial toll of treating uninsured patients, will continue to push for expanded coverage and higher enrollment.

States have emerged as key players in the roll-out of health reform.



Marketplace management decisions impact competition.

The ACA also gives states leeway in how they manage their marketplaces. Some states—such as Colorado—have adopted an open marketplace model, accepting any insurer that meets the qualified health plan standard.

This gives consumers greater decision-making responsibility and leaves issuers susceptible to greater market competition. Others—such as California—act as "active purchasers," using market leverage and the tools of managed competition to negotiate product offerings. These states selectively pick and choose which insurers may participate, creating competition in a different way.

States also exercise varying levels of oversight in the review of premium rate filings.[41] HRI analysis indicates that, in states where the insurance department must approve rates prior to implementation, insurers saw a median drop of 2.9% between proposed and final rate increases for 2015. In states without this authority—such as Arizona—the median decrease was 1.3%. In addition, the median rate increase approved in states with more authority (6.0%) was lower than in states with less oversight (6.6%).

Outlook: Looking ahead, insurers trying to enter or expand their presence in exchanges may face

barriers to entry depending on the rules of engagement set up by a state. States are likely to continue to have a major influence on the implementation of the ACA specifically and how the business of healthcare is conducted more broadly.

Expanding the role they play in the management of costs, states are positioned to lead a proactive movement in drug pricing as Medicaid directors and state health plans seek to address high drug costs. This will challenge the pharmaceutical industry's old model of doing business.

In response, drug companies will need to champion the notion of innovative drug value, highlighting cost offsets and the return on investment from drug treatments that actually cure or slow disease. Purchasers, including states, must also broaden the lens on the concept of value.

States—such as Arkansas, Ohio and New York—have also begun to take leadership in redesigning care models and delivery, actively arranging for insurers and providers to collaborate. Facing higher-risk populations such as dual-eligibles, they have become hotbeds of innovation as they are challenged to deliver better quality care at lower cost.

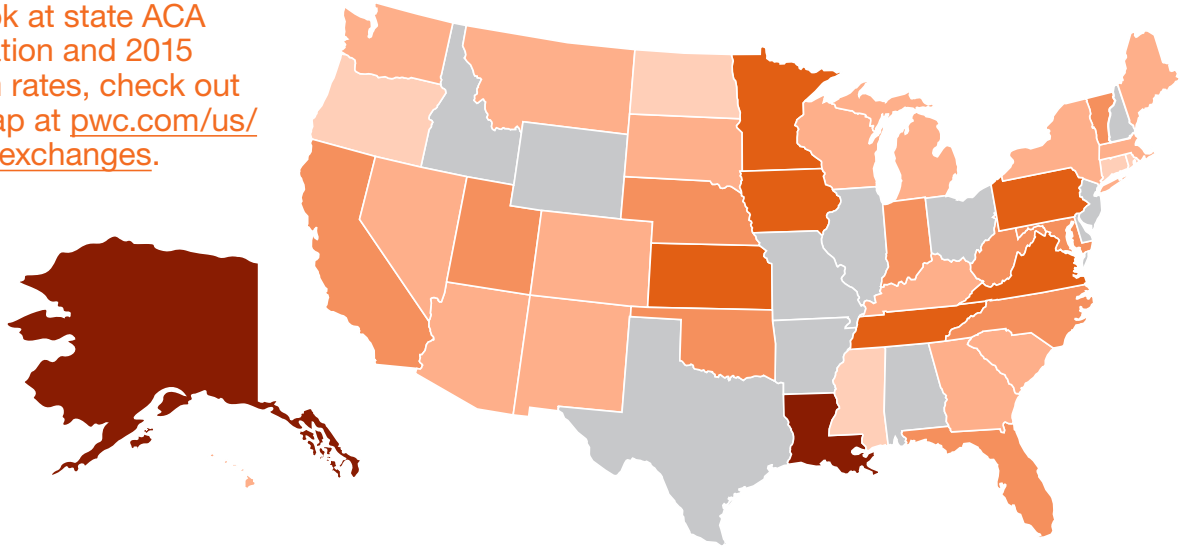
State and federal exchange involvement varies.

Today, 16 states and the District of Columbia run their own exchanges. However, three—New Mexico, Nevada and Oregon—are considered "federally-supported" state-based exchanges because they rely on the federal government's IT infrastructure: HealthCare.gov.

The remaining states are in the federal marketplace, though some have a "partnership" with the federal government that permits them to administer consumer assistance and outreach functions. Others, such as Kansas and Virginia, have received approval to conduct plan management activities, allowing them to maintain maximum regulatory authority over their insurance markets. Utah and Mississippi, while relinquishing control of their individual markets, have opted to retain responsibility for their small business exchanges.

Outlook: States that currently use the federal marketplace may have the opportunity to establish their own exchanges in the event that premium subsidies are abolished in *King v. Burwell*. Some state insurance commissioners are already exploring the feasibility of doing so.[42] While some commissioners are optimistic, others remain concerned about their capacity to meet technological requirements and challenges posed by state legislatures.

For a look at state ACA participation and 2015 premium rates, check out HRI's map at pwc.com/us/acastateexchanges.



The next five years
Strategies in the post-ACA world

Much like the last five, the ACA will continue to face political crosswinds. However, in its brief history, the health reform law has already had a profound, and likely irreversible, impact on the business of healthcare. With federal dollars, new regulations and the government's role as a purchaser, the ACA has catalyzed fundamental shifts in an industry historically slow to change.

Across the entire health sector, executives recognize that yesterday's business models will not work in the New Health Economy. As these five key trends continue over the next five years, industry leaders should:

1

Risk shift:
Weigh the risks of taking on new functions as business models change.

With reimbursement and competitive pressures, revisit strategies to emphasize saving over spending and quality over quantity, to serve more consumers effectively and demonstrate affordability.

2

Primary care:
Watch closely as the reimbursement pendulum swings.

Shifting from fee-for-service to accountable care, consider ways to deliver quality care that satisfies the increased demand generated by the newly insured.

3

New entrants:
Innovate to meet the demands of the new healthcare consumer.

Rather than trying to do it all, businesses will need to identify what they do best and then consider alternatives—such as partnerships—to fill in the gaps.

4

Health insurance:
Target the consumer.

Pursue opportunities to enhance consumer choice and engagement in selecting health benefits.

5

States:
Work with states.

Engage states as they continue to shape the future landscape and to assume an even bigger role in the management of healthcare costs.

Endnotes

1. PwC Health Research Institute, "New Health Economy," April 2014. (http://www.pwc.com/us/en/health-industries/healthcare-new-entrants/assets/pwc-hri-new-health-economy-essay-2.pdf)
2. US Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Linking quality to payment," Medicare.gov. (http://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html?AspxAutoDetectCookieSupport=1)
3. US Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Fact sheets: Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume," January 26, 2015. (http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html)
4. PwC Health Research Institute, "The FDA and industry: A recipe for collaborating in the New Health Economy," January 2015. (http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-hri-pharma-fda.pdf)
5. MD Anderson News Release, "MD Anderson, AstraZeneca enter collaboration to help improve patient outcomes in ovarian and gynecologic cancers," January 29, 2015. (http://www.mdanderson.org/newsroom/news-releases/2015/md-anderson-astrazeneca-collaberate-to-improve-patient-outcomes-in-ovarian-and-gynecologic-cancers.html)
6. Health Care Transformation Task Force Press Release, "Leaders Forming New Health Care Transformation Task Force Commit to Putting 75% of Their Businesses in Value-based Arrangements by 2020," January 28, 2015. (http://www.hcttf.org/releases/2015/1/28/major-health-care-players-unite-to-accelerate-transformation-of-us-health-care-system)
7. Ridgely Ochs, "State OKs North Shore-LIJ to start selling health insurance," Newsday. July 31, 2013. (https://www.northshorelij.com/about/news/new-york-approves-north-shore-lij-insurance-license)
8. Minuteman Health Profile. (http://minutemanhealth.org/MinutemanHealth/media/MMH/Files/Minuteman-Press-Kit-10-11-2013.pdf)
9. Congressional Budget Office, "Updated Budget Projections: 2015 to 2025," March 2015. (https://www.cbo.gov/sites/default/files/cbofiles/attachments/49973-Updated_Budget_Projections.pdf)
10. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Profile of Affordable Care Act Coverage Expansion Enrollment for Medicaid/CHIP and the Health Insurance Marketplace 10-1-2013 to 3-31-2014," April 2014. (http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/pdf/national.pdf)
11. US Department of Health and Human Services, Health Resources and Services Administration, "The Affordable Care Act and Health Centers." (http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf)
12. US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation, "Report to Congress," December 2014. (http://innovation.cms.gov/Files/reports/RTC-12-2014.pdf)
13. US Department of Health and Human Services, Centers for Medicare & Medicaid Services, "ACOs Moving Ahead," The CMS Blog. December 22, 2014. (http://blog.cms.gov/2014/12/22/acos-moving-ahead/)
14. US Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Next Generation ACO Model." (http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/)
15. US Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Fact sheets: Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume," January 26, 2015. (http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html)
16. US Department of Health and Human Services, Health Resources and Services Administration, "The Affordable Care Act and Health Centers." (http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf)
17. US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation, "Report to Congress," December 2014. (http://innovation.cms.gov/Files/reports/RTC-12-2014.pdf)
18. Medicaid and CHIP Payment Access Commission. 2014. Transcript of a public meeting of the Medicaid and CHIP Payment Access Commission, Washington, DC, October 30-31. (http://www.macpac.gov/home/meetings)
19. Karen Davis, Melinda Abrams, and Kristof Stremikis, "How the Affordable Care Act Will Strengthen the Nation's Primary Care Foundation," Journal of General Internal Medicine. 26(10): 1201-1203. October 2011. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181291/)
20. Ibid.

21. Telecommunications Services Industry Profile, Yahoo Finance. (http://biz.yahoo.com/ic/42.html)
22. Rock Health, "Digital Health Funding Year in Review 2014," January 1, 2015. (http://rockhealth.com/resources/rock-reports/)
23. UC Office of the President, "University of California proposes creation of new venture fund to invest in UC innovation," September 15, 2014. (http://www.universityofcalifornia.edu/press-room/university-california-proposes-creation-new-venture-fund-invest-uc-innovation)
24. PwC Health Research Institute, "Healthcare's new entrants: Who will be the industry's Amazon.com?" April 2014. (http://www.pwc.com/us/en/health-industries/healthcare-new-entrants/assets/pwc-hri-new-entrants.pdf)
25. Zina Moukheiber, "Health IT Soars With Castlight Health IPO," Forbes.com, March 14, 2014. (http://www.forbes.com/sites/zinamoukheiber/2014/03/14/health-it-soars-with-castlight-health-ipo/)
26. PwC Health Research Institute, "Healthcare's new entrants: Who will be the industry's Amazon.com?" April 2014. (http://www.pwc.com/us/en/health-industries/healthcare-new-entrants/assets/pwc-hri-new-entrants.pdf)
27. CVS Health Press Release, "CVS Caremark Announces New Clinical Affiliation with MedStar Health," PRNewswire. August 27, 2014. (http://www.cvshealth.com/newsroom/press-releases/cvspharmacy-cvsminuteclinic/cvs-caremark-announces-new-clinical-affiliation)
28. Theranos Press Releases and Statements, "Theranos Selects Walgreens as a Long-Term Partner Through Which to Offer Its New Clinical Laboratory Service." (https://www.theranos.com/#!/news/theranos-selects-walgreens-as-a-long-term-partner)
29. MDLIVE Press Releases, "Walgreens Expands Telehealth Platform to Offer Virtual Doctor Visits Through MDLIVE via Walgreens Mobile App," December 8, 2014. (https://www.mdlive.com/news/press_12082014.html)
30. PwC Health Research Institute, "Top health industry issues of 2015: Outlines of a market emerge," December 2014. (http://www.pwc.com/us/en/health-industries/top-health-industry-issues/newly-insured.jhtml)
31. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," March 10, 2015. (http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf)
32. Congressional Budget Office, "Updated Budget Projections: 2015 to 2025," March 2015. (https://www.cbo.gov/sites/default/files/cbofiles/attachments/49973-Updated_Budget_Projections.pdf)
33. UnitedHealth Group News Release, "UnitedHealth Group Reports 2014 Results, Highlighted by Strength in Growth Markets," January 21, 2015. (http://www.unitedhealthgroup.com/~/media/UHG/PDF/2014/UNH-Q4-2014-Release.ashx)
34. Anna Wilde Matthews and Theo Francis, "Aetna Sets Wage Floor: $16 an Hour," The Wall Street Journal. January 12, 2015. (http://www.wsj.com/articles/aetna-to-boost-incomes-of-lowest-paid-workers-1421105445)
35. PwC, "Health and Well-being Touchstone Survey," June 2014. (http://www.pwc.com/en_US/us/hr-management/publications/assets/pwc-touchstone-survey-results-june-2014.pdf)
36. Ibid.
37. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Addendum to the Health Insurance Marketplace Summary Enrollment Report for the Initial Annual Open Enrollment Period," May 1, 2014. (http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollAddendum.pdf)
38. US Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Medicaid & CHIP: December 2014 Monthly Applications, Eligibility Determinations and Enrollment Report," February 23, 2015. (http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2014-enrollment-report.pdf)
39. PwC Health Research Institute, "Medicaid 2.0 Health system haves and have nots," September 2014. (http://www.pwc.com/us/en/health-industries/health-research-institute/assets/pdf/pwc-hri-aca-medicaid-expansion.pdf)
40. Angela Chen, "Tenet Upbeat on 2014 Results," The Wall Street Journal. January 12, 2015. (http://www.wsj.com/articles/tenet-upbeat-on-2014-results-1421072166)
41. PwC Health Research Institute, "Regulatory Spotlight: States use rate approval authority to manage individual health insurance premium prices for 2015," January 2015. (http://www.pwc.com/us/en/health-industries/health-research-institute/assets/pwc-rate-review-spotlight-01-23.pdf)
42. Rachana Pradhan, "States regulators raise exchange issue with Tavenner," PoliticoPro. November 19, 2014. (https://www.politicopro.com/story/healthcare/?id=41021)

About the PwC network

PwC helps organizations and individuals create the value they're looking for. We're a network of firms in 158 countries with more than 180,000 people who are committed to delivering quality in assurance, tax and advisory services. Tell us what matters to you and find out more by visiting us at www.pwc.com. PwC refers to the PwC network and/or one or more of its member firms, each of which is a separate legal entity. Please see www.pwc.com/structure for further details.

About the PwC Health Research Institute

PwC's Health Research Institute (HRI) provides new intelligence, perspectives, and analysis on trends affecting all health related industries. The Health Research Institute helps executive decision makers navigate change through primary research and collaborative exchange. Our views are shaped by a network of professionals with executive and day-to-day experience in the health industry. HRI research is independent and not sponsored by businesses, government or other institutions.

Acknowledgments

Donald (Trey) Cole, III, MD
Austin Regional Clinic

Sean Duffy
Omada Health

Derek Newell
Jiff

Health Research Institute

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

Ceci Connolly
HRI Managing Director
ceci.connolly@us.pwc.com
(202) 312-7910

Trine Tsouderos
Director
trine.k.tsouderos@us.pwc.com
(312) 298-3038

Ben Comer
Senior Manager
benjamin.comer@us.pwc.com
(919) 791-4139

Sarah Haflett
Senior Manager
sarah.e.haflett@us.pwc.com
(267) 330-1654

Marianne DeWitt
Research Analyst
marianne.t.dewitt@us.pwc.com
(410) 659-3453

HRI Regulatory Center

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

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

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

Laura McLaughlin
Research Analyst
laura.r.mclaughlin@us.pwc.com
(703) 918-6625

HRI Report Advisory Team

Jaime Estupinan, Partner
Todd Evans, Director
Sandra Hunt, Principal
Gary Jacobs, Managing Director
Ashish Kaura, Partner
Jack Rodgers, Managing Director
Michael Thompson, Principal
Robert Valletta, Partner

Additional contributors

Jamay Beebe
Derek Gaasch
Kulleni Gebreyes
Barbara Gniewek
Jason Heider
Susan Kellam
Bob Kim
Karen Montgomery
Ross Stromberg
Carol Wells

To have a deeper conversation about how this subject may affect your business, please contact:

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

Sandra Hunt
Principal
sandra.s.hunt@us.pwc.com
(415) 498-5365

Ceci Connolly
HRI Managing Director
ceci.connolly@us.pwc.com
(202) 312-7910

www.pwc.com
www.pwc.com/us/healthindustries
www.pwc.com/hri
twitter.com/PwCHealth