

Behind the numbers

Medical cost trends for 2011



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The heart of the matter

Medical costs will be buffeted by reactions inside and outside the nearly \$3-trillion health industry in 2011.

The past 18 months have been extraordinary for employers and medical costs. The worst recession in a quarter-century was followed by the most extensive changes in federal health funding and regulation in 45 years. The full consequences of both continue to play out, but medical costs will be buffeted by reactions inside and outside the nearly \$3-trillion health industry in 2011.

To aid employers in designing their health benefits, PricewaterhouseCoopers' (PwC) Health Research Institute (HRI) provides annual estimates of how much private medical costs will grow over the next year, and what the leading drivers of the trend are expected to be. This report looks at the projected increase in costs of medical services assumed in setting premiums for health insurance plans. Insurance companies use medical cost trends to estimate what the same plan would cost in the next year.

In estimating the medical cost trend growth for 2011, HRI interviewed health plan executives, surveyed employers and hospital-based health plans, and reviewed analyst reports. All numbers are national estimates. Cost trends may vary from market to market, depending on the level of provider and health plan competition and the regional economy. In addition, these numbers will vary with benefit plan design. HRI conducted a survey of more than 700 employers from 30 industries. In addition, the research included interviews with health plan actuaries and other executives whose companies have a combined 47 million in covered lives.

An in-depth discussion

The medical growth trend is expected to decrease from 9.5% in 2010 to 9% in 2011. The small decrease hides a more complicated set of forces.

This year's **Behind the numbers** was especially challenging because of a high degree of uncertainty among health plans and employers. Thanks to the worst recession in a quarter century, employers had less to spend on their workforces. Then came health reform with dozens of small-bore changes about how healthcare is financed, delivered, packaged and regulated. Some changes will drive the trend up, while others will push it down.

Here's what employers can expect to see in 2011:

- Growth in medical costs for 2011 is expected to be 9%, down 0.5% from 2010.
- Three primary **deflators** that will help hold down the medical trend.
 - **Employers are moving network benefits toward pre-managed care benefit design by increasing deductibles and replacing co-pays with coinsurance.** By requiring workers to spend more out-of-pocket at the point of care, employers believe they're reining in utilization of services and drugs. The number of employers using coinsurance for physician visits has nearly doubled and one-third use coinsurance for brand-name drugs, according to PwC's survey of 700 employers. In addition, high-deductible plans were the most prevalent plan for 13% of employers surveyed in 2010, up from 6% in 2008.
 - **Generics continue to eat into brand-name drug market share.** About \$26 billion in drugs are expected to go off patent in 2011, including the world's best-selling drug, Lipitor. Generics, which account for as much as 80% of all prescriptions in some plans, continue to erode the market share of brand name drugs, and remain a drag on medical cost trends.
 - **COBRA costs are expected to return to more normal levels in 2011.** COBRA subsidies passed by Congress in 2009 created a 1% upswing in the medical trend. Laid-off workers who continued their healthcare coverage typically incurred medical costs of two to four times higher than those of other workers. In 2010, the combination of higher unemployment and new government subsidies to pay for COBRA coverage led to a significant increase in COBRA coverage. A combination of declining unemployment and expiration of the COBRA subsidies is expected to lead to reduced enrollment in COBRA in 2011.
- The biggest **inflators** of the medical trend will be in provider costs, which make up 81% of the medical benefit.
 - **Cost-shifting from Medicare is expected to increase as hospitals see their rates cut for the first time after seven years of increases that nearly matched or exceeded inflation increases.** Some hospitals that benefitted from higher payments in 2008 and 2009 may be able to manage this type of cut by tapping their reserves. Yet, more are likely to renegotiate terms and shift more costs to commercial payers during their negotiations.
 - **Provider consolidation is increasing, which is expected to increase their bargaining power.** The number of physicians involved in mergers or acquisitions in 2009 was 2,910, nearly twice that of 2008. In addition, 2010 has seen record activity as well. Payment changes, embedded in the federal health reform law, also encourage models that align financial incentives among providers.
 - **Spurred by stimulus funding that begins in 2011 and Medicare penalties that begin in 2015, hospitals will invest billions of dollars into certified electronic health record (EHR) systems.** While many hospital systems were planning to implement EHRs in the near future, the government's new regulations dramatically condensed their timelines to invest in technology, IT staff, training and process redesign. Healthcare CIOs surveyed by PwC said they will make their largest investments to meet the new EHR regulations in 2011.

How the medical cost trend is determined

This report looks at the projected increase in costs of medical services assumed in setting premiums for health insurance plans. Insurance companies use medical cost trends to estimate what the same plan would cost in the next year. For example, a 10% trend indicates that a medical plan that costs \$10,000 per employee this year would cost \$11,000 the next year. Medical cost trend is influenced primarily by:

- Unit cost inflation, or changes in the intensity, and changes in the unit price of medical products and services
- Utilization increases, or changes in the volume of services used, which may be affected by demographic changes, advertising, and the use of new technology

Aspects of regulatory, marketplace changes will impact the 2011 medical trend

Pushing trend down

- Drug costs
- More coinsurance
- COBRA returns to normal levels



Pushing trend up

- More cost shifting from Medicare
- Provider consolidation
- Investment in health IT

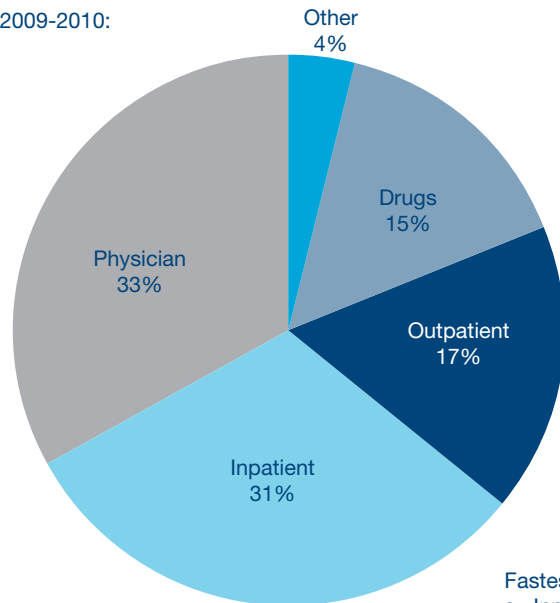
According to the Milliman Medical Index, the biggest portion of the private health insurance benefit is spent on physician services, at 33%. At 31%, the next biggest portion is inpatient hospital services followed by 17% on outpatient services and 15% on prescription drugs. (See Figure 1.) Compared to the growth in total spending, physician services have had the lowest rate of increase and trended slightly downward in recent years. Consistent with past years, spending on outpatient services is growing the fastest, spurred by more

specialty procedures that are moving out of the hospital operating rooms and into ambulatory settings. (See Figure 1) Nearly 40% of hospital revenues are generated from outpatient services, according to the American Hospital Association. In addition, outpatient spending includes some drugs. Just over half of specialty medication is accounted for on the medical side of the benefit through drugs administered in outpatient clinics, according to Express Scripts.

Figure 1: 2010 Private health insurance benefits by medical spending category

Slowest annual growth, 2009-2010:

- Physician, 5%
- Drugs, 6%
- Other, 4%



Fastest annual growth, 2009-2010:

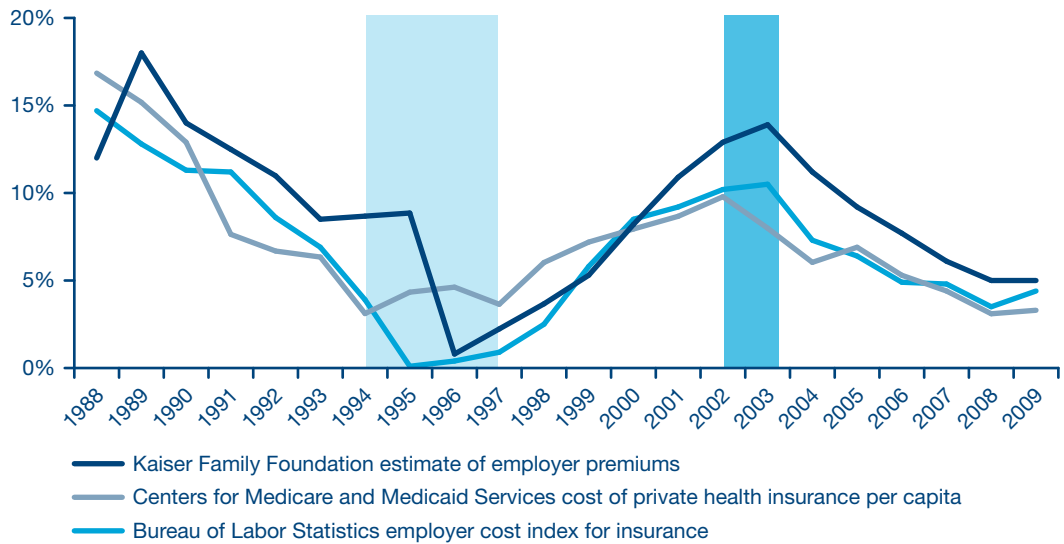
- Inpatient, 10%
- Outpatient, 12%

Source: PwC Analysis of Milliman Medical Index 2009 and 2010

Prior to 2009, the growth of employer-sponsored health insurance premiums and costs decelerated for five years, according to the Kaiser Family Foundation. Figure 2 compares trends from the Kaiser Family Foundation's estimate of employer premiums, the cost of private health insurance (PHI) per capita, and the employer cost index for insurance. This illustrates

the deceleration from 2003 to 2008 and the distinct peaks and troughs (shaded in Figure 2) in healthcare cost growth over time. However, this deceleration came to an end in 2009 as demonstrated in the chart below. Premiums in the next year or two will show whether the US is in a new period of acceleration in premiums or just a pause in the deceleration that began around 2003.

Figure 2: Growth in premiums, spending per capita and employer cost index



Sources: Kaiser Employer Health Benefits Annual Surveys for 2009, 2008 and 2007 (note: 1991, 1992, 1994, 1995, 1997, and 1998 are estimates); Center for Medicare and Medicaid Services; Bureau of Labor Statistics.

Unpredictable factors that affected the trend in 2009 and 2010, will impact 2011

A recession coupled with high unemployment threw the US economy into a spin, although medical costs were less affected than other goods and services. Still, benefit costs in employer plans increased because of expansions in the number of higher-than-average-cost employees who enrolled in COBRA during the recession. Enrollment in COBRA typically rises during recessions as workers are laid off, but this tendency was magnified by the American Recovery and Reinvestment Act (ARRA), which established a temporary federal subsidy to pay part of the cost of continued health insurance for workers laid off between Sept. 1, 2008 and Dec. 31, 2009. As expected, more workers enrolled in COBRA once subsidies became available.

The medical growth trend is expected to decrease from 9.5% in 2010 to 9% in 2011 (See Figure 3.) The small decrease hides a more complicated set of forces. The impact of the recession on the age of the work force and the higher COBRA enrollment pushed the trend up in 2010 beyond what PwC predicted last year. In 2010, we said the trend would be 9.0%, but our research shows that it is coming in closer to 9.5% because of COBRA. In 2011, we expect that medical trend will be pulled down as the number of COBRA enrollees falls, and more young workers are hired. If it were not for these confounding effects, our estimate of the trend would be lower in 2010 and higher in 2011.

Figure 3: Estimates for the medical cost trend from 2008 to 2011

	2008	2009	2010	2011
Medical cost trend	9.9%	9.2%	9.5% (2009 estimate 9.0%)	9.0%

Source: PricewaterhouseCoopers

Health reform delivers minor impacts in 2011, major impacts in 2014

The new health reform law¹ passed in March 2010 expands health insurance coverage through expansions in Medicaid, tax subsidies and credits, and penalties on employers that do not provide insurance to their workforce and individuals who do not purchase insurance. The health reform legislation also makes dozens of small-bore changes in the healthcare system designed to reduce costs and improve efficiency.

In many cases, these changes would affect employers' healthcare costs, but will not affect what is considered the medical trend. For example, in 2011, they cannot have waiting periods longer than 90 days for employees to start receiving benefits. In this case, total costs to employers would rise but this might actually lower medical trend if the newly insured workers were younger and healthier than the average covered workers. Adding more adult children to family plans would also tend to increase the costs of a family plan. Other changes, however, would clearly increase both total costs to employers as well as trend. For example, the ban on denying coverage to children with pre-existing conditions would bring in more expensive children on plans and raise the annual costs of a family plan.

While the biggest changes don't start until 2014, the new health reform law requires employers to make changes in their benefit designs, beginning with the next plan year. Some of those are:

- Must cover dependents to age 26. Some health plans have already decided to allow dependents to remain on family plans immediately rather than waiting for the plan year that would be affected by the legislation.
- Can no longer have lifetime limits on

coverage. Lifetime limits are provisions that limit the total dollars in benefits that the insurance plan will pay out over the lifetime of an enrollee in the plan. For example, a health plan might specify that once \$1 million in benefits are paid out in claims, they no longer will pay for further medical treatment for that enrollee. Lifetime limits can be reached a number of ways. In the case of a catastrophic medical condition, beneficiaries may reach the limit in one year. A patient suffering from chronic disease, such as hemophilia, may reach the limit over five years by having \$200,000 in medical expenses each year. However, removing lifetime limits, which many employers have already dropped, won't add much to cost trend. PwC's analysis in 2009 estimated that raising or removing lifetime limits would elevate monthly premiums by 1%.²

- Health plans are subject to minimum medical loss ratios (MLRs).

Then, in 2014, the most substantive changes begin with funding for new coverage and mandates on employers and individuals. Similarly, providers, pharmaceutical companies, and health plans may begin to alter prices, products, and policies in anticipation of the 2014 changes. Health plans, for example, may be careful not to introduce new benefit designs that will not be allowed when 2014 rules become effective. Prices may also be increased in anticipation of higher demand in 2014 and beyond when more people have insurance coverage. The opposite may also be true if market participants are concerned about the negative publicity from large price or premium increases, especially in an environment where the healthcare system is often politicized.

¹ The law comprises two acts: the "Health Care and Education Affordability Reconciliation Act of 2010," PL 111-152), which amends the "Patient Protection and Affordable Care Act," PL 111-148, "PPACA".

² PricewaterhouseCoopers, *The Impact of Lifetime Limits*, National Hemophilia Foundation, March 2009.

Deflators will be cost-sharing, generics and COBRA

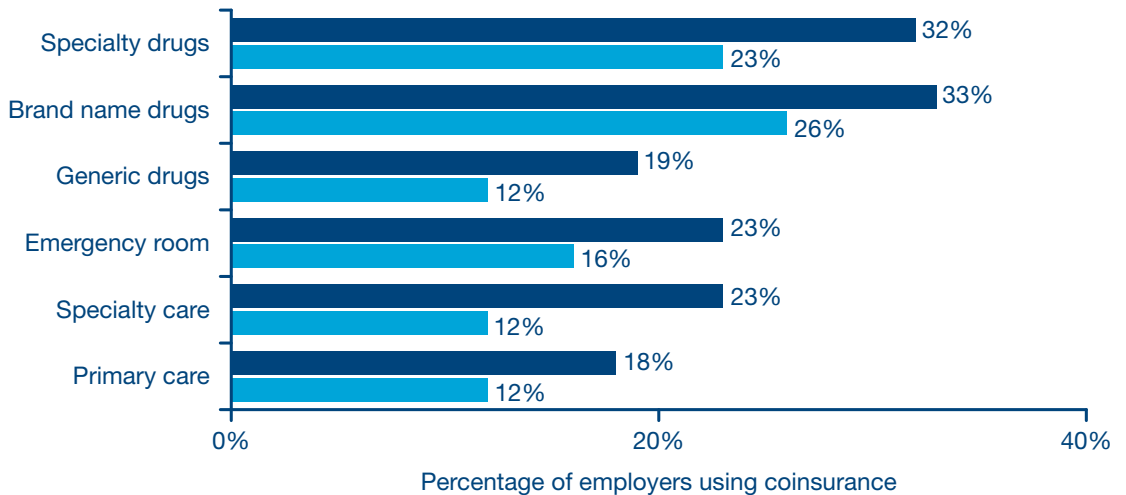
Coinsurance is increasingly replacing co-pays; deductibles are high and rising

Employers are returning to pre-managed care benefit design by increasing deductibles and replacing co-pays with coinsurance. In 2011, for the first time, most employers are expected to have a deductible of \$400 or more. According to PwC's survey of 700 employers, in 2010, the most common plan among employers surveyed by PwC had a deductible of between \$400 and \$999. The trend in deductibles has been remarkably fast. In 2008 and 2009, the most common plan had no deductible. In addition, according to the PwC survey, high-deductible plans are now the primary plan for 13% of employers surveyed in 2010, up from 6% in 2008.

With coinsurance as with high deductibles, workers are more aware of the full cost of the drugs or the services they're using, and consequently can be more likely to shop around or delay or avoid services. Co-pays are nominal flat payments for medical services or drugs. Coinsurance is a percentage of the cost; typical coinsurance is between 10% and 20%. Prescription drugs have been based on co-pays for the past 20 years, but one-third of employers are now using coinsurance instead, up from 26% two years ago, according to the PwC survey. Figure 4 shows the use of coinsurance among employers' plans.

The number of employers using coinsurance for physician visits has nearly doubled and has increased for ER visits as well. In addition, more employers are using co-pays, leaving very few plans with no cost sharing.

Figure 4: Percentage of employers surveyed that are using coinsurance for selected services continues to rise



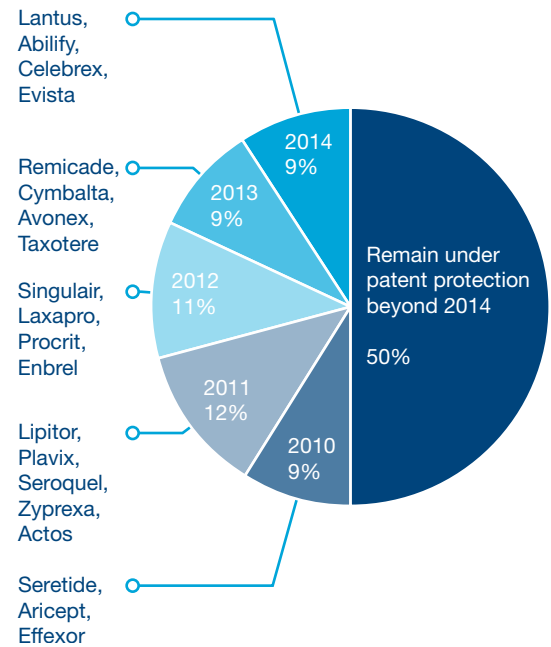
Source: PricewaterhouseCoopers Touchstone survey; based on employers' plans with the highest enrollment

Drug costs continue to be tempered by generics

Drug costs, while rising, continue to be a drag on the medical trend, and that is expected to be the case in 2011 as well. Workers are using more and more generics, and almost 80% of them are members of pharmacy benefit managers, which have become efficient at redirecting patients from brands and to generic alternatives. In 2008, generics accounted for more than 65% of all US prescriptions and were reaching almost 80% for some plans.

In 2011, payers will benefit from several preceding years in which drugs lost patent protection. In addition, some \$26 billion of drug spending is expected to go off patent in 2011. This includes the world's biggest selling drug, Lipitor, although its expiration is expected in late 2011 and may cause more downward pressure on the trend in 2012. Other drugs that lose patent protection in 2011 are Plavix, which is used to inhibit blood clots; Actos, which treats diabetes; and Seroquel and Zyprexa, two drugs that treat schizophrenia and bipolar disorder. Figure 5 shows that half of brand-name drugs will lose patent protection between 2010 and 2014.

Figure 5: Percent of 2009 sales of branded drugs by the year they lose patent protection



Source: PricewaterhouseCoopers analysis—2010

COBRA costs are expected to return to normal levels

Increases in COBRA enrollment in 2009 and 2010 pushed up the medical trend in 2009 and 2010. Decreases in COBRA enrollments over the next two years will tend to pull the medical trend down. Traditionally, laid-off workers pay up to 102% of the premiums for health insurance provided through their former employers. For that reason, workers who enroll in COBRA plans tend to be those with expensive, chronic conditions or conditions that preclude them from purchasing affordable coverage on their own. As a result, workers on COBRA tend to have higher medical costs, and their premiums do not cover all of their medical costs. As unemployment levels rise during a recession, more of these high-cost individuals enroll under COBRA, pushing up the medical trend.

Medical trend was affected more than would have been the case in 2010 because Congress passed the ARRA, under which the federal government agreed to pay 65% of the cost of COBRA with individuals paying the remaining. As a result, enrollment in COBRA plans doubled during the past year, according to industry reports and interviews with insurers. From March 2009 to June 2009, monthly COBRA enrollment rates for Americans eligible for the subsidy averaged 38%, up from 19% between September 2008 and February 2009. The increase in COBRA enrollment increased the average cost of employer plans in 2009 and into 2010, the first full plan year with COBRA subsidies. A typical employer,

whose COBRA enrollees were 1% of total lives and 1.5% of total cost, would have seen an increase in COBRA enrollment to 2% and costs to 3%. Given the way that the costs were spread across the two years, this might account for an increase in the trend of one percentage point above what it would be otherwise, according to PricewaterhouseCoopers' estimates.³

The end of the COBRA subsidies on May 31, 2010, combined and the expected economic recovery are expected to create a downswing in the medical trend between 2010 and 2012. As employment levels return to prerecession levels, fewer workers will be eligible for COBRA coverage. Moreover, the end of the 65% federal subsidy, will make the purchase of COBRA coverage more expensive and further reduce enrollment rates. This reversal in COBRA should reduce the trend in 2011 by about 0.5% below what it would be otherwise.⁴

³ It might be expected that because COBRA was affordable to a wider range of individuals, enrollees would be healthier than in the absence of subsidies. However, insurers reported the costs to be as high as when subsidies weren't offered.

⁴ However, if the economy does not improve and if Congress extends the subsidies again, the medical trend would be expected to increase an additional 0.5% in 2011.

Inflators will be cost-shifting, IT and consolidation

Providers will shift more costs from Medicare

Health reform has created anxiety and uncertainty among health systems. While this report focuses on the medical cost trend for 2011, hospital system executives are worried about long-term factors and their effects on costs and payer mix. Both public and private payers will be impacted by health reform, and the patient population that is expected to increase the most—Medicaid—pays the least. The Medicaid population is expected to grow by 40% between 2010 and 2019, but that expansion won't occur until 2014 and later.

Cost-shifting varies from community to community depending on hospital systems' clout in the market. However, it is almost universally blamed as a source for higher medical costs regardless of geography. In a PwC survey of 11 system-based insurance companies from throughout the country, cost-shifting was identified as the number one reason for the medical trend pushing higher in 2011.

Frequently, Medicaid is a major source of cost-shift because it covers far less than the costs incurred by hospitals. However, in 2011 Medicaid enrollment is expected to decrease, making it less of a problem for hospitals than in 2010. Medicaid enrollment is expected to drop by 1 million as the economy improves and another 1 million because of the new health reform law, according to the CBO.⁵ The health reform law adds high-risk pools and other mechanisms that may apply to some individuals now covered by Medicaid.

A bigger problem for hospitals in 2011 is Medicare, which is the single largest payer for hospitals. In 2011, Medicare payment rates will drop—a major turnaround after seven years of payment increases that either exceeded or nearly equaled inflation increases. (See Figure 6.) Medicare payment increases are tethered to a market basket index, which is an inflation proxy that CMS uses to determine Medicare payment increases for hospitals. It is calculated through predicting the next year's cost of

⁵ Congressional Budget Office and the staff of the Joint Committee on Taxation.

Figure 6: Medicare inpatient rates compared with inflation updates



* 2009–2011 market basket figures are forecasted
 Source: Centers for Medicare and Medicaid Services (CMS)—Market Basket Data; CMS 1406-F FFY 2010 Final Rule (pg. 379)

supplies and labor for hospitals through a “market basket” of prices. In 2009, actual Medicare payments to hospitals rose far above the market basket prediction because the recession affected prices of all goods and services and because hospitals benefitted from a coding change. In 2006, Medicare created severity-adjusted diagnosis related groups (MS-DRGs) to more accurately capture the acuity of patient cases. Although the new coding system was supposed to be revenue neutral, Medicare found that hospitals were using the more expensive codes, thus driving up spending. As a result, Medicare will reduce Medicare rates to hospitals by 2.9% in 2011, a reduction it’s calling a behavioral coding adjustment. On top of that, the new health reform law automatically mandates that inflation updates be shaved by 0.25%. That produces a drop in Medicare rates to hospitals of about 0.35%.

Some hospitals that benefitted from higher payments in 2008 and 2009 may be able to manage this type of cut through their reserves. Yet, others are likely to shift more costs to commercial payers. All will have to focus on cost reduction in the years ahead. The federal government estimates that Medicare will subtract 6.8% from payments in future years.

The market basket index used by Medicare to forecast whether hospitals should receive an increase in payment rates each year relies on an industry-specific index of input prices. The forecasted rate is an inflation update, and Congress uses it as a benchmark for implementing rate increases. Figure 6 shows what the market basket actually turned out to be for the years 2004 through 2008. The year 2009 through 2011 are forecasted.

Consolidation of physicians, hospitals increases their negotiating clout

Consolidation carries the benefit of economies of scale as well as increased bargaining power with suppliers, payers, and labor. Relatively small provider organizations or networks are joining the ranks of national provider conglomerates and demanding premium rates for their services. Physician and hospital consolidation are expected to increase in 2010 and 2011.

About a half million physicians work in a cottage industry that has been slow to consolidate. While managed care and the specter of health reform under the Clinton administration prompted some to consolidate practices in the 1990s, the overwhelming majority of physicians continue to practice solo or in small groups. However, the new health reform law and other changes in government reimbursement are changing the business and prompting more physicians to sell their practices to each other or to local hospitals.

One specialty particularly affected by this trend is cardiology, which has experienced the deepest Medicare payment cuts. Because most private insurers base their payment rates on Medicare, the changes affect physicians’ total earnings. CMS projected an 8% cut in Medicare payment rates for cardiovascular services in 2010, and a 13% decrease over the next four years. Some practices will see much deeper cuts than others. A survey by the American College of Cardiology found that 39% of cardiology practices were considering selling to a hospital system.

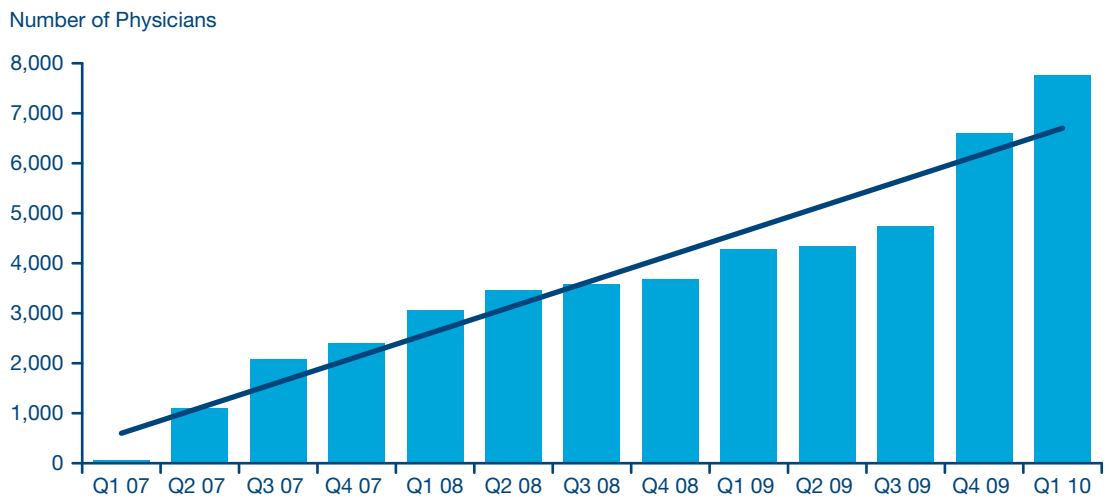
In addition, other aspects of health reform are encouraging much closer alignment of physicians and hospitals. Bundled payments and accountable-care organizations, both of which include incentives to share payment among doctors and hospitals, create shared risk and shared savings on Medicare payments for groups that can coordinate inpatient, outpatient and physician services. Figure 7 shows the ramp-up in physicians involved in mergers between 2007 and early 2010. Payers expect to see more negotiating power and higher prices from larger physician groups who are working in tandem with hospital systems. Eventually, consolidation is expected to produce increases in efficiencies for providers that may be passed along to payers in lower or moderated rates.

Hospitals invest billions into IT systems and professionals

The last few years have been booming construction years for hospitals and outpatient facilities. However, construction growth has ebbed as providers are ramping up capital investments in IT.

As part of the stimulus act passed in 2009, the federal government will spend \$36 billion between 2011 and 2015 on incentives for hospitals and physicians to purchase health IT. To get the incentives, hospitals must invest in interoperable electronic health record (EHR) systems. They also have to demonstrate “meaningful use,” a set of criteria aimed at enabling significant and measurable improvements in population health through the effective use of clinical information systems. According to the

Figure 7: Physicians involved in mergers and acquisitions (cumulative) 2007–2010



Source: Irving Levin Associates

Department of Health and Human Services (HHS), the ultimate vision is one in which all patients are fully engaged in their healthcare, and providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities.

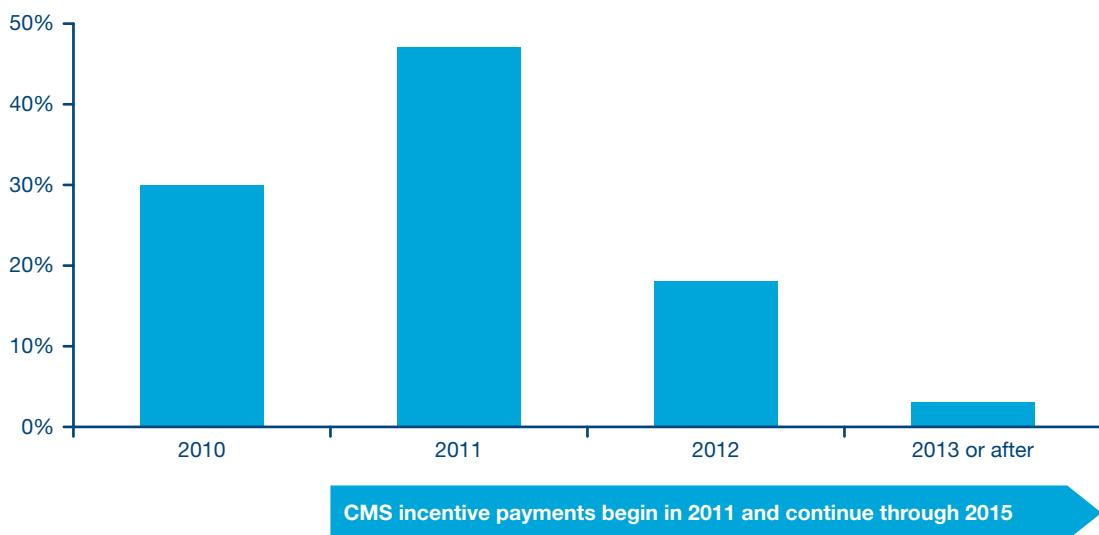
Two-thirds of healthcare IT leaders said they would increase their IT staff in a 2010 survey by the Health Information and Management Systems Society. The top reason cited for increasing IT budgets was the new federal rules around meaningful use of EHRs.

The mandates in the HITECH Act, passed in 2009, lit a fire under health systems because of the potential bonuses and future penalties for not complying with the new regulations. Nearly 70% of CIOs surveyed this year by PwC and the College

of Healthcare Information Management Executives said that the new regulations accelerated health IT efforts that they were going to invest in anyway. When asked when their systems would incur most of the cost for implementing EHRs and other mandates, 34% said in 2010 and 47% said 2011. (See Figure 8.)

In the long term, EHRs are expected to save costs; one estimate is that physician practices with EHRs experience a 10% drop in revenues because of less service duplication. In the face of health reform, continued squeeze on reimbursements and the increased need for capital related to such things as IT modernization, a new and significant wave of provider consolidations is underway.

Figure 8: When will your health system incur most of the costs for implementing EMRs and other mandates in the HITECH Act?



Source: PwC—College of Healthcare Information Management Executives Survey results

What this means for your business

While this report looks at changes from 2010 to 2011, it's important for business leaders to look at long-term changes from health reform and other sources.

Employers use health benefits as a competitive advantage to recruit and retain workers. The value and context of this competitive advantage has been changing. As medical costs continue to grow faster than general inflation, the value of these benefits has become a larger part of the overall compensation package.

Now, the new health reform law fundamentally alters the health insurance market, impacting virtually all aspects of employer-sponsored insurance, from eligibility and plan design to underwriting rules, tax deductions and funding. Once a voluntary benefit, health insurance will become an entitlement to workers in 2014, enforced by an employer mandate. State exchanges will also create a whole new market for insurance products beginning in 2014 for small employers and potentially available to large employers starting in 2017. Employers will be subject to an excise tax on high premium plans beginning in 2018. CEOs must combine all of these changes and new options to customize a new post-recession, post-health reform strategy as their next competitive advantage. (See Figure 9.)

The changes in health reform will play out over 10 years. While this report looks at changes from 2010 to 2011, it's important for business leaders to look at long-term changes from health reform and other sources.

- **Reduction in cost shifting from the uninsured.** Employers have been adjusting to a system in which more people are uninsured each year. This will change in 2014 when Medicaid opens up to everyone below 133% of the federal poverty level (FPL) and tax subsidies are available to others with incomes below 400% FPL.
- **Changes in payment system for providers.** One of the overarching implications of health reform is a move away from siloed payment towards more coordinated care. However, this will bring disruption to the system, which could drive up costs in the short term, but eventually may drive them down. As currently configured, health reform may bring new choices and transparency to workers buying insurance. The effect on costs is uncertain.
- **New markets for health insurance.** State exchanges will begin offering health insurance to individuals and small employers in 2014. They may also open up to large employers in 2017. Employers will, of course, perform price comparisons between their current plans and the plans in the insurance exchanges. The exchanges will offer only commercial insurance, which will be subject to state premium taxes. However, employers may find cost savings opportunities in the exchanges.
- **Excise tax on high premium plans, beginning in 2018.** Beginning in 2018, employer-sponsored plans that have premiums above specified levels will face a 40 % tax on the excess premiums. Employers will have to change plan designs before 2018 in order to make the transition smoother. To do this, employers will need to increase cost sharing, reduce benefits, move to more tightly managed care, or come up with other approaches to trim benefit costs in order to avoid the excise tax.

For more on the details on implications of health reform, go to www.pwc.com/healthreform.

Figure 9: Health benefits as a competitive advantage during a decade of health reform		
Optimize	Grow	Lead
Calculate the immediate impact from various aspects of the new health reform law.	Re-evaluate your overall approach to rewards and how health benefits figure into that context.	Review the new equilibriums in the market from changes in tax policy.

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Health Research Institute

PricewaterhouseCoopers' Health Research Institute (HRI) provides new intelligence, perspectives, and analysis on trends affecting all health-related industries, including healthcare providers, pharmaceuticals, health and life sciences, and payers. HRI helps executive decision-makers and stakeholders navigate change through a process of fact-based research and collaborative exchange that draws on a network of more than 3,000 professionals with day-to-day experience in the health industries. HRI is part of PricewaterhouseCoopers' larger initiative for the healthrelated industries that brings together expertise and allows collaboration across all sectors in the health continuum.

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