PricewaterhouseCoopers'
Health Research Institute

Behind the numbers*

Medical cost trends for 2010

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The heart of the matter

Medical costs will continue to increase in 2010, albeit at a slower rate than in previous years.

Even after the US economy recorded its worst contraction in a quarter-century in late 2008 and early 2009, medical costs continued to grow. The perplexing contrast of health spending growing amid a deflated general economy will present employers with unique challenges for their 2010 healthcare benefits strategies. The following are what they can expect to see:

- Growth in medical costs for 2010 is expected to be 9 percent, slightly lower than in previous years; however, it will still outpace inflation and increases in worker earnings.

- The recession and the prospect of health reform will help temper medical costs, impacting the pricing, utilization and behavior of both industry participants and consumers.

- As the recession pounded corporate profits in early 2009, employers surveyed said they were ready to push more of the costs of health insurance to their workers in 2010 while expecting more responsibility from workers for managing their personal health. Regarding which strategies employers were planning to implement over the next two years, improving wellness and increasing cost sharing led all responses.

  – More than two-thirds of employers are expecting to expand wellness and disease management programs, although few are convinced that they are very effective at mitigating healthcare costs.

  – Forty-two percent of employers surveyed said they would increase employee contributions, up from 38 percent in 2008.

  – In addition, 41 percent said they expect to increase medical cost sharing through plan design changes.

- Increased cost sharing could squeeze workers, many of whom took wage cuts in 2009 because of the recession. In the last five years, health insurance premiums have increased four times faster than wages, a trend that is expected to continue in 2009 and 2010. If employers follow through on plans for increased cost sharing, the affordability gap could grow even larger.

- The economy is creating both positive and negative pressures on medical costs.

  – An unprecedented number of workers are in high-deductible health plans (HDHPs), which are expected to see lower utilization among cash-strapped workers who lack the resources to pay for medical procedures. This trend is expected to slow the rate of medical cost increases.

  – The workers who have retained their jobs, but are fearful of losing them, may be using more services while they still have health insurance. Health plan executives interviewed indicated they are not seeing a reduction in overall utilization.

- Although health reform will have a major impact on the industry, its effect on medical costs likely will not be felt until 2011 or later. However, the prospect of health reform may have a dampening effect on overall healthcare price increases as it did during the Clinton health reform years.

An in-depth discussion

The recession, ongoing market changes in healthcare, and the prospect of industry reform will help temper the medical cost trend in 2010.

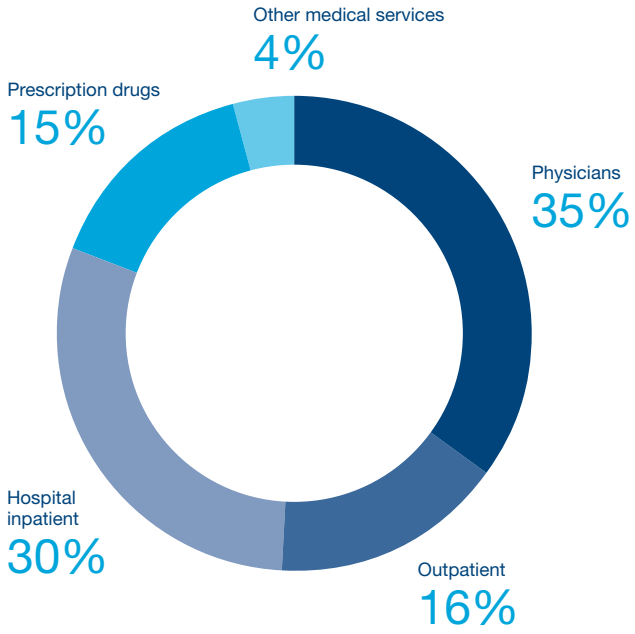
Medical cost trend is the projected increase in the costs of medical services assumed in setting premiums for health insurance plans. Insurance companies use medical cost trends to estimate what the same plan would cost in the next year. For example, a 10 percent trend indicates that a medical plan that costs $8,000 per employee one year would cost $8,800 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

At 35 percent, the biggest portion of the private health insurance benefit is spent on physician services, according to PricewaterhouseCoopers' analysis. The next biggest portion is inpatient hospital services at 30 percent followed by 16 percent on outpatient services and 15 percent on prescription drugs. (See Figure 1.)[1] In recent years, spending has increased for outpatient services as more surgeries and treatments move to less intense settings. In addition, physicians are doing more services and testing in their offices. The portion spent on each category can change from year to year, depending on volume, pricing, and consumer reaction to cost sharing.

Figure 1: 2008 private health insurance benefits by spending category



Source: 2008 Milliman Medical Index

1 Milliman, 2008 Milliman Medical Index, http://www.milliman.com/expertise/healthcare/products-tools/mmi/pdfs/milliman-medical-index-2008.pdf

Flat to slightly decelerating trend expected in 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 details trends from the Kaiser Family Foundation's estimate of employer premiums, the cost of private health insurance per capita (PHI), and the employer cost index for insurance.[2] This illustrates the deceleration and the distinct peak and trough in the medical cost trends over time.

In estimating medical cost trend growth for 2010, PricewaterhouseCoopers' 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. Similarly, tighter provider networks or formularies can reduce the trend as well.

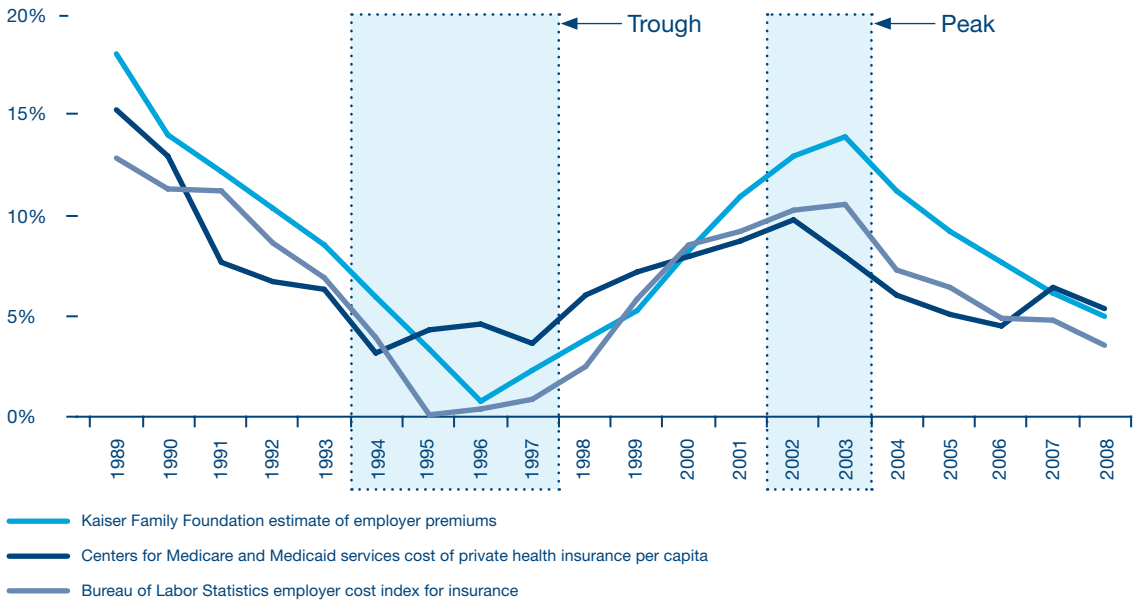
The medical growth trend is expected to increase at a rate of 9 percent in 2010. Although costs are expected to increase in 2010, the rate at which costs are growing is slower than in prior years and will be impacted most by the recession, ongoing trends that continue to deflate spending growth, and proposed healthcare reform.

Figure 3: Medical cost trend, 2008-2010

	2008	2009	2010
Medical cost trend	9.9%	9.2%	9.0%

Source: PricewaterhouseCoopers analysis

Figure 2: Between 1989 and 2008, premium and cost trends witnessed trough and peak periods



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

2 Kaiser Family Foundation Employer Health Benefits Annual Surveys for 2008 and 2007 (note, 1991, 1992, 1994, 1995, 1997, and 1998 are estimates). Note that increases in health benefit costs from the Kaiser Survey are generally net of changes in plan design; Centers for Medicare and Medicaid Services; Bureau of Labor Statistics

Impact of the recession

In late 2008, the US economy suffered its worst contraction in 25 years. Although the health industry has been somewhat resilient to current economic forces, it is not totally unaffected. The recession will have some impact on health industry pricing, cost sharing, utilization, cost shifting, and financial margins. More importantly for 2010, medical costs will be affected by the reaction of the industry and consumers to the recession.

Recession creates countervailing demand trends

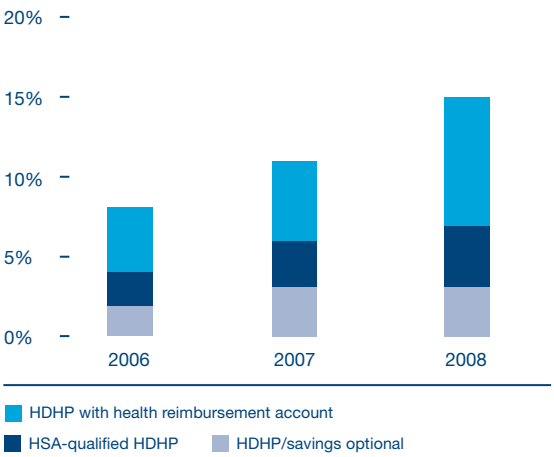
According to the Centers for Medicare and Medicaid Services (CMS), the out-of-pocket share of medical spending historically declines during a recession as individuals have less income to spend.[3] This has the biggest effect on services that have higher cost sharing, such as physician office visits, prescription drugs, and outpatient services. To the degree that the economic downturn continues through 2010, patients are likely to further put off care and treatments. As an example of this effect, hospitals reported year-to-year drops in elective procedures and inpatient admissions in 2009, according to the American Hospital Association.[4]

Sensitivity to medical costs is enhanced by higher levels of cost sharing, especially in higher deductibles and co-pays. As employees lose their group coverage, more are likely to buy low cost HDHPs, which has helped contribute to the record number of workers in HDHPs. More than 6 million workers were in HDHPs in 2008, up from 1 million in 2005, according to America's Health Insurance Plans.[5] While some types of HDHPs have tax-advantaged savings accounts that workers can use to pay out-of-pocket expenses, the fastest-growing segment of HDHPs are the ones in which a savings account is optional, according to a report on employee health benefits by the Kaiser Family Foundation.[6] (See Figure 4.)

Neither employers nor employees may be funding these optional accounts. Of the employers responding to a PwC survey, 42 percent said that less than half of employees with HSA-qualified HDHPs were adding money to their health savings accounts.[7] With larger deductibles and no associated savings account, employees become more selective in their utilization of services. In addition, the falling stock market and declining employment mean that individuals have less liquid assets to pay for procedures they select.

Despite the growth in this type of plan, individuals with high-deductible health plans remain a small percentage of the 160 million workers with employer-sponsored health insurance. High cost sharing probably accounts

Figure 4: Percentage of workers enrolled in an HDHP or HSA-qualified HDHP, 2006-2008



Source: Kaiser Family Foundation, Survey of Employer-Sponsored Health Benefits

3 Sisko, A.,Truffer, C., Smith, S., Keehan, S., Cylus, J., Poisal, J., Clemens, M.K., and Lizonitz, J., "Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook," Health Affairs, February 24, 2009

4 American Hospital Association, "The Economic Crisis: The Toll on the Patients and Communities Hospitals Serve," http://www.aha.org/aha/content/2009/pdf/090427econcrisisreport.pdf

5 America's Health Insurance Plans, "Health Savings Accounts & Account-Based Health Plans: An Overview of Research," America's Health Insurance Plans February 2009, http://www.ahip.org/content/default.aspx?docid=25947

6 Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2008

7 PricewaterhouseCoopers, "2009 Touchstone Survey"

for more of the delays in patients seeking care that hospitals and physicians were reporting in 2008 and 2009.

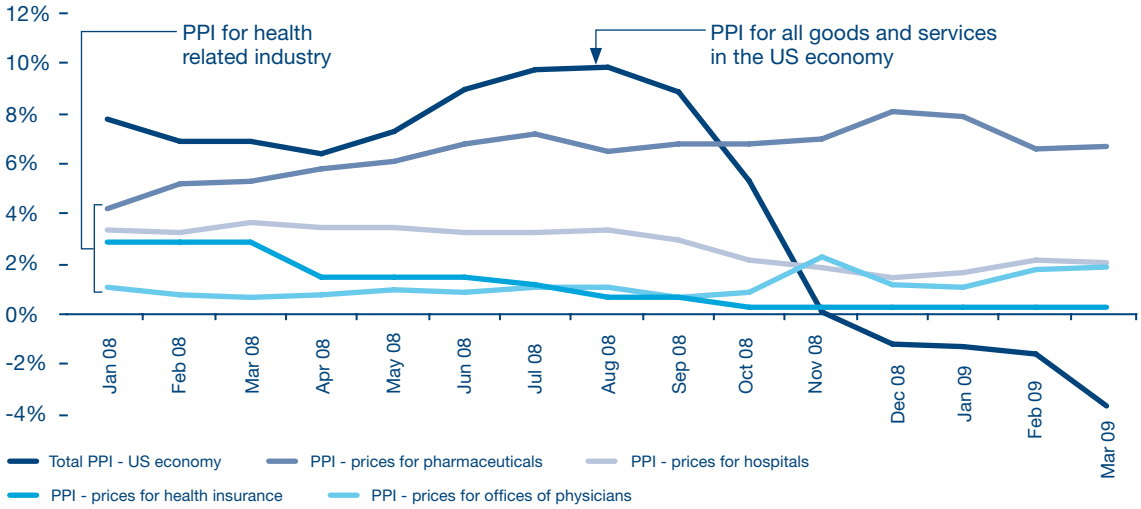
However, health plans interviewed for this report said the recession was creating countervailing trends: Some patients with insurance were using services more intensely. The recession has prompted workers to worry about job security and the potential loss of their health coverage, thus causing them and their providers to go ahead with treatments while they have insurance. In addition, they said providers who are experiencing slumping demand may be inducing demand from their insured patients.

One example of this could be in-office imaging. Currently, internists and other physicians who are not radiology specialists that meet certain Medicare requirements are permitted to install imaging devices in their offices and bill for imaging services they perform without violating Medicare's self-referral rules. Research has shown that there are benefits to in-office imaging access. Patients are more likely to receive same-day imaging services and physicians are more likely to receive the results faster than if the imaging services were performed off-site. However, MedPAC reported in 2009 that episodes of care involving self-referring physicians had 5 percent to 104 percent higher imaging spending than those episodes of care that did not involve a self-referring physician.[8] As more office-based and outpatient imaging centers are becoming available to patients, the growth in the utilization of imaging is likely to accelerate. This increased utilization is an inflator of premiums passed on to employers and employees.

Medical price growth still high but may be decelerating

As the recession deepens, prices of finished goods and services within the economy as a whole have fallen as measured by the Producer Price Index (PPI); however, producer prices within the healthcare sector have either risen or remained steady during the same period. (See Figure 5.)

Figure 5: Producer Price Indices — Comparison of prices for medical goods and services compared to all prices



Source: Bureau of Labor Statistics; total PPI is seasonally adjusted. Hospital, physician offices, and health insurance PPI are not available on a seasonally adjusted basis

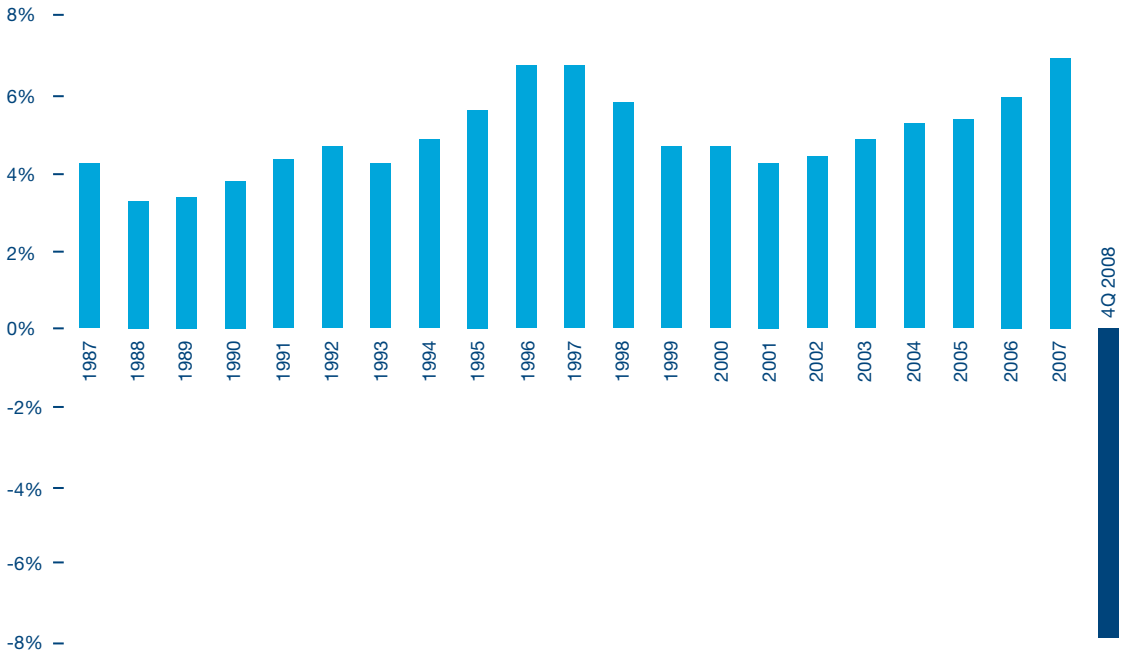
8 Winter, A., and Stensland, J., "Impact of physician self-referral on use of imaging services within an episode," MedPAC, April 8, 2009; http://www.medpac.gov/transcripts/self%20referral%20&%20imaging_April%2009_public_.pdf

Because of healthcare's third-party payment system, pricing isn't impacted as quickly as in more market-based industries. Provider contracts, for example, are typically renewed annually, or in some cases, biannually, and they tend to be tied to Medicare fee schedules, which also change annually. Additionally, price growth could differ among the healthcare sectors such as pharmaceutical manufacturing, providers, and payers.

For example, hospitals may push for higher prices in 2010 because of recessionary influences, which will cause further deviation from overall economic trends. Like all investors, hospitals were hit hard by the drop in the stock market during 2008. On average, a portion of hospitals' patient care expenses are covered by investment income. The drop in investment income coupled with the rising cost of capital and decreases in charitable giving meant that hospital margins went from one of the best years ever in 2007 to one of the worst by the fourth quarter of 2008, according to the American Hospital Association. (See Figure 6.)

Hospitals are also coming off one of the biggest building booms in history. Construction was one of the key inflators cited in our 2009 medical cost trend growth report, as hospitals were in the midst of a 40-year high in building.[9] In the latter part of 2008 and early 2009, however, the credit crisis increased the cost of capital for many borrowers, including hospitals. An early 2009 survey by the Healthcare Financial Management Association reported that 78 percent of hospitals said they intended to reduce capital expenditures.[10] Healthcare construction began to drop in late 2008, according to the Census Bureau. Monthly

Figure 6: Aggregate total hospital margin



Source: American Hospital Association. 2008 hospital profit margin is reflective of Q4 2008 as the final numbers for 2008 were not available at the time this report was published

9 Behind the Numbers: Medical Cost Trends for 2009, PricewaterhouseCoopers' Health Research Institute
10 The Financial Health of US Hospitals and Health Systems, HFMA, January 2009

Recession triggers a complex healthcare cost environment, with some factors increasing and others decreasing expected medical cost trend

Decreases

- Employer groups are increasingly sharing in the costs of the services they utilize.
- Employers are using more incentives to encourage workers to be more accountable for their health related behaviors.
- Slower trend in input price inflation is reducing the need for providers to increase prices as much as in the past.
- Falling demand could create pricing competition in some markets.

Increases

- Rising unemployment causes increasing uninsured and underinsured, drops in commercial membership, and higher percentage of population covered by Medicaid.
- Providers see overall decreased utilization of healthcare services but will create new services to maintain their revenue stream.
- Workers who are expecting to be laid off use more services.
- Providers may raise prices to cover losses on Medicare and Medicaid patients.

construction spending decreased 15 percent from a high of $4.2 billion in October 2008 to $3.5 billion in February 2009, according to a 2009 MedPAC report.

Despite the recent drop-off in construction, more hospitals have opened than closed since 2002, according to MedPAC.[11] And new hospital construction creates staffing needs. Hospitals continued to report difficulties hiring nurses in 2008, and in early 2009, hospitals hired about 500,000 more workers than they laid off, according to the Bureau of Labor Statistics. In addition, the issue is complicated by the prospect of increased union activity. Hospital executives were preparing for the possible passage of the federal Employee Free Choice Act. Supported by Senator Obama during the 2008 presidential campaign, the act is supported by major healthcare unions, such as Service Employees International Union (SEIU), as a way to make it easier for workers to ask for union representation. Fear of unionization is likely to keep wages high for nurses.

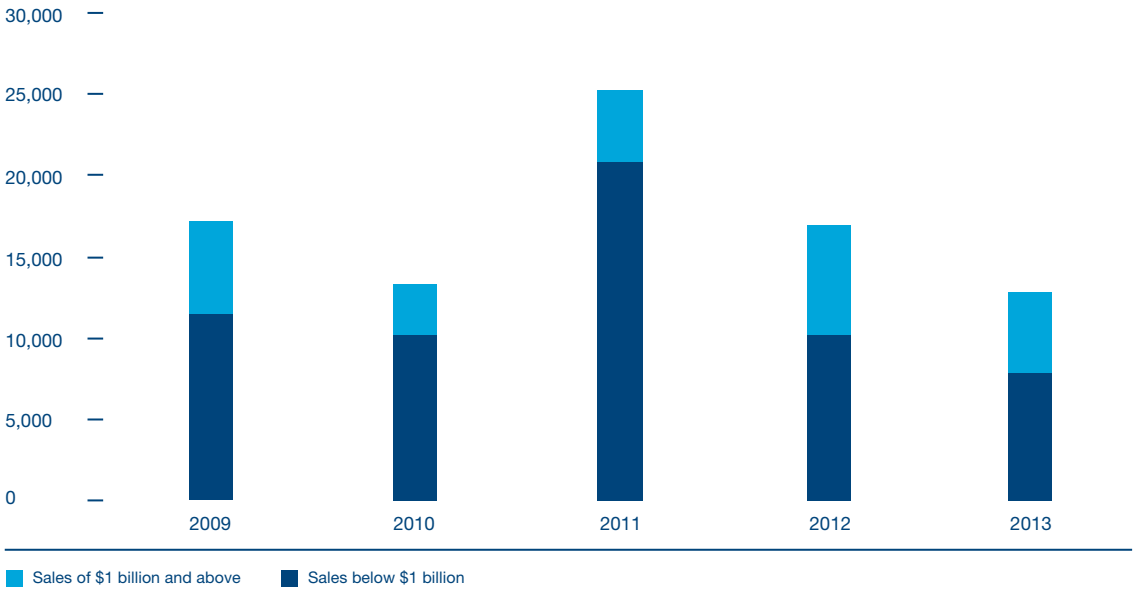
11 Report to the Congress, Medicare Payment Policy, Medicare Advisory Commission, March 2009

Ongoing trends continue to deflate spending growth

Drug spending trend continues to fall

Health plans are seeing much smaller growth in drug spending as the generic dispensing rate has continued to increase. In 2007, 67 percent of all drugs were generic, up from 60 percent in 2005, according to CMS.[12] Drugs expected to go off patent in 2010 include Arimidex, Advair, Femara, Aricept, and Taxotere. Figure 7 shows that the number of drugs going off patent will be down slightly in 2010 and projected to increase in 2011 and 2012. The other factor affecting the growth in drug spending is the lack of new "blockbuster" drugs coming to market. Partially offsetting this is the growth in specialty drugs that are very expensive but more narrowly focused.

Figure 7: Revenue of drugs going off patent, dollars in millions



Sources: Pharmaceutical company documents, PricewaterhouseCoopers analysis

12 "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998," Health Affairs

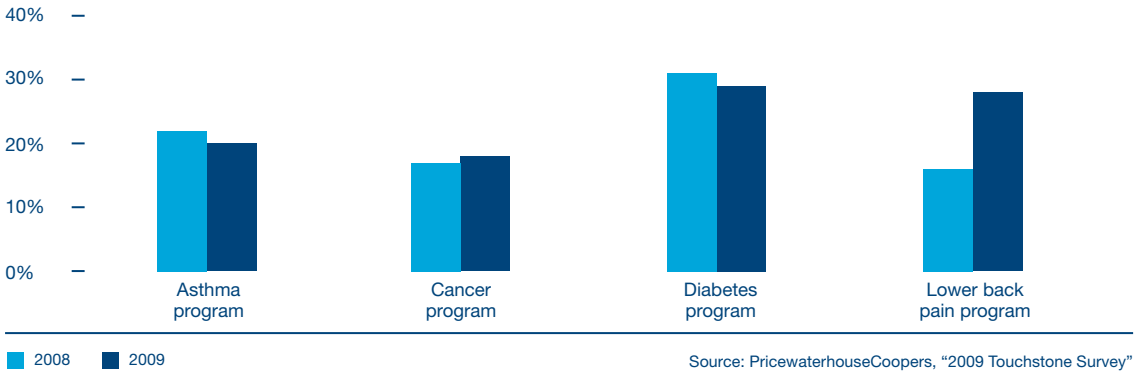
More employers expanding wellness and disease management programs

Employers are increasingly turning to wellness and disease management in hopes that these approaches will reduce costs. According to a PwC survey, while 71 percent of employers are offering wellness programs, few said they are very effective at lowering costs. However, participation in these wellness programs remains low with less than 40 percent of those who are eligible to participate actually enrolling. In addition, participation in disease management programs also remains low with less than 15 percent of those who are eligible actually participating.[13] (See Figure 8.)

High-cost diseases, such as cardiovascular disease and diabetes, have received the most attention in disease management. In 2009, employers reported looking at more disease management programs for lower-cost chronic diseases such as asthma and depression.

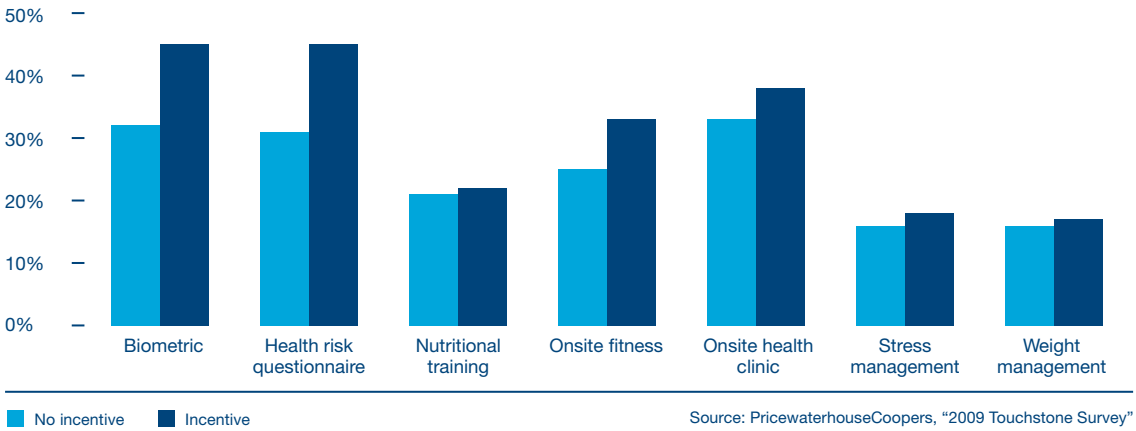
Incentives can increase participation. For example, 64 percent of employers surveyed by PwC said they provided incentives to workers to fill out a health risk assessment, up from 57 percent in 2008. (See Figure 9.)

Figure 8: Percentage of employers reporting greater than 15 percent participation in disease management program



Source: PricewaterhouseCoopers, "2009 Touchstone Survey"

Figure 9: Impact of incentives on participation



Source: PricewaterhouseCoopers, "2009 Touchstone Survey"

13 PricewaterhouseCoopers, "2009 Touchstone Survey"

Impact of healthcare reform will be post-2010, but prospect of healthcare reform may contribute to short-term restraint in medical trend

While health reform could have a big impact on medical cost growth, the impact is more likely to occur in 2011 or beyond. Major healthcare reform, which could pass in 2009, would probably phase in new policies. For example, Medicare Part D was enacted in 2003, but coverage did not begin until 2006. One likely scenario would be health reform legislation that passes Congress in 2009 and has a five-year phase-in beginning in 2012.

The Obama administration has framed health reform around three goals, all of which could affect medical cost trends:

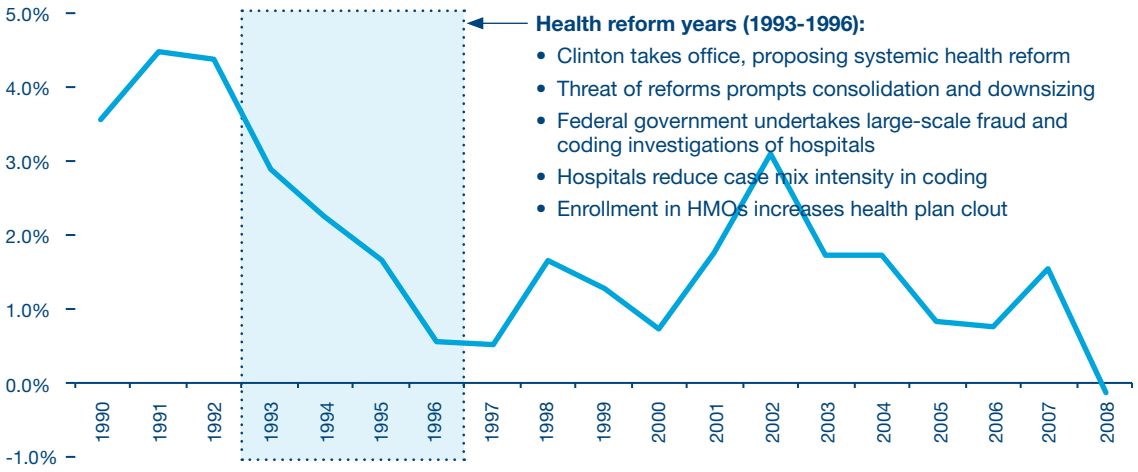
- **Universal coverage**. The administration made a down payment on this pledge with the expansion of SCHIP, the state Children's Health Insurance Program. In addition, Obama's proposed budget includes a reserve fund to expand adult coverage. Broader coverage, particularly if paired with an individual mandate, could reduce the cost shifting that increases medical costs to private payers.

- **Modernizing the health system**. The stimulus legislation, passed in early 2009, allocates $36 billion in bonuses to providers that install interoperable electronic health record systems. Hospitals and physicians can begin to draw down incentives in late 2010, but most likely won't get them until 2011 or 2012. Providers must make the investment prior to receiving the incentives (in the form of higher Medicare and Medicaid reimbursement). In the short term, the investment could raise costs, which will be passed on to health plans. In the long term, digital health records are expected to reduce them.

- **Prevention and wellness**. The stimulus legislation also included about $1 billion for prevention and wellness, but the relatively small size of the investment coupled with the long-term payment for these programs means little impact in 2010.

While the reforms themselves will have minimal short-term impact, if history is a guide, the prospect of health reform may help to sustain pressure on medical pricing in 2010. The last sustained period of national health reform debate was during the first Clinton administration. Although no significant health reform legislation was passed during that period, it created anxiety and disruption throughout the industry. The effect on medical prices appears to have been significant, dropping from 4.5 percent growth in 1992 to 0.5 percent in 1996. (See Figure 10.)

Figure 10: Medical consumer price index less CPI



Source: Bureau of Labor Statistics

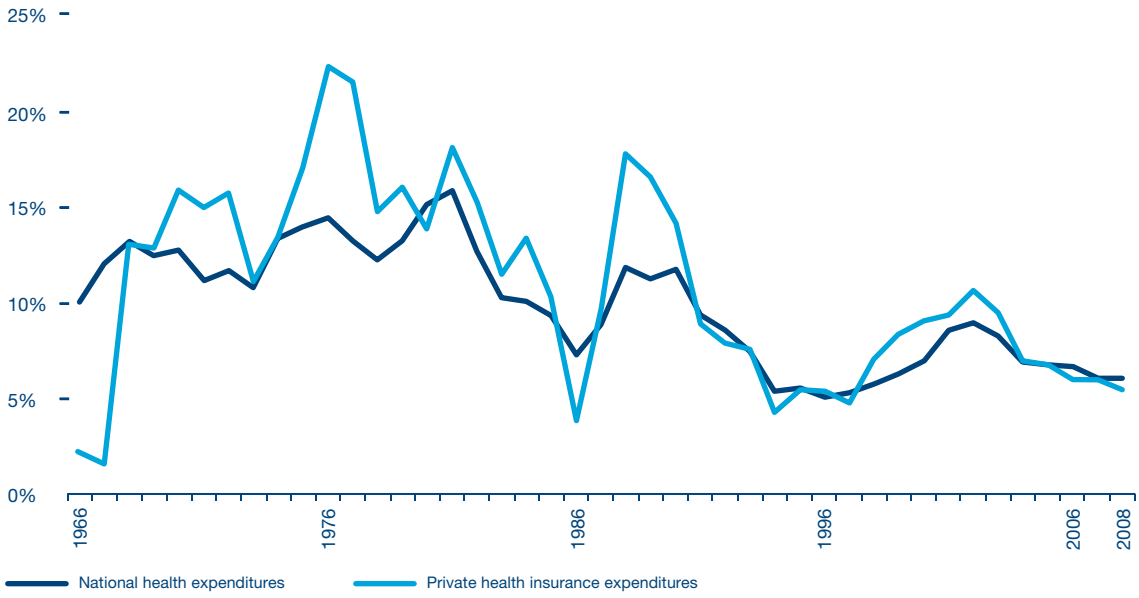
It is worth noting, though, that this time period was also marked by increased federal investigations into provider billing fraud, particularly a practice called “upcoding.”

For example, hospital systems were accused of billing payers for advanced pneumonia when the clinical records indicated a lower-priced diagnosis of simple pneumonia. The rash of investigations led hospitals and physicians to be more conservative in their coding procedures, which likely affected overall pricing. Similarly, Medicare is currently expanding a coding audit pilot that collected more than $900 million from providers in six states between 2005 and 2008. The Recovery Audit Contractor program will expand nationwide in January 2010 and could similarly have a chilling effect on coding and pricing. In addition, the Obama administration has indicated that it will step up fraud detection, which carries a high return on investment to the government.[14]

Long-term forecast remains the same — cost trend will decelerate, but outpace inflation

Despite the extraordinary economic developments of 2008 and 2009, the long-term trend for medical costs that we discussed in last year’s report remains the same. Over the longer haul, private healthcare spending has been increasing faster than the gross domestic product and CPI and is expected to continue to do so for at least the next decade. However, at the same time, the trend in private healthcare spending growth has been slowing slightly. Figure 11 shows that the trend in national health spending growth as well as private health spending growth has been decelerating over time. However, we estimate that private per capita spending will increase at roughly 2.5 percent more than CPI in 2018 compared with 3.3 percent in 2008.

Figure 11: Growth in national health spending and private health insurance premiums (1966-2008)



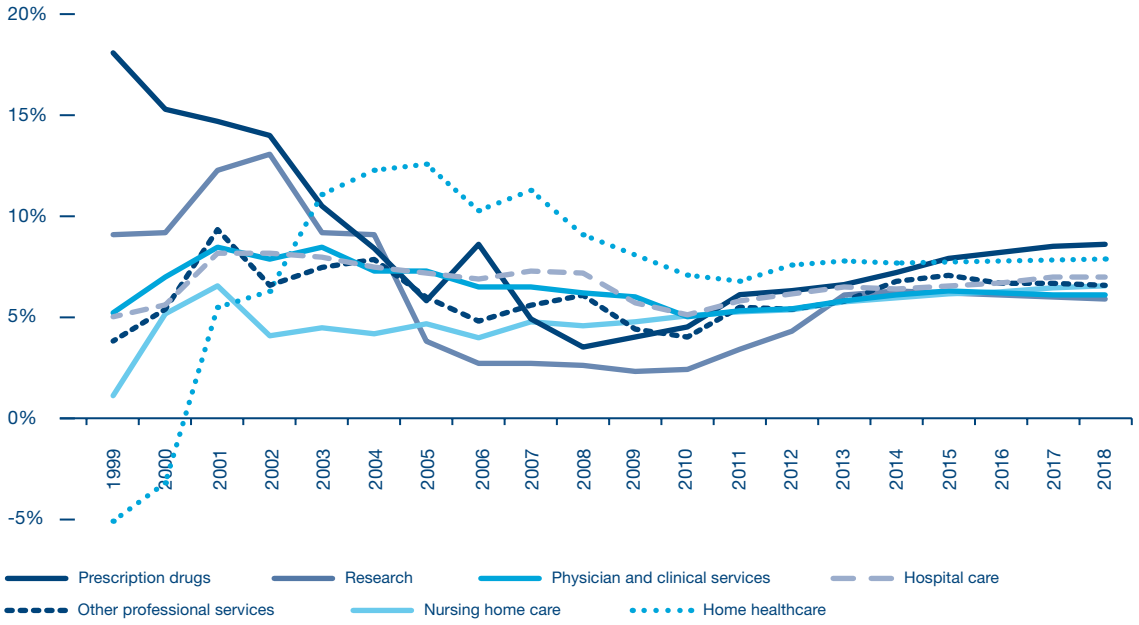
Note: 2008 values are projections.
Sources: Centers for Medicare and Medicaid Services (expenditures) and National Bureau of Economic Research

14 Curbing Fraud, Waste, and Abuse Must be an Essential Component of Any HealthCare Reform Strategy, Statement of Lewis Morris, chief counsel, Office of Inspector General, Department of Health and Human Services April 22, 2009

The downward trend is consistent with economic theory as well. As healthcare grows faster than other components of spending, an increasing share of income is devoted to healthcare and resistance to further increases begins to slow down the growth. Another long-term trend in the healthcare system is the growth in the government's share of overall spending. Since the government tends to underfund healthcare, more cost shifting to private plans may be in store.

In addition, future health spending growth could become more predictable. While the portion of spending on each category varies, the rate of increase has become remarkably similar. The drop in drug spending growth is particularly noticeable. As Figure 12 shows, during the past 10 years, the disparity in the growth rate among the sectors has narrowed dramatically. And the long-term rate of increase is expected to narrow further, although costs overall are expected to grow, according to CMS estimates.

Figure 12: Growth in national health expenditures - cost per capita (1999-2018)



Note: Values for 2008 through 2018 are projections.
Sources: Centers for Medicare and Medicaid Services, US Census Bureau

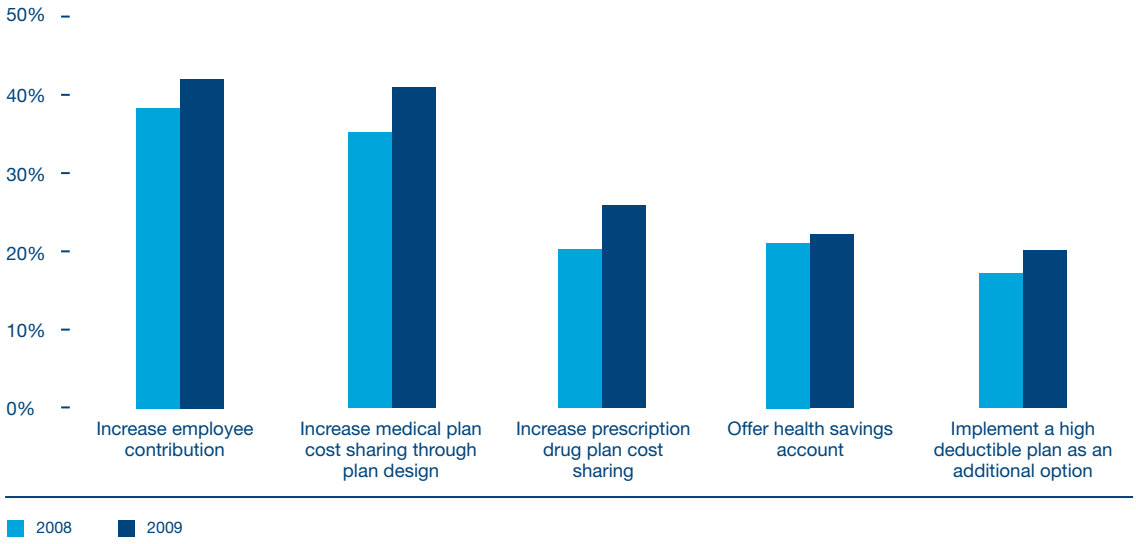
What this means for your business

Reacting to higher medical costs as the economy recovers will require innovative approaches to deal with workers and healthcare stakeholders.

Engage employees who have increasing share of healthcare cost burden

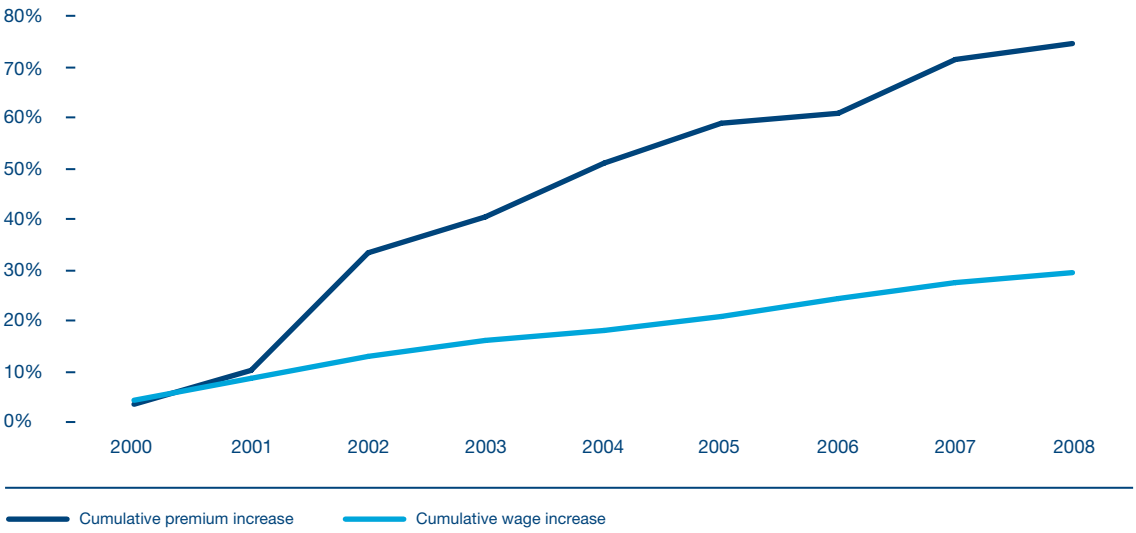
As the recession pounded corporate profits in early 2009, nearly half of employers surveyed said they were ready to push more of the costs of health insurance to their workers in 2010. Regarding which strategies employers were planning to implement over the next two years, cost sharing led all responses. Forty-two percent of employers surveyed said they would increase employee contributions, up from 38 percent in 2008. (See Figure 13.) However, employers must understand the financial pressure for workers; thus, there is a shared interest between employer and their workers regarding medical cost containment. For the past 10 years, the increase in health insurance premiums has far outstripped wage growth. (See Figure 14.)

Figure 13: Cost sharing strategies that employers are looking to implement over the next two years



Source: PricewaterhouseCoopers, "2009 Touchstone Survey"

Figure 14: Cumulative comparison hourly wages vs. monthly premiums



Sources: Bureau of Labor Statistics (wage increase), Kaiser Family Foundation/HRET Survey of Employer-sponsored Health Benefits, PwC analysis

Increase cost sharing at the point of care

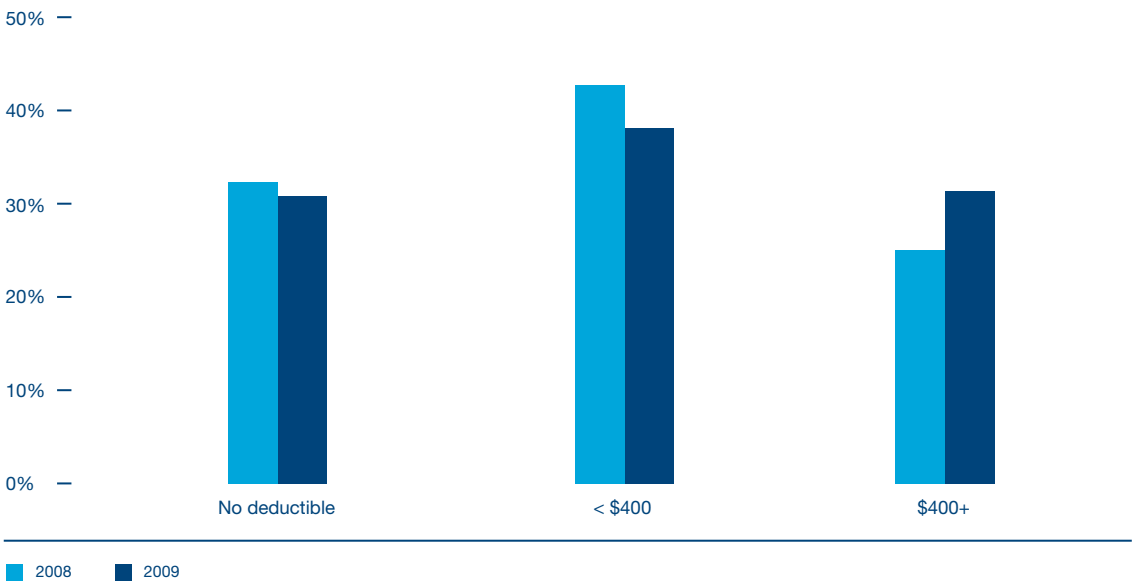
Cost sharing is not just a cost-reduction strategy for employers, however. They also hope that awareness of rising healthcare costs will influence workers' demand for medical care, sometimes at the point of care. As a result, many employers have increased co-pays and deductibles. As Figure 15 shows, employers raised in-network deductibles in 2009. The biggest increase in those deductibles was the category of $500 or more.

Employers are increasing deductibles in order to pass more of the cost on to employees. In 2009, 26.7 percent of employees had deductibles greater than $500. This compared with 21.6 percent of employees in 2008.[15]

Use incentives to increase participation and improve effectiveness of wellness and disease management programs

Since payers have increasingly adopted pay-for-performance programs to reward efficient providers, employers are increasingly introducing incentives to reward employees who better manage their health, whether helping them to stay healthy or helping the chronically ill to better manage their conditions. Sixty-four percent of employers offer incentives related to wellness programs, according to the PwC Touchstone survey. Participation in these programs is much greater when incentives are offered.

Figure 15: In-network deductibles



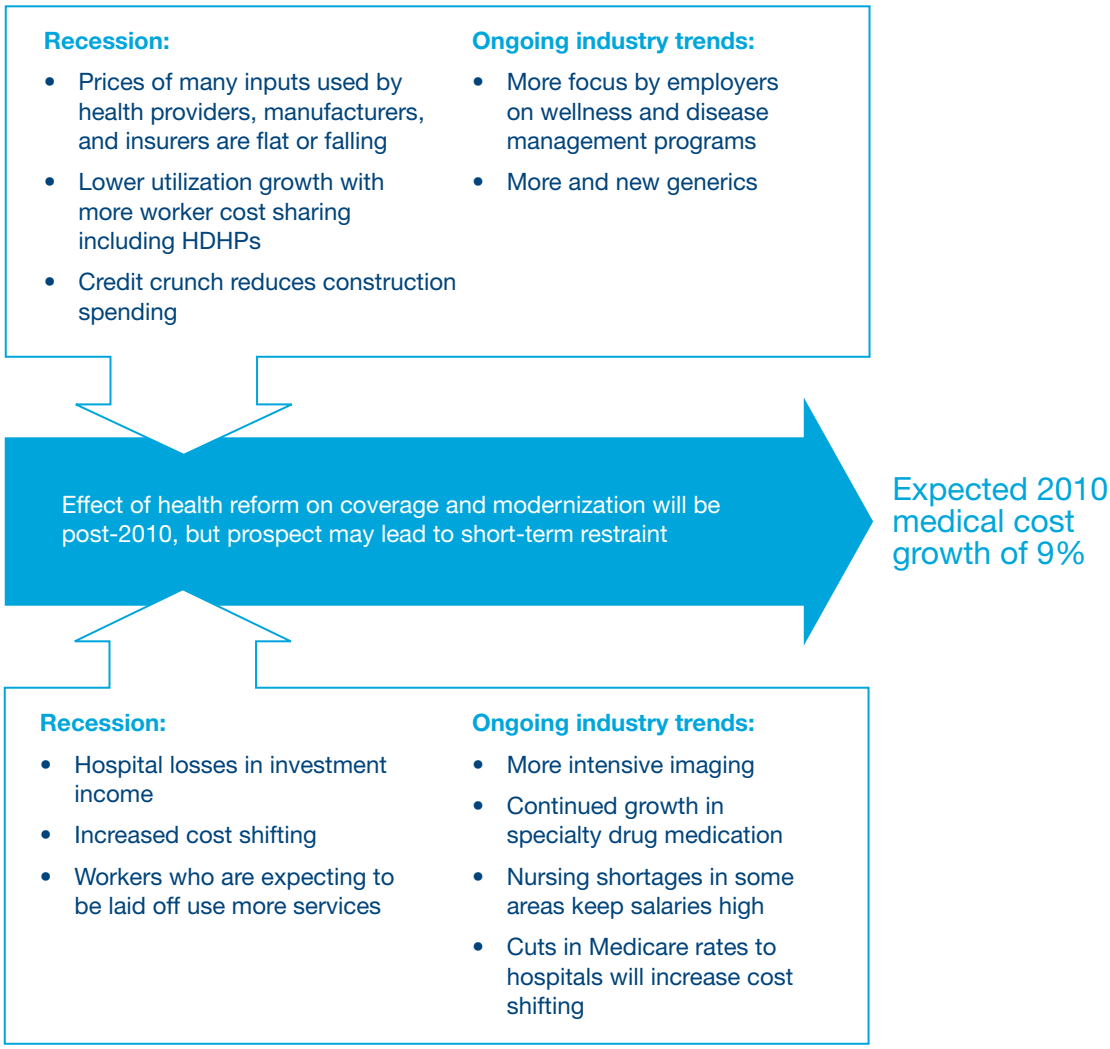
Source: PricewaterhouseCoopers, "2009 Touchstone Survey"

15 Behind the Numbers: Medical Cost Trends for 2009, PricewaterhouseCoopers' Health Research Institute

In summary

By 2010, the health industry is expected to be 18 percent of the US economy, according to CMS. However, its impact on every other industry — both in benefit costs and health of the workforce — heightens its importance. The debate around national health reform, ongoing trends in health, and the recovery of the economy will help temper medical costs in 2010, especially as it reacts to the worst economic contraction in 25 years.

Pressure on medical costs in 2010



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About the research

PricewaterhouseCoopers' Health Research Institute (HRI) reviewed the past and projected medical cost trends and the drivers of change behind them. This was undertaken through a series of interviews, analysis of published reports, and focused surveys. HRI conducted a survey of more than 500 employers and numerous provider-based health plans to discover common themes and trends in cost influencers.

The analysis of medical cost trends incorporates a review of historical aspects and current inflators and/or deflators of trend growth to approximate a growth percentage for the coming year. The medical cost trend is used by insurers in estimating annual changes in premiums for the coming year. Typical inflators of medical cost trends include increases in medical supplies and services, increases in utilization of healthcare services, and cost shifting by public insurers to private insurers. These same factors can also serve as deflators of cost trends in any given year.

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