Speakers and panelists at the daylong summit grappled with a host of issues surrounding the nation’s fractured healthcare system, the impact of health reform and possible solutions to the urgent challenges of unsustainable health costs, patient access, rising chronic disease rates and new technologies.

Those challenges are considerable, conference speakers agreed. But along with the hurdles to better, more cost-effective care they explored throughout the day, participants also offered plenty of ideas aimed at putting the nation’s $3 trillion-plus healthcare system on a path to a more sustainable, rational and integrated network of patient-centered care.

Underlying much of the discussion: the need to align health spending more effectively with the goals of improved patient outcomes, healthier behaviors and a reimbursement system that will “change the incentives to wellness,” in Dooley’s words.

“The system of delivery of care and the incentives for that are dramatically changing, and California has embraced that,” Dooley added. “We will have to push the system to create this integration and coordination of care.”

Much of the discussion at the summit revolved around health reform spawned by the Affordable Care Act. “The ACA,” Dooley said, “is changing everything about health care. The theory is that if you have everyone in a system of care, you can manage their care earlier and avoid catastrophic circumstances to a larger degree. But it also creates the opportunity for payment and delivery reform” as the focus by health plan payers and insurers shifts to wellness and disease prevention.

Leading health systems like Cleveland Clinic are helping to drive the revolution in patient-centered wellness programs, disease management and accessible, community-based care, Cosgrove said.

“As a healthcare industry and frankly, as physicians who are going to lead this [change], we have to create a vision of greater health care and what we want it to be, and take the steps that will get us there,” he told an audience of physicians, health plan administrators, insurance experts and other stakeholders. “We have a once-in-a-century opportunity to make a new healthcare delivery system that can be better for everybody. And we have to remember that the reason we’re in health … is so that we can look after and take care of people.”

Defending health reform: Experts assess ACA

Despite a rocky start, the full rollout of health reform under the Affordable Care Act has already brought major benefits to the nation’s troubled health system and affordable coverage to millions of formerly uninsured or underinsured Americans, one of the Obama administration’s top health officials asserted recently.

Marilyn Tavenner, administrator of the U.S. Centers for Medicare and Medicaid Services, strongly defended the controversial health reform law in a panel discussion at the New York Times “Health for Tomorrow” conference. She was joined onstage by John Bertko, chief actuary and director of research for Covered California, the Golden State’s health insurance exchange, and by Elisabeth Rosenthal, M.D., correspondent and senior writer for the New York Times.

“It’s been a tough year of implementation, but a great success,” Tavenner said in a presentation on the progress of the ACA rollout. (Photo credit: Michael Loccisano/Getty Images for the New York Times)
Defending reform

Continued from page 80

and the impact of health reform. “More than 8 million people are now covered in the health insurance exchanges, and a little more than half the United States has expanded Medicaid coverage [state by state].”

Bertko predicted a big jump in the number of new enrollees over the next two to three years, from 8 million to roughly 20 million, along with “a smaller number of people buying the same health plans … separately, without the exchanges.”

“The goal now is to make those plans much more efficient,” he said.

According to Tavenner, the reimbursement and coverage changes mandated by the health reform law are beginning to yield larger health and cost-saving benefits as public and private health plans begin to shift the focus of coverage from standard fee-for-service payments to prevention and the avoidance of hospitalizations. “A lot of the ACA removes co-pays and deductibles around preventive care because part of our mission is to encourage folks to have early care in an outpatient setting,” said the CMS chief. “And that’s what we’re seeing. Early indications are it’s tracking as we thought.”

Whatever the pace of those changes in health delivery, they can’t come fast enough, asserted Karen Ignagni, president and CEO of the insurance industry trade group America’s Health Insurance Plans, or AHIP. “On the cost issue … we’re getting to the point where the chickens are coming home to roost, and to keep people in the healthcare system, you have to talk about the issue of affordability … and sustainability,” she said in a separate panel discussion at the conference on the impact of the Affordable Care Act and the economics of health reform.

Out-of-pocket costs, Ignagni said, are “the kitchen-table test of healthcare reform” that many lower- and middle-income families are grappling with as they try to balance higher insurance deductibles and lower monthly premiums in the plans available either through the health insurance exchanges or via employers or the private health plan marketplace.

“All research suggests there are families very focused on out-of-pocket healthcare costs … as they face a range of choices,” Ignagni said. “We need a better support system in terms of what works.”

Will Obamacare help improve that system? “It will certainly help prevent bankruptcies and help patients with pre-existing conditions, but it still involves considerable outlays for patients who can’t afford it,” Rosenthal said in a separate presentation. “We still have to figure out a way to get those initial price tags down.”

Rosenthal ticked off some dramatic comparisons to underscore the rise in healthcare costs in the United States. “In 2012, childhood vaccines averaged more than $1,700 to immunize a child against childhood diseases to the age of 18, versus about $70 in 1990,” she said. “The cost of our hospital stay is many, many times what it is in other countries. And we don’t get better results for that.”

According to research published by the New York Times, a day’s stay in a hospital averages more than $4,200 in the United States, and can range as high as $12,500, Rosenthal said. That compares with an average of less than $1,500 in Australia, $853 in France, $731 in the Netherlands, $476 in Spain and $429 in Argentina.

Bending the healthcare cost curve nationally won’t be easy. There’s no simple fix, said Mark Pauly, Bendheim professor of healthcare management at the Wharton School of the University of Pennsylvania, who joined Ignagni in the talk on healthcare economics.

Much of the dramatic rise in health spending over the past two decades, Pauly said, has been driven by factors like expensive new technology; an insurance system that historically has shielded patients from much of the cost impact of lab tests, MRIs and other health services; and the fact that “we pay healthcare people better than almost any other country.”

“In terms of controlling healthcare spending growth, we know how to do it, but it’s hard to know how to do it in ways that do more good than harm,” Pauly said.

“The bottom line is we could have lower healthcare spending growth if we’re willing to have lousy new technology, terrible job [growth] in the healthcare sector, more skin in the game [by patients] and a continuous political debate about healthcare reform,” Pauly said. “To get lower prices [for care], we’ll have to give up something.”

Americans covered under the Affordable Care Act still face an out-of-pocket maximum expenditure of $6,350 in potential annual health costs, according to several conference panelists. “We’re all facing greater co-pays, deductibles and out-of-network issues,” Rosenthal said. “Americans aren’t accustomed to these kinds of charges … [especially] in an era of stagnant wages. How do you educate people to learn the language of health insurance?”

That question is clearly on the minds of federal health officials. As reforms continue to roll through and transform different sectors of the nation’s healthcare system, Tavenner said, “there is going to be more and more personal responsibility” for patients, along with more choices that will have to be made. That will require a big and ongoing commitment to “consumer education,” she told participants.

It also will require new thinking from all health providers and stakeholders, and an insurance industry and health plan payment system that supports continuing innovation and new approaches to patient-centered, cost-effective and holistic care. “Our job is to help consumers balance access and affordability by recognizing that premium costs are something they are very focused on,” AHIP’s Ignagni said. “So we’re [supporting] things like dis...
Pharmacists aren’t the only professionals grappling with the uncertainties of health reform, shifting patient-care delivery models and changing reimbursement standards. Doctors also are trying to redefine their health mission, patient relationships and practice priorities, said Toby Cosgrove, M.D., the top executive at Cleveland Clinic, one of the nation’s premier healthcare organizations.

A decade from now, the U.S. healthcare system “is going to be very different,” said Cosgrove, president and CEO of Cleveland Clinic. “I think … we’re dealing with probably the biggest social change going on in the United States since the New Deal,” Cosgrove said in a presentation on the future of health care at the “Health for Tomorrow” summit. “It affects 100% of the people and 18% of the GDP. And it’s changing a business that’s gone from B-to-B to B-to-C. So there’s going to be enormous change, and as a profession and an industry, we’re having slow adoption of this, and difficulty moving through it.”

Hampering the medical profession’s embrace of change, Cosgrove said, is the disruption that comes with it. “When we got into medical school, our career was pretty much fixed. Now, it’s very different. We don’t know what we’re going to get paid, what we’re going to get paid for or where we’re going to practice,” he said. “And we don’t know what kind of medicine we’re going to be practicing.”

“We’re going through a very interesting period,” Cosgrove said. “It’s a tough transition.”

Even well before the onset of the Affordable Care Act and health reform, mounting cost concerns were driving big changes in U.S. healthcare delivery, he said. “Twenty years ago, there were a million hospital beds in the United States. Now there are 800,000, and it’s 65% occupancy,” Cosgrove said. “You’re going to see a consolidation, a closure of hospitals and a reduction in hospital beds as more and more things move out of the hospital.”

Where have those patients gone? For one thing, they’re shifting to outpatient care sites like clinics and pharmacies staffed by clinically oriented pharmacists who can deal with patients with chronic conditions. They’re also being transferred out of the hospital and into the community care setting and their own homes much more quickly following most surgeries, Cosgrove said. Nowadays, “people don’t get hospitalized for chronic disease until they reach desperate straits; that’s taken care of by outpatient [settings].”

What’s more, he added, many surgeries like knee reconstruction, mastectomies and thyroidectomies are now being done on almost an outpatient basis, involving just one- or two-night stays.

“That is going to decrease demand for hospitals,” he said.

Cosgrove was joined onstage by physician and New York Times senior writer Elisabeth Rosenthal, who posed a question that was never far from the surface at the daylong summit. Given that drop in demand, she asked Cosgrove, “as we close hospitals and move patients to an outpatient setting, why aren’t there more cost savings?”

One big reason, Cosgrove said, is cost shifting. As health systems lowered prices on procedures within their hospitals to compete more effectively for insurer reimbursements, they raised prices for outpatient care. “The costs just got moved from one place to another,” he said.

Cosgrove offered some solutions to this ever-rising cost spiral. “We recognize we have too costly a healthcare delivery system. There are only two ways we can take costs out of it. One is by having a more efficient delivery system. And the second is by having less disease … if we kept people healthy.”

To that end, Cleveland Clinic adopted a sweeping set of initiatives aimed at making its own 43,000 employees healthier. “We started by taking steps to try to prevent disease,” he said, by addressing “smoking, lack of exercise and obesity or food intake.”

The health system, which is Cleveland’s largest employer, began by adopting a no-smoking policy on its own campuses, and by offering free smoking-cessation programs and nicotine patches not only to its own employees, but also to all residents of Cuyahoga County. “Then we took a bold step; we said we’re not going to hire smokers anymore.”

In addition, Cleveland Clinic pushed the Ohio Board of Regents to ban smoking from all public universities in the state. The result was a reduction in smoking in Cuyahoga County over a five-year period, from 27% of residents to 15%. “And the incidence of smoking among employees of Cleveland Clinic is [now] 6%,” Cosgrove said.

The clinic also overhauled the menus in its own cafeterias, removing unhealthy offerings and even candy machines. It also began

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Focusing clinical collaboration on prevention

“It’s not enough to pull drowning victims out of the river. You have to walk upstream to find out who’s throwing them in.”

Physician and educator David Kilgore invoked that piece of wisdom from Episcopal bishop V. Gene Robinson to describe the current state of medicine in the United States — and the steps needed to drag the nation’s outmoded, costly and inefficient healthcare system into the 21st century. For doctors and other health providers, Kilgore noted in a panel discussion at the New York Times’ “Health for Tomorrow” conference, “walking upstream” means changing the focus of care from treating serious health complications after they occur to preventing them in the first place whenever possible.

“We’re still stuck in the model from the first transformation of medicine, which did a great job with infectious disease, acute illness and injuries. But it’s not an effective model for chronic disease,” said Kilgore, clinical professor of family medicine at the University of California School of Medicine. “The river is full of drowning people, and we’re going to need a lot more than drugs or devices to usher in the second transformation of medicine.”

That transformation, he said, “has to … focus on prevention, health and wellness.”

“We have more than two decades of research that clearly shows what keeps us healthy and what prevents chronic disease,” Kilgore said in a group presentation on the future of the doctor-patient relationship. “It’s the four foundational pillars of health: healthy diet and nutrition; exercise and activity; [attention to] mind/body living conditions, including social support; and healthful sleep.”

Those factors, along with “toxin avoidance,” Kilgore said, are critical to long-term wellness. “These are powerful interventions that keep us alive longer, that help us have less disability and suffering for a lower-cost, greater-quality of life and less side effects. So the challenge for us as a profession and a society is how to move that second transformation … into [community outpatient settings like] clinics, so that the primary care physician, instead of rushing from room to room … is replaced by a new kind of healthcare team that surrounds and is part of that physician’s practice.”

That collaborative team of professionals, including nurses, pharmacists, clinic staff and nutritionists, Kilgore said, “then helps patients develop healthy lifestyle skills, self-management skills and self-efficacy.”

Driving the acute need for fundamental transformation in healthcare delivery, he added, is the fact that “in just the last 20 years, there’s just been an explosion of chronic disease. The incidence of diabetes has more than tripled. Sixty-eight percent of U.S. adults are now overweight or obese.”

“It’s a tsunami of diabetes and chronic disease,” Kilgore said. “And it’s completely changed what it means to be a family physician on the front lines. It very much seems like a ‘sick care’ system.”

Indeed, Kilgore said, “out of the $2.7 trillion [U.S. healthcare] budget, just 5% is spent on prevention and public health. We need to think about moving the whole enterprise upstream, targeting people even before they have that chronic disease. That means bringing tools for health and wellness to the workplace … to schools, to community centers. It’s really incumbent on us to make sure patients have the tools they need for a healthy lifestyle.”

Other panelists agreed. “Despite life-

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Defending reform

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It’s been a tremendous challenge in that there’s still a lot of uncertainty that’s being worked through in this country.”

One big source of that uncertainty, Tyson said in a talk at the Health for Tomorrow conference titled “Transforming Health Care to Achieve Affordability,” is whether the vision of universal coverage for Americans is sustainable. “We have no idea at this point what the risk level is of this population because it’s too early to tell,” he said. “We’re going to work to figure all of that out.”

Costs will ease

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Dealing effectively with that challenge, Cosgrove said, “is a societal issue” that “is going require educators, physicians, universities, government, food producers, food servers — all beginning to realize that it’s in their best interest to deal with this issue. It’s going to take a big national discussion.”

He predicted that the health system would undergo “the disintermediation of hospitals,” adding, “I think you’re going to see lab tests going to Walmart or Walgreens and radiology leaving the hospital. It’s going to be like a department store, and that will increase the efficiency and decrease the costs.” And price, he said, will drive many choices in sites of care.

Health care, in short, is evolving into “a consumer-driven organization … with transparency around costs” that’s driving a more competitive and efficient health system, Cosgrove said.

Focusing clinical

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“I think there’s a missing provider … who partners in a relationship-centered, client-driven process to facilitate and empower patients to achieve the health beliefs and behavior changes that they want,” Lawson said. “We call that person a health coach … who applies their knowledge and skills to assist clients to mobilize their own internal strengths, to access their best external resources and to make the changes they want to make to optimize their well-being.”
Abuse of REMS drives up healthcare costs

The generic drug industry — and by extension, patients across the United States — is being adversely impacted by what some are calling branded drug makers’ abuse of risk evaluation and mitigation strategies, or REMS.

“When brand manufacturers use these programs to withhold access to drug samples for generic manufacturers’ bioequivalence testing and development, they can delay generic market entry and competition, thereby preserving high drug prices and preventing the cost savings generic drugs are known to deliver,” Matrix Global Advisors CEO Alex Brill noted in “Prescription Drug Savings from Use of REMS Programs to Delay Generic Market Entry,” a study his firm recently did for the Generic Pharmaceutical Association.

The impact that the growing use of REMS is having on healthcare spending is substantial, the report said. Through a detailed analysis of pricing and utilization data for just 40 drugs, Brill concluded that the delays caused by overusing REMS adds $5.4 billion a year in healthcare costs, with the federal government picking up a third of these costs and private insurers covering $2.4 billion. In addition, consumers pay $960 million in extra out-of-pocket costs, Brill said, and state and local governments foot the bill for $240 million of added healthcare costs.

“These estimates should not be construed as the entirety of the lost savings from REMS misuse,” Brill said. “Not all currently restricted products are included in our analysis, and as the problem of brand drug companies’ misuse of REMS and other restricted access programs grows, this lost savings will increase.”

REMS were created in 2007 to improve drug safety for certain products by ensuring that the benefits for patients outweigh the risks. However, Brill said that in recent years, branded drug makers have stepped up their use of “elements to assure safe use” — the component of REMS programs that mandates restricted distribution. The report noted that in 2009 only about a quarter of REMS programs included these provisions. Today, more than half of the 70 approved REMS programs — 64 individual REMS and six shared system REMS — include elements to assure safe use.

In addition, the report noted that some branded drug manufacturers also have begun applying restricted access programs to drugs for which the FDA has not required a REMS program.

While both houses of Congress and lawmakers in a handful of states across the country have tried to enact legislation forcing branded drug companies to share their bioequivalency data with generic manufacturers, these efforts have so far failed to become law.

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<th>ANNUAL LOST SAVINGS FROM REMS MISUSE*</th>
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<tr>
<td>Total: $5.4 billion</td>
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<tr>
<td>State, local and other payers $0.2</td>
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<tr>
<td>Out of pocket $1.0</td>
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<tr>
<td>Federal government $1.8</td>
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<td>Private insurance $2.4</td>
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*In billions
Source: Matrix Global Advisors calculations based on IMS Health and National Health Expenditure data

Biologics restrictions result in lost savings

Restricting access to samples of generic biological drugs would lead to nearly $140 million in lost savings for every $1 billion in biologics sales, Matrix Global Advisors said.

“This potential lost savings has enormous implications for the large and growing segment of pharmaceutical spending that biologics represent,” Matrix Global Advisors CEO Alex Brill wrote in “Prescription Drug Savings from Use of REMS Programs to Delay Generic Market Entry,” a report the firm issued last month examining how overuse of risk evaluation and mitigation strategies, or REMS, is slowing the stream of generics into the marketplace.

Biologics are the fastest-growing segment of the pharmaceutical market, he said, growing by 9.6% last year and accounting for 28%, or approximately $92 billion, of the country’s drug spending.

“In light of the forthcoming regulatory pathway for biosimilars and the pending patent cliff among biologics, access to biologic drugs for biosimilar approvals is critically important,” Brill said. “In the current REMS environment, biologics makers will have the same opportunity to restrict access to samples of biologic drugs, with negative consequences to payers and patients.”

Of the 64 approved individual REMS programs in effect today, 15 are for biologics. Brill said some generic drug makers already have reported restricted access to biologics samples.

More restrictions, he noted, are likely to have a dramatic impact on efforts to control healthcare spending.

“To capture the magnitude of the potential lost biosimilar savings from REMS misuse, we use the Congressional Budget Office’s assumptions about the market dynamics following biosimilar market entry,” Brill wrote in his report. “The competitive dynamics of the biologic drug market are not expected to mimic the dynamics in the small molecule market. CBO expects an eventual 40% biosimilar price discount and 35% substitution rate.”
Backlog of generic drug applications at FDA

By Richard Monks

Despite creating a detailed plan to speed up the rate at which generic drug applications are reviewed, experts say a backlog has developed at the Food and Drug Administration’s Office of Generic Drugs.

“They are buried,” Robert Pollock, a former acting deputy director of the OGD, told the Wall Street Journal earlier this month.

“They are on track to receive more than 1,500 [applications] this fiscal year,” he said. “The estimates were for between 800 and 850 applications, and the funding was based on assumptions of a workload that were far below what they are seeing. I believe OGD needs to change the way it reviews applications.”

Pollock, who is now with Lachman Consultants, where he advises generic drug makers on regulatory issues, said the FDA needs to find ways to boost staffing even as it faces budgetary constraints.

Two years ago, the agency was authorized to start collecting fees from generic drug makers in order to increase the number of facility inspections — especially those overseas — and speed up application reviews in order to ensure safety and bring new generics to market faster.

This summer, however, the FDA has seen an unexpected number of applications that have not been processed. Regulators say the situation was created partly by a deadline for submitting applications that reflected required changes in testing medicines.

However, some in the industry contend that the backlog is due to a more fundamental problem, as the FDA struggles to deal with a growing amount of paperwork.

Pollack said he feels OGD’s problems could worsen if the number of applications from companies based in China starts to accelerate. Any further slowdown in approvals, he said, could result in generic drug makers and the FDA sparring over the next round of fees that are used to fund the program.

“The estimates were for between 800 and 850 applications, and the funding was based on assumptions of a workload that were far below what they are seeing. I believe OGD needs to change the way it reviews applications.”

Robert Pollock, former acting deputy director, FDA’s Office of Generic Drugs

The number of generic drugs approved by the FDA has been relatively stable over the past few years. In fiscal 2010, the agency approved 426 medicines. A year later, the total hit 458, and the number of approval topped out at 517 in fiscal 2012. Last year, the FDA approved 330 generics.

The number of applications received, however, has not kept pace with the approval rate. The FDA said that in the current fiscal year, it already has received 1,440 approval requests, including 600 in July alone.

While not causing any disruptions in the market so far, some have suggested that further approval delays could adversely impact efforts to control healthcare spending.

According to the IMS Institute for Healthcare Informatics, 86% of all prescriptions in the United States last year were for generics.
Mylan acquires Abbott’s non-U.S. specialty, branded generics business
PITTSBURGH — Mylan entered into a definitive agreement with Abbott whereby Mylan will acquire Abbott’s non-U.S. developed markets specialty and branded generics business in an all-stock transaction. Upon closing, Abbott will receive 105 million shares of the combined company worth approximately $5.3 billion based on Mylan’s closing price of $50.20 on July 11.

The specialty and generics portfolio include more than 100 products in five major therapeutic areas — cardio/metabolic, gastrointestinal, anti-infective/respiratory, CNS/pain, and women’s and men’s health — and include several patent protected, novel and/or hard-to-manufacture products with continued growth potential. The portfolio is expected to provide approximately $1.9 billion in annual additional revenues at deal close. The business includes an active sales organization of approximately 2,000 representatives in more than 40 non-U.S. markets, as well as two high-quality manufacturing facilities.

Higi, StayHealthy merge to create connected retail health kiosk network
CHICAGO — Higi and Stayhealthy announced that the companies have completed a transaction creating the largest connected retail health kiosk network in the United States. The business will operate as higi. The two companies have combined to carry out a shared vision of helping consumers take small but meaningful steps in their health-and-wellness goals.

A platform has been developed that makes it simple, fun and rewarding to take control of one’s health and wellness, the companies stated.

In addition to offering consumers basic health screenings — blood pressure, pulse, body fat, weight and BMI — the platform integrates with many popular fitness tracking devices currently available, allowing users to monitor their fitness-and-health tracking activity while also being rewarded for their efforts via higi’s wellness engagement incentive program.

Sandoz takes step toward first U.S. generic biosimilar with FDA filing
HOLZKIRCHEN, Germany — The Food and Drug Administration has accepted a license application by Sandoz, Novartis’ generics company, for a potential generic biologic drug, the company announced.

If approved, it would be the first biosimilar generic in the United States since the passage of the Biologics Price Competition and Innovation Act, which cuts down the approval process for potential biosimilar generics.

The application is to create a generic version of the biosimilar drug filgrastim, which is used to treat neutropenia, a condition that typically accompanies cancer or bone marrow diseases that causes a low white blood cell count. Amgen sells filgrastim as Neupogen.

Camber adds new marketing, sales operations directors
PISCATAWAY, N.J. — Generics supplier Camber Pharmaceuticals added two new executives to its team, bringing on Kirk Hessels as marketing director and Amanda Rebnicky as its sales operations director.

Hessels, who founded and spent 20 years at KH Advertising, leaves his most recent position as VP at marketing and graphic design firm Vision Creative Group to join Camber.

Rebnicky has previously worked with such generics companies as Fougera Pharmaceuticals and Dr. Reddy Labs in sales and marketing roles.
New health economy, patient-centric system yield opportunities for tech providers

BY RICHARD MONKS

As health care in the United States continues to move toward a patient-centric system, new opportunities are opening up for technology providers.

According to “Healthcare’s new entrants: Who will be the industry’s Amazon.com?” a report released this spring by the PricewaterhouseCoopers Health Research Institute, the United States’ $2.8 trillion healthcare industry is being upended by “companies attuned to the needs and desires of empowered consumers.”

These emerging players, the report noted, are setting the stage for what researchers call the “New Health Economy” that has the potential to alter how the country’s healthcare dollars are spent, and give more companies a piece of the pie.

“These new entrants are poised to shake up the industry, drawing billions of dollars in revenue from traditional healthcare organizations while building lucrative new markets,” a team of PwC analysts wrote in the 20-page report that was released in April.

“Within a decade, health care will feel very different than it does today,” the report said. “The players may be different, with partnerships between new entrants and traditional organizations.”

PwC, which surveyed 1,000 people across the country as part of its research, said that many of the companies that will drive this revolution will be able to provide healthcare providers with cutting-edge technologies that will make delivering patient care more efficient and convenient.

The report stressed that these technology providers are in a particularly good

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NEW ENTRANTS: THE $3 TRILLION U.S. HEALTH ECONOMY

$2.8 trillion
U.S. healthcare system

$267 billion
Fitness and wellness market

Over time, these newer players will draw billions from traditional healthcare systems, while expanding the fitness and wellness space.

Source: HRI analysis and Centers for Medicare and Medicaid Services National Health Expenditures (2012)

THREATENING THE STATUS QUO

New entrants are creating options consumers want, threatening billions of dollars in hospital and physician revenue.

How likely would you be to choose these options, if they cost less than the traditional choice. Percent of respondents answering “very likely” and “somewhat likely.”

54.8% Send a digital photo of a rash or skin problem to a dermatologist for an opinion

$358 million for evaluation of contact dermatitis and other minor rashes.

43.6% Have an electrocardiogram at home using a device attached to your phone, with results wirelessly sent to your physician

$2.9 billion for routine ECG

42.6% Have a pacemaker or defibrillator checked at home wirelessly by your physician

$110 million for pacemaker evaluation

34.4% Get an MRI at a clinic in a retail store or pharmacy

$11.6 billion for an MRI without contrast

Continued on page 98
position to play a central role in the New Health Economy. Many of those polled for the study said they are ready to abandon traditional care models for ones that more closely resemble experiences in banking, retail and entertainment. Many of the healthcare services that would be directly affected by these new models are ones that are already being offered in pharmacies and in-store clinics.

“Respondents were presented with a series of familiar medical tests and treatments, from strep throat diagnosis to administration of chemotherapy, in new settings closer to home and often enabled by technology,” the researchers wrote. “About half indicated they were likely to choose these alternatives.”

PwC noted that people between the ages of 35 years and 54 years, and those struggling to cope with rising healthcare costs, were most likely to choose the new possibilities.

Many of the technology companies that will become more central players in providing health care in the future are already staking their claim. PwC said that 38 of the Fortune 50 companies with a major stake in health care, 24 are new entrants, with eight of them being technology and telecommunications firms.

Armed with consumer prowess, brand recognition and digital savvy, these companies already have begun making forays into health care. Many of them have centered their efforts on mobile technologies, something the report said will be a centerpiece of the New Health Economy.

Earlier this year, for example, Samsung included a built-in heart-rate monitor in its new Galaxy S5 smartphone. That comes on the heels of Apple being given a patent last year for a “seamlessly embedded heart-rate monitor” for such devices as its iPhone.

Meanwhile, AT&T, Time Warner Cable Business Class and Google have formed spinoff companies or entered into joint ventures with established healthcare providers, melding traditional services with new technologies to make health care more convenient for consumers.

“[They are] helping customers make wise, cost-effective health choices,” the authors wrote. “And with the array of mobile apps, online e-docs, neighborhood retail clinics, urgent care clinics, primary care doctors and hospital emergency departments, the appetite for smart customer guidance will grow.”

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“The players arrive on the health scene with strong consumer credentials,” the PwC report noted. “Many have deep relationships with millions of customers and rich databases of information on them.”

The researchers said that as the possibilities of these new ventures become apparent and they find their way into everyday use, investors are becoming more willing to back further game-changing technologies.

“At a time when venture capital investment in life sciences is down, money is pouring into start-ups targeting digital health, price transparency, workflow and electronic medical records systems and population health management,” PwC said. “In some cases, these companies are looking for a piece of the $2.8 trillion pie. In others, they hope to entice customers to other parts of their business with quality health care.”

“Respondents were presented with a series of familiar medical tests and treatments, from strep throat diagnosis to administration of chemotherapy, in new settings closer to home and often enabled by technology,” the researchers wrote. “About half indicated they were likely to choose these alternatives.”

PwC noted that people between the ages of 35 years and 54 years, and those struggling to cope with rising healthcare costs, were most likely to choose the new possibilities.

Many of the technology companies that will become more central players in providing health care in the future are already staking their claim. PwC said that 38 of the Fortune 50 companies with a major stake in health care, 24 are new entrants, with eight of them being technology and telecommunications firms.

Armed with consumer prowess, brand recognition and digital savvy, these companies already have begun making forays into health care. Many of them have centered their efforts on mobile technologies, something the report said will be a centerpiece of the New Health Economy.

Earlier this year, for example, Samsung included a built-in heart-rate monitor in its new Galaxy S5 smartphone. That comes on the heels of Apple being given a patent last year for a “seamlessly embedded heart-rate monitor” for such devices as its iPhone.

Meanwhile, AT&T, Time Warner Cable Business Class and Google have formed spinoff companies or entered into joint ventures with established healthcare providers, melding traditional services with new technologies to make health care more convenient for consumers.