



Increasing Consumer Choice in Coverage and Care: Implications for Hospitals

The marketplace for health insurance has become increasingly consumer-driven, with important implications for the way care is paid for and delivered. In an effort to stem the rising costs of providing health insurance, employers are increasingly shifting more costs to employees, selecting lower-cost plan options that restrict access to a narrower range of providers and limiting employer contributions to health insurance premiums to a fixed dollar amount. These changes are accompanied by the emergence of private health insurance exchanges that offer employees additional health insurance options, leaving employees, rather than the

employer, to make trade offs between upfront premium costs versus coverage, cost-sharing levels and provider access. Likewise, in the individual and small group markets, the Affordable Care Act's (ACA) health insurance exchanges place the purchasing decision for health insurance coverage in the hands of millions more Americans.¹

As consumers look to balance premium costs against other plan features, many will likely choose coverage with narrow networks and greater cost-sharing in the form of higher copays, coinsurance and/or deductibles. With a greater personal and financial stake in their health care coverage, consumers

are demanding more provider transparency in cost and quality. At the same time, there is often confusion among consumers about key concepts and terms that impact their financial obligation when they receive health care services. As a result of consumers taking on a greater share of their health care costs, providers may experience increased bad debt, declining revenue due to decreases in utilization, changes in market share due to exclusion or inclusion in networks or patients seeking care in lower-cost settings, and poorer patient outcomes associated with avoided or delayed care due to higher out-of-pocket costs.

Individuals share in the cost of health insurance in a variety of ways.

Chart 1: Elements of Health Plan Design

Element	Definition
Premium	The amount that must be paid for health insurance. The individual and/or an employer usually pay the premium monthly, quarterly or yearly.
Copay	A fixed amount (for example, \$20) paid by an enrollee for a covered health care service, usually paid when the individual receives the service. The amount can vary by the type of covered health care service.
Coinsurance	Enrollee's percentage share of the costs of a covered health care service. This (for example, 20 percent) is based on the allowed amount for the service provided. Enrollee pays coinsurance, plus any relevant deductibles, for covered services.
Deductible	The amount an enrollee owes for health care services before the health plan begins to pay. For example, if an individual's deductible is \$1,000, the health plan won't pay anything until he/she has paid \$1,000 out-of-pocket for covered health care services. The deductible may not apply to all services.
Out-of-Pocket Maximum	The limit on the total amount a health insurance company requires an enrollee to pay in deductible and co-insurance in a year. After reaching an out-of-pocket maximum, the enrollee no longer pays co-insurance because the plan will begin to pay 100 percent of medical expenses. This only applies to covered services.

Source: Healthcare Financial Management Association. (2014) Understanding Healthcare Prices: A Consumer Guide.

Employer changes in plan design have important implications for hospitals

Increasing coinsurance and deductibles will make consumers more price sensitive at the point of care

As health insurance costs continue to rise, employers are seeking ways to reduce the burden of providing health benefits to their employees. One strategy common among employers is to shift health care costs to consumers in the form of higher coinsurance and deductibles.

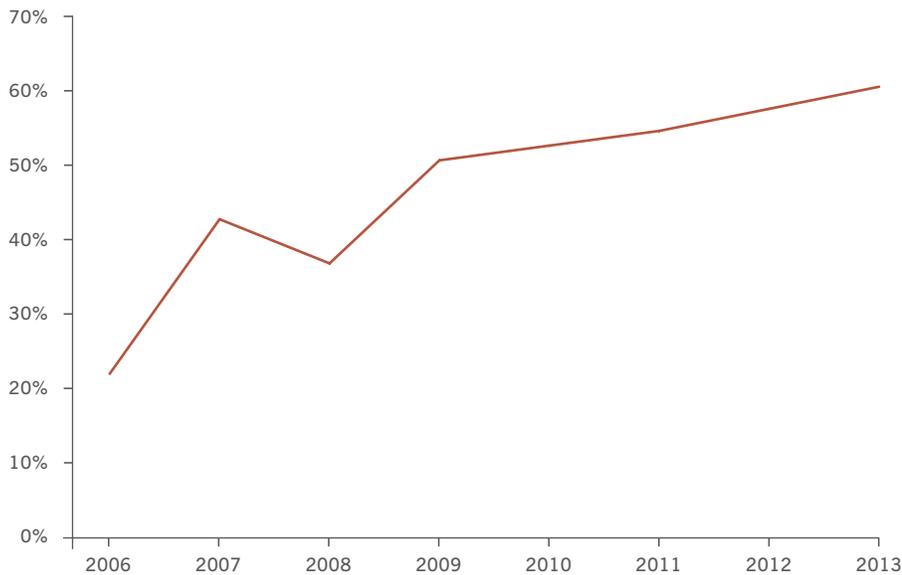
Historically, typical employer-sponsored plans had flat rate copays for selected services.^{2,3} These copays did not vary by the individual provider's fee for the service and, in the end, reflected only a small portion of the cost of care provided. Increasingly, employers have been shifting away from copays to coinsurance, which requires employees or their family members to pay a percentage of the costs they incur for medical

care. The percentage of workers with employer-sponsored plans with coinsurance for a primary care visit grew from 11 percent in 2008 to 20 percent in 2013. The percentage of workers with coinsurance for hospital admissions increased from 37 percent to 61 percent during the same period.^{4,5} Because the amount the patient pays varies with the price of the provider service, coinsurance provides an incentive for the patient to shop around for the lowest cost provider.

Another way in which employers are shifting costs—and the decision about whether to incur those costs—to employees is by increasing the amount of the deductible that an employee or family member must pay before the health plan begins to pay for care. In 2007, the percentage of workers with employer-sponsored insurance with a deductible of \$1,000 or more for single coverage was 12 percent. By 2012, that percentage had risen to 34 percent.⁶ Employers also are increasingly offering high-deductible health plans (HDHPs), a newer plan option that typically has lower premiums and may be paired with individual health savings accounts (HSAs). Overall, there has been a rise in uptake of HDHPs relative to traditional health maintenance organizations (HMOs) and preferred provider organizations (PPOs) across all employers.⁷ The HDHP market grew from 4 percent to 20 percent of the employer-based population from 2006 to 2013.⁸

Employers have been increasingly shifting employee benefits to include coinsurance.

Chart 2: Percentage of Covered Workers in a Plan that Requires Coinsurance for Hospital Admission, 2006-2013



Source: The Kaiser Family Foundation and Health Research and Educational Trust. 2006-2013. Employer Health Benefits.

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from the field

“To find more effective ways to manage health costs, many employers are focusing on reshaping their health strategy for the next three to five years.”⁹

— Ron Fontanetta, Senior Health Care Consultant, Towers Watson

High-Deductible Health Plans (HDHPs)

HDHPs feature lower premiums and higher deductibles than traditional insurance plans. As of 2014, the Internal Revenue Service (IRS) set the HDHP minimum annual deductible at \$1,250 per year for individual coverage and \$2,500 for family coverage.¹⁰ Plans that meet these minimums are formally defined as HDHPs; however, other health plans with high deductibles are often also referred to as HDHPs, but are not subject to the same regulations and cannot be paired

with health savings accounts (HSAs).

An important feature of HDHPs, as defined by the federal government, is the continued ability to provide coverage for preventive care, such as an annual physical, without a deductible.¹¹ This helps prevent the consumer from delaying annual visits or missing screening examinations. The consumer may still pay any relevant copayments or coinsurance, however, up to a maximum out-of-pocket expenditure limit.

To further mitigate the impact of

high or unexpected out-of-pocket costs associated with HDHPs, the Medicare Modernization Act of 2003 created HSAs, which are medical savings accounts available to consumers who are enrolled in a HDHP that meets the IRS's minimum deductible requirements. Individuals and/or employers contribute pre-tax funds to the account, up to an annual limit, which can be used to pay for qualified medical expenses. Unused funds roll over year to year without penalty.¹²

Consumers will demand cost information to guide decision-making

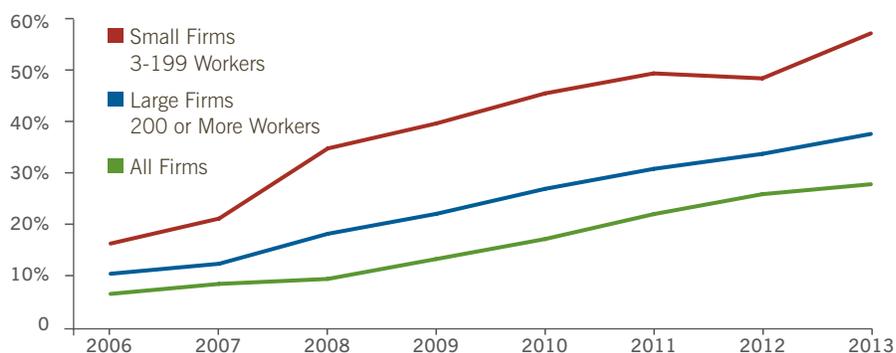
With greater financial exposure, consumers will demand more transparent quality, cost and customer satisfaction data from providers. Enrollees in HDHPs are more likely to be sensitive to price and quality differences in products and services. Further, they are more likely to inquire about and negotiate cost, while prioritizing lower prices and convenience.¹³

Federal and state governments, providers, and plans are leading multiple efforts to equip consumers with more information on health care cost and quality. These efforts face challenges with ensuring that data released for public consumption are complete (e.g., represent the entire episode of care), clearly explained, placed in context and made applicable to each consumer's interaction with the health care system.¹⁴

Several private sector tools have emerged to tackle these issues. These newer tools often pair claims data from payers and providers with quality data to offer consumers a more comprehensive understanding of their

The portion of employees with deductibles of \$1,000 or more has been rising rapidly.

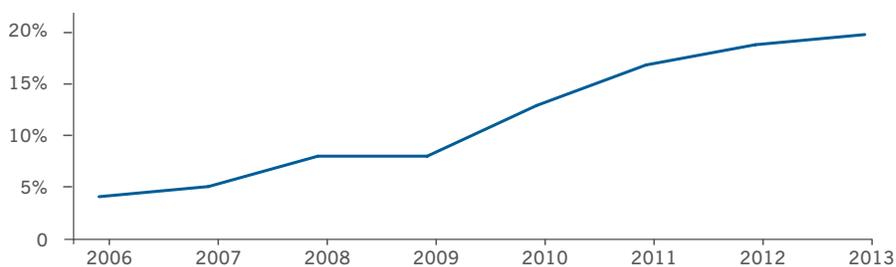
Chart 3: Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$1,000 or More for Single Coverage, by Firm Size, 2006-2013



Source: The Kaiser Family Foundation and Health Research and Educational Trust. Data Released 2013. Employer Health Benefits.

Enrollment in employer-sponsored high-deductible health plans is rising.

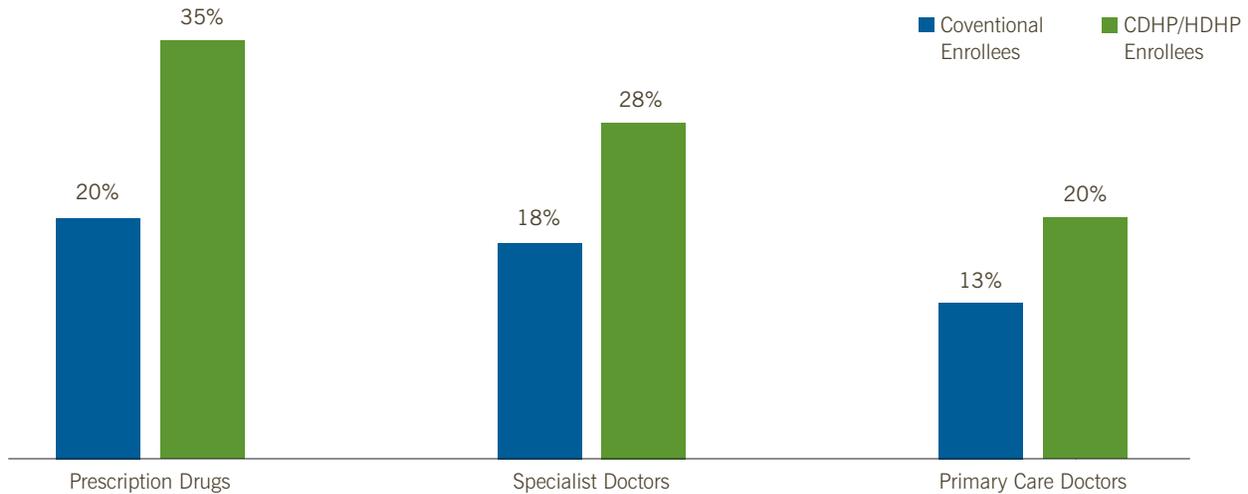
Chart 4: Growth in Enrollment in HDHPs Among Covered Workers, 2006-2013



Source: The Kaiser Family Foundation and Health Research and Educational Trust. Data Released 2013. Employer Health Benefits.

HDHP enrollees are more price sensitive than conventional health plan enrollees.

Chart 5: Consumers Who Inquire Most or All of the Time about Prices before Products or Services Are Purchased (Conventional vs. HDHP Enrollees)



HDHP: High deductible health plan CDHP: Consumer directed health plan
 Source: Booz Allen Hamilton, Inc. (2008). Health Care's Retail Solution: A Consumer-Focused Cure for the Industry.

financial obligations and, in some cases, guidance on how to reduce their out-of-pocket costs. While it is still unclear how often consumers use these transparency and decision-making tools,¹⁵ consumer demand is expected to increase as patients face greater out-of-pocket costs.¹⁶

The ACA requires hospitals to establish and make public a list of their standard charges for items and services. In the 2015 Inpatient Prospective Payment System proposed rule, the Centers for Medicare & Medicaid Services (CMS) reminded hospitals of this obligation and indicated that it will give hospitals the flexibility to determine how they make information on charges public.

The Healthcare Financial Management Association (HFMA) recently released a set of principles and

recommendations related to price transparency that represented the work of a task force including providers, plans, employers and consumers, among others.¹⁷ An accompanying consumer guide provides information on how to seek pricing information.¹⁸

Providers will carry the burden of patient education at the point of care Patients often do not fully understand their insurance or how to estimate out-of-pocket costs.¹⁹ This places greater pressure on the provider to educate the patient and deliver potentially unexpected news on out-of-pocket costs, often after the fact.²⁰ Not only does this increase the time and expense related to registering, billing and collecting from patients, it can also adversely impact patient satisfaction scores.²¹ To help with this issue, the

ACA requires health plans to provide a standardized, consumer-friendly summary of benefits and coverage and a uniform glossary of insurance terms to individuals at the time of plan selection.²² However, this requirement assumes the patient will understand how coverage guidelines apply in the beneficiary's unique circumstances.

Greater exposure to costs may lead to delayed or avoided care While many patients may be eligible for hospital financial assistance that would help limit or spread out out-of-pocket expenses, as overall exposure to costs increases, patients may skip or delay care. Deferred care can lead to a decline in patient volume in the short-term, but possibly increase high-acuity cases over the long-term as uncared for conditions worsen. The number

of patients delaying treatment for a serious condition has risen since the 2000s.²³ In fact, 32 percent of privately insured Americans forego medical care because of financial pressures.²⁴ As a result of these trends, patients, particularly those in HDHPs with disadvantaged socioeconomic status, are likely to have more high-acuity hospital visits.²⁵

Higher patient cost-sharing can increase bad debt

As patients bear higher out-of-pocket costs for needed care, providers are likely to see bad debt increase. The prevalence of HDHPs and increased consumer cost-sharing may weaken hospital finances by increasing accounts receivable, if patients are not able to pay on time, and increasing the magnitude of bad debt, if patients default.²⁶ As a result, Moody's Investors Service has downgraded its financial outlook for non-profit hospitals in 2014.²⁷ Tenet Healthcare Corporation and the Cleveland Clinic have attributed the increase in their bad debt to the growing enrollment in HDHPs.^{28,29}

Narrow or tiered networks can shift market share

Many employers now offer narrow or tiered network plans to tackle rising coverage costs. In narrow networks, plans restrict their networks to a smaller subset of providers that are willing to offer deeper discounts in

exchange for increased patient volume, which in turn helps lower premiums for consumers. In tiered networks, health insurers place providers, typically hospitals and specialists, into tiers based on efficiency and quality measures. Patients accessing providers in a higher tier are subject to higher copay or coinsurance rates.³⁰ Most commercial health insurers offer a tiered network product³¹ and approximately 20 percent of employers offer tiered and/or narrow network plans.³²

Employers are increasingly using reference pricing, where the company or insurer will pay "first-dollar" up to a pre-determined limit for specific procedures while the employee is responsible for any costs above the reference price. This encourages consumers to select providers that will perform the service for a price below or close to the employer's contribution. Both the California Public Employees' Retirement System (CalPERS) and the grocery store chain Safeway have used reference pricing and have disseminated lists of providers that offer selected procedures for a price less than the established reference price.³³

In addition, some employers are covering travel expenses for patients who are willing to get lower cost care at a remote location.³⁴ In both examples, while employees retain access to a broad network, in practice employees are likely to choose from a narrower set of providers with lower costs in order to minimize their cost-sharing obligation.

As consumers become more price-sensitive and networks narrow, hospitals also may gain or lose business as a result of their own or payers' network contracting strategies. Hospitals may see declining revenues if they are not included in narrow network or tiered products. On the other hand, hospitals that contract to participate in narrow networks could see gains in volume as insured patients are directed to a smaller number of hospitals for their care. In response to the increased prevalence of narrow networks, some integrated health care delivery systems are expanding their insurance presence and establishing their own narrow networks to proactively manage patient care, control costs, direct the premium dollar and maintain volume. For example, Baylor Scott & White Health, a health system in Texas, is actively using its insurance plan to sell narrow network plans featuring its own providers to individuals shopping for insurance on the exchanges.³⁵

Hospitals may lose volume to lower-cost providers

As patients' exposure to the cost of care increases, providers also could begin to see care shift from the hospital to lower-cost settings or to hospitals with lower prices. Utilization of retail health care clinics, such as those based in discount stores and pharmacies, has grown sharply as consumers seek options that are cost-effective, accessible and provide extended operating hours for health care needs.³⁶

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from the field

“To navigate an environment where they are no longer shielded from the costs of their care, consumers need reliable information on both the relative price and quality of health care services to choose the best value.”³⁷

— Pacific Business Group on Health

Broader choice places more responsibility on consumers

The shift to defined contribution is often coupled with increased choice

Over the next three to five years, many employers expect to reduce the level of premium subsidies they provide toward the cost of health insurance, resulting in higher premium contributions from employees.³⁸ Other employers are moving away from offering a small number of specific benefit package choices, or a “defined benefit plan,” to providing a specific fixed-dollar contribution that workers can use to purchase a plan from among a range of options, known as a defined contribution plan.

Private exchanges broaden choice

The shift to a defined contribution model is often accompanied by a move to a private exchange for the purchase of health insurance coverage. Private exchanges are

typically operated by benefits consultants and/or health plans to offer employers and their employees an array of plan options and price points from which to choose their coverage level and network of providers. Leading private exchange operators include Towers Watson, Mercer, Buck Consultants, and Aon Hewitt. Private exchanges were created, in part, to respond to employers’ desires to limit their contributions to health insurance premiums, step out of decision-making around health plan benefits, and give employees greater choice. While the public marketplaces are available only to individuals and small businesses, private exchanges generally include mid-size and large employers.

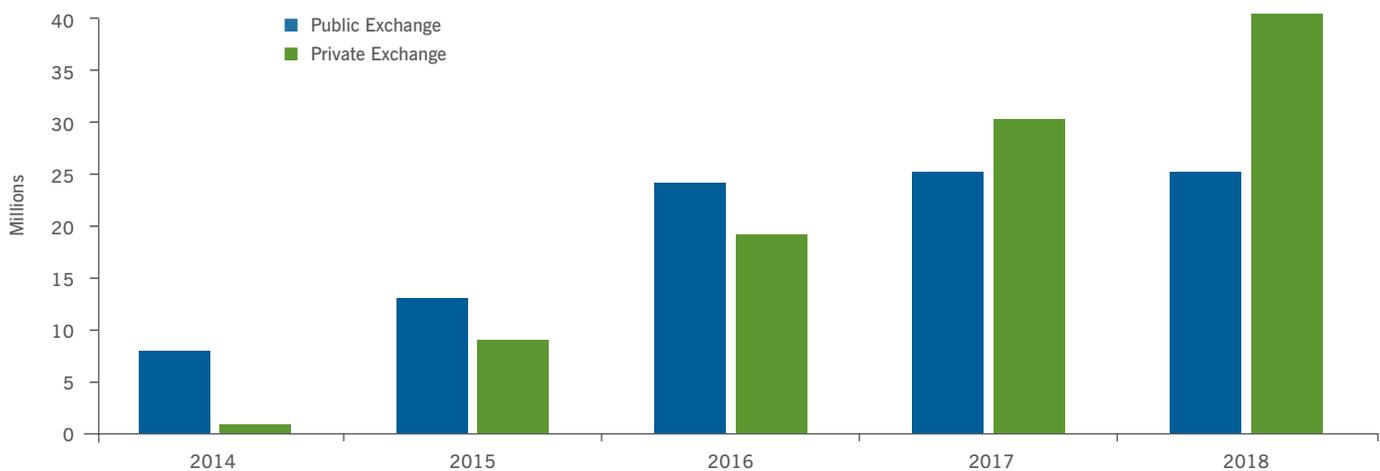
Private exchanges permit employees to make determinations about what level of benefits they desire, what personal contributions toward premi-

ums they are willing or able to supply and what provider network they want available to them. Private exchanges help employers to reign in insurance costs and lessen internal insurance administrative costs, while simultaneously creating more choice for employees. Private exchanges offer as many as 20 coverage options side-by-side.³⁹

One in four employers is considering shifting from traditional health plan offerings to private or corporate health care exchange models with defined contribution funding.⁴⁰ For example, as of September 2013, 18 large employers, including Walgreens, Sears Holdings Corporation and Darden Restaurants, Inc., offer health benefits through Aon Hewitt’s multi-carrier exchange for the 2014 coverage year.⁴¹ Each of these large employers

Enrollment in public and private exchange-based products is expected to increase rapidly.

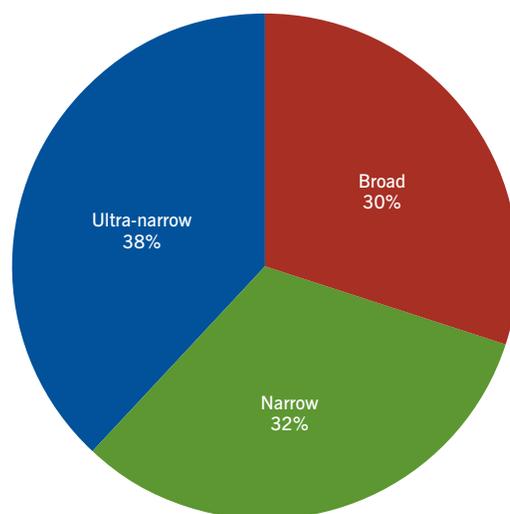
Chart 6: Projected Growth in Public and Private Exchange Enrollment, 2014-2018



Sources: 2014 Public Exchange Enrollment: Office of the Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief, Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Enrollment Period, October 1, 2013 – March 31, 2014. Including Additional Special Enrollment Period Activity Reported through April 19, 2014. Released May 1, 2014. Public Exchange projections 2015-2018: Congressional Budget Office, April 2014 baseline, Effects of the Affordable Care Act on Health Insurance Coverage. Private Exchange projections: Accenture, Are You Ready? Private Health Insurance Exchanges Are Looming, Released May 17, 2013.

Narrow and ultra-narrow network plans are prevalent in the public marketplace.

Chart 7: Distribution of Individual Exchange Narrow Networks by Network Breadth, 2014*



Source: McKinsey Center for US Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available filings and carrier information; AHA Database (November 2013).

*Broad networks: less than 30% of largest 20 hospitals by number of beds are not participating; Narrow networks: 30-69% of largest 20 hospitals are not participating; Ultra-narrow networks: At least 70% of largest 20 hospitals are not participating.

N=120. Analysis of networks on the individual market offered in silver in Atlanta, Bridgeport, Dallas, Nashville, Houston, Salt Lake City, Miami, Tampa, Louisville, Indianapolis, St. Louis, Los Angeles, San Jose, Pittsburgh, Denver, Philadelphia, Seattle, Chicago, Washington, DC, and Portland, ME.

has migrated to defined contribution arrangements and allowed employees to select from the broader plan options available in the private exchange.

ACA plan options mirror private market trends

The ACA extends the exchange concept to the individual and small group markets nationwide. The individual marketplace is for those who do not receive health care coverage through an employer or through an existing government program,⁴² and the small group marketplace—known as the

Small Business Health Options Program (SHOP) exchange—serves employers that currently employ 1-50 individuals, increasing to up to 100 individuals in 2016.⁴³

Public marketplaces offer consumers greater choice and spur competition among plans. For coverage in 2014, individuals had an average of 53 qualified health plan choices in the 36 states where the federal government fully or partially operated the marketplace.⁴⁴

Public marketplaces offer plans with varying levels of premiums, cost-sharing and benefits for individuals. The plan

design of the majority of ACA exchange products largely mirrors the direction of the private market with higher deductibles and narrow networks. In fact, the majority of ACA plan offerings are bronze and silver plans, which cover smaller portions of enrollees' costs than the gold and platinum offerings (see page 8). Further, in 20 large urban areas, two-thirds of hospital networks on all ACA exchange plans are narrow (30 to 69 percent of area hospitals included in-network) or ultra-narrow (fewer than 30 percent of area hospital included in-network).⁴⁵



from the field

“Not infrequently, narrow networks exclude the most expensive doctors and hospitals in a community, including some specialists and academic health centers. More expensive doctors and hospitals are not necessarily better, but for patients with a rare or complex health problem, such restrictions can be problematic.”⁴⁶

— David Blumenthal, M.D., President, Commonwealth Fund

Bronze, Silver, Gold, and Platinum Plans

Qualified health plans offered in the individual and Small Business Health Options Program (SHOP) exchanges, as well as in the individual and small group markets outside of the exchange, must comply with one of four ACA-mandated “metal levels” of coverage known as bronze, silver, gold and platinum. Each metal level is tied to an actuarial value, which refers to the share of health costs that a plan will cover for an average enrollee. The ACA mandates that plans must cover 60 percent of health care costs under the bronze level, 70 percent under silver, 80 percent under gold and 90 percent under platinum.⁴⁷

Each metal level differs in the amount of consumer cost-sharing required. Bronze plans generally have lower monthly premiums, but higher out-of-pocket costs at the time of care. At the other end of the spectrum, enrollees in platinum plans typically have lower out-of-pocket costs when accessing care, but they must pay more each month in premiums.

For example, the average premium for a single, 27-year-old in a gold plan is \$240⁴⁸ with an average plan deductible of \$1,713.⁴⁹ Under a bronze plan, the average premium for a 27-year-old is \$163.⁵⁰ The average bronze deductible, however, is significantly higher at \$4,959.⁵¹

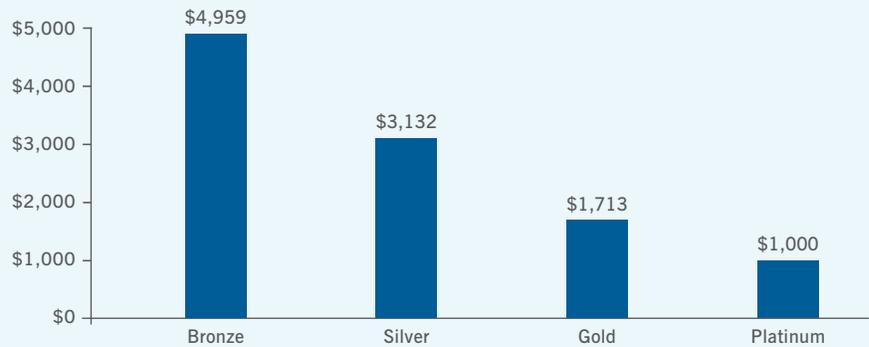
Platinum plans represent only 8 percent of plan offerings. Two-thirds of plan offerings are either silver or bronze, which have lower premiums but require patients to bear, on average, 30 and 40 percent of

costs, respectively. The majority of individual exchange enrollment is in silver plans. Premium subsidies for low income consumers are tied to the

price of the second-lowest cost silver plan and cost sharing assistance, for those who qualify, is only available in silver plans.⁵²

Deductibles vary widely by metal level in the public marketplace.

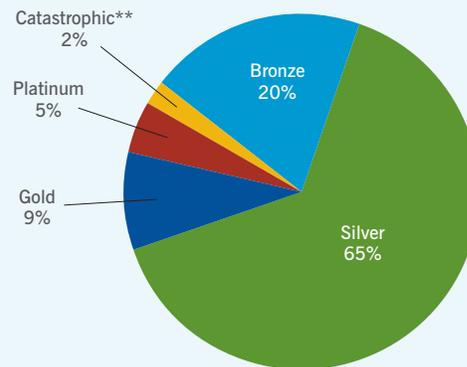
Chart 8: Average Medical Deductible By Metal Level



Source: Avalere PlanScape, Updated January 28, 2014. Avalere analysis U.S. Department of Health & Human Services data file of all exchange plans in Federally Facilitated Marketplace (FFM) states.

Most individuals are enrolling in silver plans.

Chart 9: Marketplace Plan Selection By Metal Level, October, 1, 2013 – March 31, 2014*



Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief. Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Enrollment Period. October 1, 2013 – March 31, 2014. Including Additional Special Enrollment Period Activity Reported through April 19, 2014. Released May 1, 2014.

*Based on the total number of plan selections for which the applicable data are available (excluding unknown). Percentages do not add to 100% due to rounding.

**Catastrophic plans do not cover benefits other than three primary care visits per year and preventive services until the deductible is met. Premiums are generally lower than other ACA health plans, but deductibles, copayments and coinsurance are generally higher. Eligible enrollees must be under 30 years old or receive a “hardship exemption.”

More options leave consumers to balance multiple plan features in decision-making

As more employees obtain their health insurance from the SHOP or private exchanges, and as a greater number of consumers access health insurance coverage through the ACA's individual market exchanges, they will be faced with a greater choice of plan options than ever before. Consumers will consider multiple factors when making health plan purchasing decisions, including premiums, cost-sharing and provider access, among other factors. However, the importance of each of these factors will vary depending on the consumer's unique circumstances.

Premiums are a major driver of health plan selection; studies show that consumers often buy lower-premium, higher-deductible plans when purchasing insurance on their own.⁵³ This may be particularly true for individuals shopping for plans on the public marketplaces, as many of these consumers are expected to have lower incomes.⁵⁴

While costs are a major driver of plan

Bronze and silver plans include high out-of-pocket costs.

Chart 10: Percentage of Patient Costs Covered by Federal Marketplace Plans, Typical Employer Plans and Medicare

Insurance Plan	Percent of Health Care Costs Covered by Plan
Typical Employer Plan (HMO) ¹	93%
PLATINUM	90%
Federal Employees Health Benefits (FEHB) Program Blue Cross Blue Shield Standard Option (PPO) ¹	87%
Typical Employer Plan (PPO) ¹	80%-84%
GOLD	80%
Medicare Parts A, B and D ¹	76%
SILVER	70%
BRONZE	60%

Source: Peterson, C. (2009). Setting and Valuing Health Insurance Benefits. Congressional Research Service.

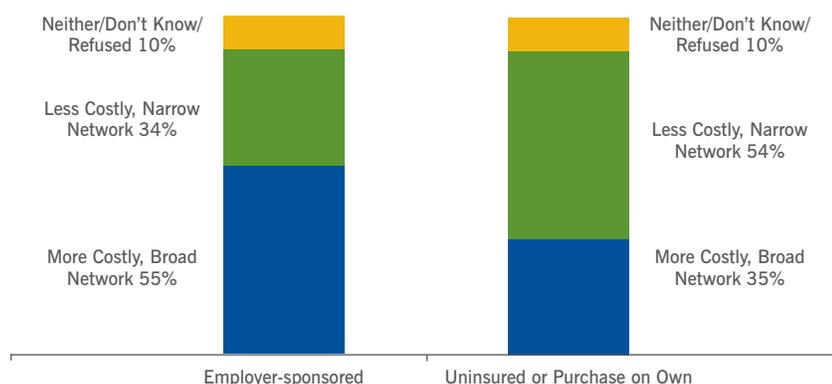
choice, benefits and access to care are also key considerations for consumers. Every consumer is different, however, and experts note that certain populations may value benefits more or less than others, particularly in public marketplaces where a large number of previously uninsured

individuals will be choosing insurance for the first time. This population may not have used many health care services in the past and may not have a regular provider. As a result, they could be more willing to choose plans with fewer benefits and limited networks.⁵⁵ However, most consumers want choice and customization when purchasing health insurance.⁵⁶

Other tradeoffs come into play when making health plan purchasing decisions, such as access to and quality of providers.⁵⁷ However, consumers react differently to these tradeoffs depending on factors such as socioeconomic status, race, ethnicity and gender.⁵⁸ Consumers with medical conditions may be more likely to prioritize access to providers, particularly to their current physician.⁵⁹ Consumers with employer-sponsored insurance are also more likely to pay more for access to a broad provider network compared to individuals accessing insurance on public exchanges.⁶⁰ The relative value placed by consumers on each component of plan selection will have important implications for hospitals.

Individuals eligible for insurance through the public marketplace are more likely to choose narrow network plans.

Chart 11: Preferences for Broad or Narrow Network Plans Among Employer-sponsored and Uninsured/Direct Purchase Consumers



Source: Kaiser Family Foundation. Kaiser Health Tracking Poll: February 2014. Conducted February 11-17, 2014.

Hospitals must implement new strategies to succeed in a market where consumers are actively engaged in the purchase of coverage and care delivery services

To respond to the demands of this new marketplace, hospitals and health systems will need to proactively promote patient and provider education, become more transparent about price and quality, develop a network strategy and revisit marketing and advocacy efforts. Each focus area presents a series of strategic questions for hospital leaders.

1. Engaging in the patient plan selection process

- Does your hospital employ or have affiliations with Certified Application Counselors?
- Is your hospital communicating to consumers regarding the plans your hospital participates in as a preferred provider?
- Has your hospital addressed the enhanced need for branding and reputation?

2. Making prices and quality ratings available

- Is your hospital prepared to provide meaningful pricing information to consumers?
- Are your hospital's comparative quality scores compelling and available?
- How are your hospital's costs portrayed by consumer organizations, health plans, independent websites and news outlets?
- Has your hospital secretly shopped your hospital and your competitors?

3. Reviewing network contracting strategy

- Is your hospital a preferred provider in networks for plans that are likely to serve your patient population?

- If not, what would your hospital need to do to be included?
- Should your hospital launch your own narrow network insurance product?

4. Evaluating branding and value to networks

- Will people demand that your hospital be in their network?
- Is your hospital a trusted provider in your community?
- How is your hospital portrayed by local health plans?
- What do your patients say about your hospital?

5. Aligning with local policies and the legal environment

- Do state and local laws and regulations support your hospital's strategy?

Conclusion

The coverage landscape is changing. Consumers have more plan options, many of which are accompanied by increased out-of-pocket costs. There are many factors to consider in selecting a health insurance plan and consumers

may not fully understand the implications of their plan choice until they need to seek care, particularly for a costly condition requiring hospitalization. At the same time, hospitals will be required to evaluate their market posi-

tion and availability in payer networks. Ultimately, while more individuals will have coverage, many may still be underinsured, leaving hospitals to face continued financial challenges related to uncompensated care.

POLICY QUESTIONS

- What can be done to encourage all stakeholders to provide enhanced decision-making tools to consumers during plan and provider selection?
- What legislative or regulatory changes can be made to reduce the unintended adverse financial impact on hospitals due to increased cost-sharing on the part of patients?
- How can information on cost and quality be communicated more clearly and consistently, in order to allow consumers to understand the relevant impact on their health coverage and care options?

ENDNOTES

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American Hospital Association
800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
202.638.1100
www.aha.org



Avalere Health LLC
1350 Connecticut Avenue, NW
Suite 900
Washington, DC 20036
202.207.1300
www.avalere.com