

EXECUTIVE BRIEFING 3

American Hospital Association

Consumer Choices in Coverage and Care

The insurance marketplace has become increasingly consumer-driven, with important implications for the way care is paid for and delivered. To stem the rising costs of providing coverage, employers are shifting more costs to employees, selecting lower-cost plan options and limiting premium contributions to a fixed dollar amount. These changes are accompanied by the emergence of private insurance exchanges that offer employees additional insurance options, forcing them to make trade-offs between up-front premium cost versus coverage, cost-sharing levels and provider access. Likewise, in the individual and small group markets, the Affordable Care Act's insurance exchanges place the purchasing decision for coverage in the hands of millions more Americans.

As consumers look to balance premium costs against other plan features, many likely will choose coverage with narrow networks and greater cost-sharing. With a greater personal and financial stake in their coverage, they are demanding more provider transparency in cost and quality. Additionally, providers may experience increased bad debt, declining revenue, changes in market share and poorer patient outcomes.

HEALTH PLANS CHANGE

Employers' changes in plan design will have major implications for hospitals.

Price sensitivity at 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 is to shift costs to consumers in the form of higher coinsurance and deductibles.

Historically, employer-sponsored plans had flat rate co-pays for selected services. These co-pays 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 co-pays to coinsurance, which requires employees or their family members to pay a percentage of the costs they incur for 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 to 61 percent during the same period. 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, it had risen to 34 percent. Employers also are increasingly offering high-deductible health plans, or HDHPs, a newer plan option that typically has lower premiums and may be paired with individual health savings accounts. Overall, there has been a rise in uptake of HDHPs relative to traditional HMOs and PPOs across all employers. The HDHP market grew from 4 to 20 percent of the employer-based population from 2006 to 2013.

Cost, quality information in demand

With greater financial exposure, consumers will demand more 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 costs, while prioritizing lower prices and convenience.

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Federal and state governments, providers and plans are leading multiple efforts to equip consumers with more information on cost and quality. These efforts face challenges in 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.

Several private sector tools have emerged to tackle these issues. These tools often pair claims data from payers and providers with quality data to offer consumers a more comprehensive understanding of their 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 tools, consumer demand is expected to increase as patients face greater out-of-pocket costs.

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 reminded hospitals of this obligation and indicated that it will provide hospitals the flexibility to determine how they make information on charges public.

Patient education needed

Patients often do not understand their insurance or how to estimate out-of-pocket costs. This puts pressure on the provider to educate the patient and deliver potentially unexpected news on out-of-pocket costs, often after the fact. Not only does this increase the time and expense related to registering, billing and collecting from patients, it also can adversely impact patient satisfaction scores.

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. However, this requirement assumes the patient will understand how coverage guidelines apply in the beneficiary's unique circumstances.

Potential for delayed, avoided care

While many patients may be eligible for financial assistance that would help to limit or spread out out-of-pocket expenses, as overall exposure to costs increases, they 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 who have delayed treatment for a serious condi-

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

Growth in bad debt

As patients face higher out-of-pocket costs, providers likely will see bad debt increase. The prevalence of HDHPs and increased consumer cost-sharing may weaken hospital finances by increasing accounts receivable if patients can't pay on time and increasing the magnitude of bad debt if they default. As a result, Moody's Investors Service has downgraded its financial outlook for nonprofit hospitals in 2014. Tenet Healthcare Corp. and the Cleveland Clinic have attributed the increase in their bad debt to the growing enrollment in HDHPs.

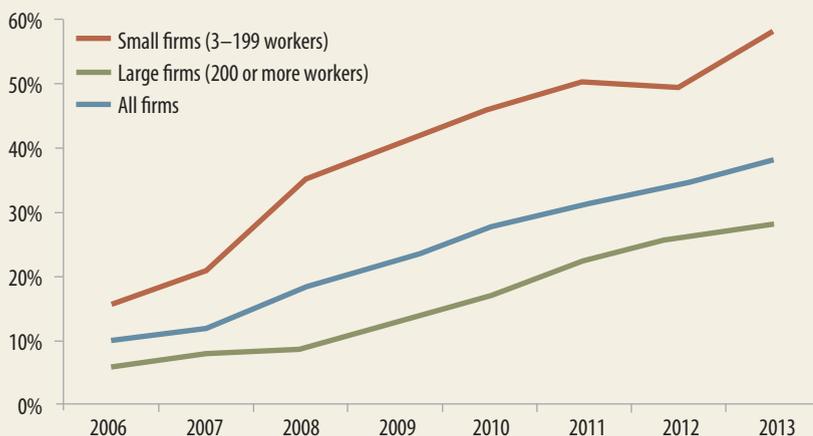
Shifting market share

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 to lower premiums for consumers. In tiered networks, 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 co-pay or coinsurance rates. Most commercial insurers offer a tiered network product, and approximately 20 percent of employers offer tiered and/or narrow network plans.

Employers increasingly are using reference pricing, where the company or insurer will pay "first-dollar" up to a predetermined 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

Portion of Employees with \$1,000 Deductibles

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 & Educational Trust, 2013

California Public Employees' Retirement System 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.

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 growth in narrow networks, some integrated 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 Texas health system, is using its insurance plan to sell narrow-network plans featuring its own providers to individuals shopping for insurance on the exchanges.

Volume lost to lower-cost providers

As the 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. Use 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.

CONSUMERS' RESPONSIBILITY GROWS

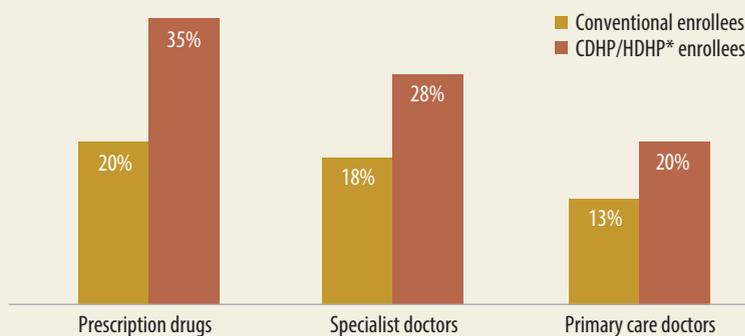
Broader choice places more responsibility on consumers.

Defined benefit plans

Over the next three to five years, many employers expect to reduce the level of premium subsidies they provide

HDHP Enrollees More Price-Sensitive

Consumers who inquire most or all of the time about prices before products or services are purchased (conventional vs. HDHP enrollees)



*CDHP: consumer-directed health plan; HDHP: high-deductible health plan

Source: "Health Care's Retail Solution: A Consumer-Focused Cure for the Industry," Booz Allen Hamilton Inc., 2008

toward the cost of insurance, resulting in higher premium contributions from employees. 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 a range of options, known as a defined contribution plan.

Private exchanges

The shift to a defined contribution model is often accompanied by a move to a private exchange for the purchase of coverage. Private exchanges typically are 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 and Aon Hewitt. These exchanges were created in part to respond to employers' desires to limit their contributions to 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.

One in four employers is considering shifting from traditional plan offerings to private or corporate exchange models with defined contri-

bution funding. For example, as of September 2013, 18 large employers, including Walgreens, Sears Holdings Corp. and Darden Restaurants Inc., offer health benefits through Aon Hewitt's multicarrier exchange for the 2014 coverage year.

ACA plan options

The ACA extends the exchange concept to the individual and small group markets nationwide. The individual marketplace is for those who do not receive coverage through an employer or a government program, and the small group marketplace — known as the Small Business Health Options Program, or SHOP exchange — serves employers that currently employ 1-50 individuals, increasing to up to 100 individuals in 2016.

Public marketplaces offer consumers greater choice and spur competition among plans. For 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.

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. Further, in 20 large urban areas, two-thirds of hospital networks on all ACA exchange plans are narrow (30–69 percent of area hospitals included in network) or ultranarrow (less than 30 percent of area hospitals included in network).

Balancing plan features

As more employees obtain their insurance from the SHOP or private exchanges, and as a greater number of consumers access 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.

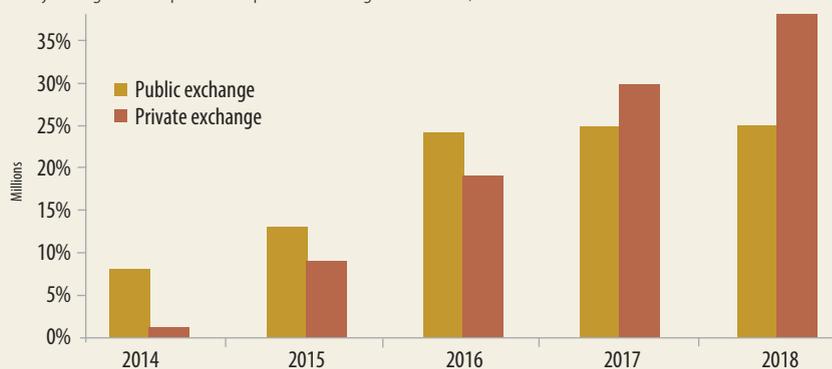
Premiums are a major driver of plan selection; studies show that consumers often buy lower-premium, higher-deductible plans when purchasing insurance on their own. This may be particularly true for individuals shopping for plans on the public marketplaces, as many of these consumers are expected to have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

While costs are a major driver of plan 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. However, most consumers want choice and customization when purchasing health insurance.

Other trade-offs come into play when making health plan purchasing decisions, such as access to and quality of providers. However, consumers

Increasing Enrollment in Exchange-based Products

Projected growth in public and private exchange enrollment, 2014–2018



Sources: Office of the Assistant Secretary for Planning and Evaluation; Congressional Budget Office; Accenture, 2013, 2014

react differently to these trade-offs depending on such factors as socioeconomic status, race, ethnicity and gender. Consumers with medical conditions may be more likely to prioritize access to providers, particularly to their current physician. Those with employer-sponsored insurance also are more likely to pay more for access to a broad provider network compared with individuals accessing insurance on public exchanges. The value consumers place on each component of plan selection will have important implications for hospitals.

NEW SUCCESS STRATEGIES

To respond to the demands of this new marketplace, hospitals and systems will need to 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 it 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 pro-

vide meaningful pricing information to consumers?

- Are your hospital's comparative quality scores powerful and available?
- How are your hospital's costs portrayed by consumer organizations, health plans, independent websites and news outlets?

- Have you secretly shopped your hospital and that of 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 narrow-network insurance products?

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? **T**

This is an excerpt from "Increasing Consumer Choice in Coverage and Care: Implications for Hospitals" from the American Hospital Association. For the complete report, including all sources, go to www.aha.org.