MEET THE NEW HEALTH CARE CONSUMER

Reluctant. Anxious.
Looking for help.

Despite industry euphemisms like **"the empowered health care consumer,"** most people are ill-prepared to shop for health care.

On January 1, 2014, a new era of health care began when some of the key provisions of the Patient Protection and Affordable Care Act (PPACA) officially took effect.

Even with the previously announced delays and promises to the contrary, the reality is that most Americans woke up that morning with health insurance coverage that is different than what they were accustomed to. According to the whitehouse.gov website, the "key facts about the Affordable Care Act are these: stronger consumer rights and protections, more affordable coverage and better access to care." Sounds like a "win, win, win" for consumers, right?

Then why does the "new health care consumer" look so reluctant… so anxious… and so confused?

Well, despite industry euphemisms like "the empowered health care consumer" and "consumer-directed health plans" and "the new age of health care consumerism," most consumers are not there by choice – making them especially ill-prepared to take the leap into shopping for and buying health care services. Even worse, most of the tools, knowledge and data they needed to be successful were not readily available beforehand.

So how did we get here and what can health care payers and providers do about it? Read on…

It appears that big businesses **have used "Obamacare" as air cover** for moving employees to public and private exchanges.

Wendy's

Walgreens

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How Did We Get Here?

EMPLOYERS MAY BE GETTING OUT OF THE HEALTH INSURANCE BUSINESS

It's been interesting to watch "big business" respond to health care reform as it's evolved. As Congress debated the PPACA, many corporations lobbied against it, warning of increased costs and job losses. And once it passed, several large employers began to change benefits packages… or offer them to fewer employees. For example, at the beginning of 2013, Wendy's joined other fast food chains in cutting employee hours to avoid providing them insurance, and over the summer, UPS announced its reductions to health care benefits by curtailing spousal coverage for employees whose spouses receive coverage at their own jobs.

In addition, as PPACA and health care exchanges have been rolled out, we've seen large businesses use reform in other ways. For example, according to an article by Tom Ryan on RetailWire.com, Trader Joe's told workers who log less than 30 hours a week that they will need to find insurance on the public exchanges in 2014 instead of getting coverage through the company. While Trader Joe's said it will provide each part-time worker with an annual $500 payment to help cover the cost of the insurance, it sounds like it pales in comparison to existing benefits. According to the article, one anonymous part-timer at Trader Joe's said she pays $35 a paycheck, or $70 per month, for a plan that covers 80 percent of medical costs, has a $500 deductible and includes prescription drug coverage. The woman told *The Huffington Post* that the coverage was "one of the best parts about the job," and was anxious over finding an affordable alternative.

At Home Depot, the company announced plans to shift about 20,000 part-timeworkers to public exchanges rather than provide coverage through a limited liability medical plan, according to an article by Dina Overland on FierceHealthPayer.com.

Even for full-time employees, there's been a noticeable shift toward using private exchanges. In Overland's article, she makes note of the fact that Walgreens, the largest drugstore chain in the U.S., will pay a fixed amount for its 160,000 employees to shop and buy health coverage through a private exchange that's operated by Aon Hewitt.

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In all these financially motivated decisions, big businesses point to PPACA or "Obamacare" as the culprit, which provides great air cover for their cost-shifting moves. If these trends continue, it's likely that more and more companies will follow suit, and that an increasing number of employers will move employees from defined benefit models to defined contribution models.

Moreover, by sending employees to exchanges – be they private or public – an employer effectively gets out of the health insurance business. While it's too early to know for sure, this could mark the beginning of the end of employer-sponsored insurance, which has been with us since WWII. (See sidebar for background.)

A CLOSER LOOK

How did employers get into the health insurance business in the first place?

Employer-sponsored health insurance plans dramatically expanded as a direct result of wage controls imposed by the federal government during World War II. The labor market was tight because of the increased demand for goods and decreased supply of workers during the war. Federally imposed wage and price controls prohibited manufacturers and other employers from raising wages enough to attract workers.

When the War Labor Board declared that fringe benefits – such as sick leave and health insurance – did not count as wages for the purpose of wage controls, employers responded with significantly increased offers of fringe benefits, especially health care coverage, to attract workers. As a result, between 1940 and 1960, the total number of people enrolled in health insurance plans grew sevenfold, from 20,662,000 to 142,334,000, and by 1958, 75 percent of Americans had some form of health coverage.

Source: Wikipedia, Health Insurance in the United States

The biggest disruptor for the health care industry is the **outsized increase in deductibles.**

How Did We Get Here?

DEDUCTIBLES ARE THE NEW COPAY

But sending people to exchanges is only one way that costs are being shifted toward individuals. The biggest culprit – and the biggest disruptor for the health care industry – is the outsized increase in deductibles.

If you shop for family health insurance on the NYS health exchange – aka NY State of Health, The Official Health Plan Marketplace – you will find 65 plans to choose from in Albany County. Of those 65 plans, only 13 – or one in five – have a $0 deductible. And the average premium cost for those plans is $19,207 per year, which is 17.5 percent more than the average family premium in 2013 (according to Kaiser/HRET's 2013 survey of employer-sponsored health benefits) and far beyond what most working families can afford. The other 52 plans come with deductibles that average $4,096 per family per year and can go as high as $11,600.

Even if you get your insurance through your employer, you're likely to have a deductible in 2014. For many, this will be a first. According to Mercer's 2013 National Survey of Employer-Sponsored Health Plans (see chart on next page), the number of employers that already offer a CDHP (Consumer Directed Health Plan), which always includes a deductible, has increased dramatically since 2008. And by 2016, it's very likely that 78 percent of employers with 5,000 or more employees will offer a CDHP. According to the 2013 PwC Health and Well-being Touchstone survey of major U.S. companies, 44 percent of employers are considering offering high-deductible health plans as the only benefit option in 2014.

Rapid growth in Consumer Directed Health Plans (CDHP) offering over the next three years seems likely

Percentage of employers offering/likely to offer CDHP – by employer size:

Description	2008	2009	2010	2011	2012	2013	Very likely to offer in 2016
Small employers (10-499 employees)	9%	15%	16%	20%	22%	23%	34%
All large employers (500+ employees)	20%	20%	23%	32%	36%	39%	64%
Employers with 5,000 or more employees	35%	41%	42%	45%	51%	55%	78%

Source: Mercer's National Survey of Employer-Sponsored Health Plans

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A bronze plan leaves

40%

of health care costs to be covered by the consumer.

That's likely to be much higher than what most people have experienced in the past.

Here's another way to understand just how much more financial responsibility/liability consumers have post-January 1, 2014. The government has established **four metal levels** into which all plans must fit, whether they are sold on or off the exchange:

- **A bronze plan covers 60 percent** of out-of-pocket costs for medical expenses.
- **A silver plan covers 70 percent** of out-of-pocket costs for medical expenses.
- **A gold plan covers 80 percent** of out-of-pocket costs for medical expenses.
- **A platinum plan covers 90 percent** of out-of-pocket costs for medical expenses.

The gold and platinum plans can be pretty pricey, which is why lots of people are likely to consider bronze or silver plans. But these plans leave 40 percent and 30 percent, respectively, of the out-of-pocket costs to be covered by the consumer.

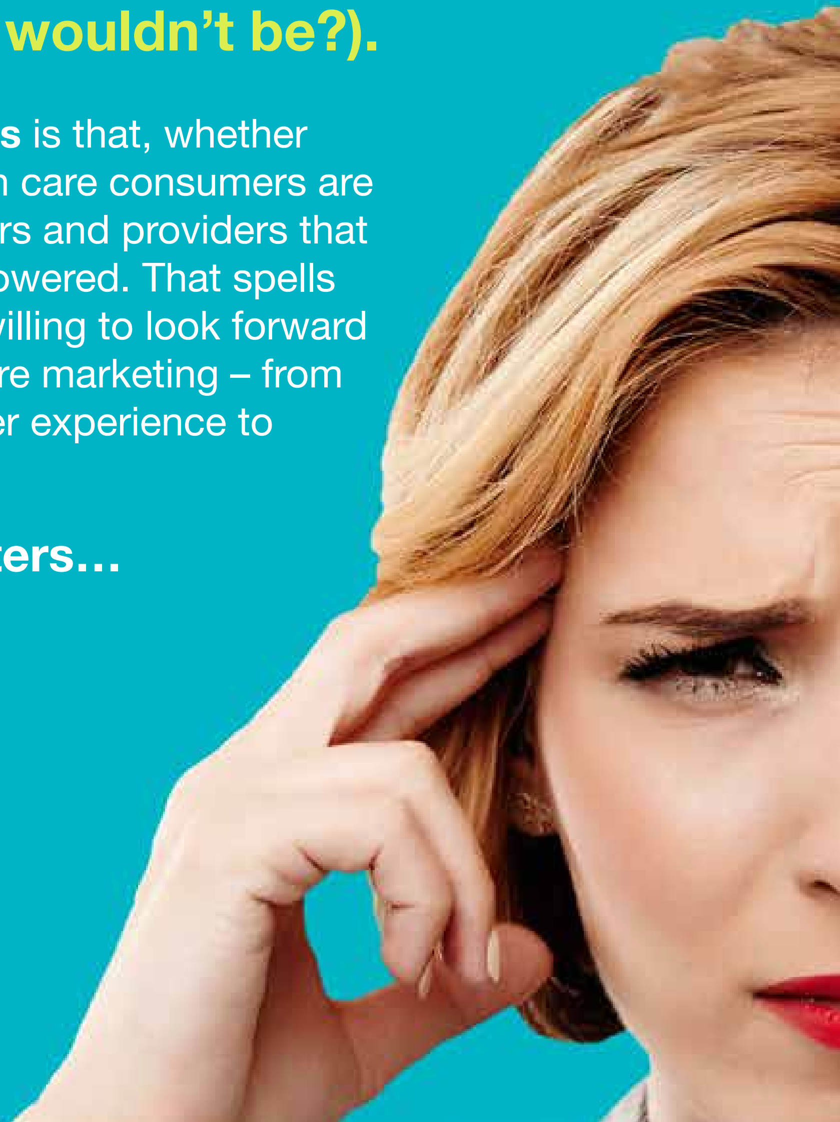
Those are very big numbers and likely to be much higher than what most have experienced in the past. To limit how much a consumer can wind up paying, the government has, thankfully, put "Out-of-Pocket Maximums" in place. But in the case of a family with a standard bronze plan, that max is $12,700 – and that's in addition to the premium that has been paid.

As more people are pushed into private and public exchanges, and are introduced to deductibles, a new health care consumer is emerging. Unfortunately, they'll be spending money on things they've never had to pay for in the past. **It's expensive. It's complicated.** What's worse, the pricing for the health care services is wildly inconsistent and nearly impossible to discern. And meaningful ratings and reviews on doctors, hospitals and procedures are almost nonexistent.

It's no wonder that the new health care consumer is reluctant (since most are not there by choice), anxious (because they're ill-equipped to shop and buy health care services) and confused (well, under the circumstances, who wouldn't be?).

That's the bad news. The **good news** is that, whether they know it or not, these new health care consumers are desperately seeking innovative payers and providers that can help them to become truly empowered. That spells **O-P-P-O-R-T-U-N-I-T-Y** for those willing to look forward and redefine all aspects of health care marketing – from product/service design and customer experience to branding and advertising.

Here are some thought-starters…



CATALYST FOR PAYMENT REFORM'S STATEMENT ON PRICE TRANSPARENCY

Information about the price and quality of health care services should be broadly available to those who use and pay for care.

1. Consumers must have access to meaningful, comprehensive information about the quality and price of services to make informed health care decisions.
2. Providers and health plans must make such information available.
3. Self-insured purchasers have the right to use their claims data to develop benefit designs and tools that meet their needs.
4. Current antitrust laws should be adhered to and enforced to ensure that providers and health plans do not use price information in an anti-competitive manner.

Opportunities for Payers and Providers

EMBRACE PRICE TRANSPARENCY

Slowly but surely, the veil is being lifted on health care costs. Information that was once closely guarded is starting to get into the hands of consumers. So far, this has mostly been driven by third parties like ACAP Health, Castlight Health, ClearCost Health, OpsCost and others, and what they're revealing is eye-popping. On its website, ClearCost Health provides the following examples for fairly common services and procedures:

Description	Highest Cost In-Network	Lowest Cost In-Network	Multiple
Urinalysis	$165	$3	55x
Cholesterol tests	$232	$13	18x
Cardiovascular stress test	$1,164	$89	13x
CT scan, pelvis	$3,071	$348	8.8x
Office visit, new patient	$186	$36	5.2x
Removal of skin tags	$207	$80	2.6x

Source: www.clearcosthealth.com

ACAP Health takes things even further with complete telephone support through which consumers are provided with detailed costs and other information on all of the providers to which they have access. ACAP Health's "Compass Health Pros" will even talk directly with the referring physician to make sure that the provider meets their needs. This video from the ACAP Health website does an excellent job of demonstrating just how helpful this could be for consumers.

To be clear, the price transparency movement is not being driven solely by the third parties mentioned above – there are even bigger players involved. Catalyst for Payment Reform (not accidentally "CPR" for short) is an "independent, national non-profit organization for employers and other purchasers committed to a high-value health care system." Their membership includes many well-known and influential companies, including AT&T, Capital One, GE, IBM, Walt Disney and Wells Fargo among others. CPR has a very simple perspective on price transparency and one that is, arguably, quite compelling – especially now that more and more consumers are or will be responsible for buying health care services with their own money.

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29 states earned a failing grade in HCI3's 2013 Report Card on State Price Transparency Laws.

While it's only been in existence since 2009, CPR has done an extensive amount of research and analysis on price transparency, and they've generated some very interesting reports. One in particular is CPR and the Health Care Incentives Improvement Institute's (HCI3) "Report Card on State Price Transparency Laws." The report grades each state on how effective its laws, if any, are in making sure that health care purchasers have easy access to comprehensive information about true health care costs.

Overall, the scores looked pretty grim – they issued just two As, five Bs, seven Cs, seven Ds and 29 Fs – but they seem to be a source of motivation. For example, roughly five months after getting an F, the state of North Carolina passed a law requiring all hospitals to submit pricing information for the 140 most common in-patient, surgical and imaging services. Moreover, the information will include payments by Medicare, Medicaid and the five largest private insurers – and will all be available on a state-run website. At the time the law was passed, Governor Pat McCrory (Rep.) said: "For too long, North Carolina patients have been in the dark…this new law gives patients and their doctors pricing information so they can make an informed financial decision with regard to their health care."

Even more recently, according to an article in *Crain's New York Business*, the NYS Department of Health uploaded hospital costs and charge data for about 1,400 conditions – all of which are available online. At the moment, the data is nearly impossible to navigate or digest, but it's a start. In the *Crain's* article, a spokesperson from CPR – which gave NYS an "F" for transparency – suggested that getting this data into a "publicly available, searchable website would have gotten [NY] an A."

At its most basic, the price transparency movement can be summed up in a single sentence by the executive directors of CPR and HCI3 in their opening letter in the above-mentioned report: "American consumers deserve to have as much information about the quality and price of their health care as they do about restaurants, cars, and household appliances."

Of course, there are those who oppose price transparency and fear it will drive up health care costs. In an article on MedPage Today's KevinMD.com, author Peter Ubel asks the question, "Will health care price transparency reduce costs?" He proceeds to lay out an argument that suggests just the opposite will happen – that is, health care costs might actually increase.

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Bottom Line

Whether or not price transparency will decrease costs or increase them, the price transparency movement is gaining momentum. As more and more consumers find themselves spending their own money for health care services, there will be an increased demand for price transparency tools. At the same time, it's likely that more states will enact legislation that significantly enhances price transparency. So it would be wise for payers and providers to figure out how to actively participate in this revolution – if not lead it – versus being portrayed as organizations that have something to hide. Remember, people like to do business with brands they trust.

A CLOSER LOOK

Extreme Price Transparency

Hip Replacement: Going Once, Going Twice, Sold! MediBid Brings Transparency in Health Care to a New Level.

In late October 2013, the TODAY Show aired a segment on MediBid, an auction site where doctors bid on procedures brought into the online marketplace by patients. And while the MediBid website indicates the service "allows you to pay less, like the insurance companies," it also downplays the low-bid element: "Remember," it insists, "MediBid isn't about finding the most affordable medical professional or facility; it is about having a choice."

Either way, it is about discussing costs openly. Consider, for example, these scrolling teasers from the MediBid homepage: "Tired and afraid of asking, 'How much will it cost?'" and "Ask one time at MediBid.com and get what you want when you want at a price you and your doctor agree to."

At first sight, this bidding model may seem absurd and slightly disconcerting, but one thing's for sure – it brings a level of transparency to health care that's never existed before.

When this story was first posted on the Media Logic blog, it prompted a response from MediBid's CFO, Chris Hobbs, who said, in part, "In your article you said that 'this bidding model may seem absurd and slightly disturbing', and there is no question that our approach is new and unique. The question I'd pose is why? Health care represents a huge portion of the overall economy, is subject to the laws of supply and demand, and yet the phrase 'you get what you pay for' doesn't apply…There is no direct correlation between how much you pay and the quality of the care that you receive…Sadly, those without much knowledge, money, or power tend to not make use of what negotiating power they have, and they get overcharged. At MediBid, we believe this is what's most absurd and strangely disturbing."

Ratings sites often lack critical mass.

A recent test of a local primary care doctor found a total **of just 14 reviews** across four separate sites.

Opportunities for Payers and Providers

EMBRACE QUALITY TRANSPARENCY

One very interesting point Ubel makes in his KevinMD.com piece is this one: "Whenever possible, price transparency should be accompanied by quality transparency." When was the last time you went shopping for a new car without first checking review sites and seeking the opinions and experiences of others? What about a new TV, a new vacuum cleaner or even tickets to the movie you're thinking about seeing (and that's just a $10 expense!)? If you're like most people, you can't imagine skipping this step in the buyer's journey.

Next question: When was the last time you did any of the above when shopping for a health care service? Sure, you probably did some research on the service itself to make sure you were comfortable getting it done. But did you try to get ratings or reviews on the service provider or physician? For some of you, the answer could be "yes"… but that's probably the exception and not the rule. This is largely due to the fact that there is a lack of tools and information out there. And the ones that are out there are not always credible or they lack critical mass.

If you want to get information on a specific physician, you can use tools like HealthGrades.com, RateMDs.com, DoctorsDig.com or Vitals.com. Unfortunately, there's a very good chance that you won't find as many opinions as you'd like (certainly, far fewer than you would about the latest movie). A recent test of a local primary care doctor found a total of 14 reviews across all four sites. That's an average of a mere 3.5 reviews per site, which is far from critical mass.

When it comes to getting information on hospitals, the ratings landscape is very close to upside down – at least that's according to HANYS' "Report Card on Hospital Report Cards," which was published by the Healthcare Association of New York State. Using a set of guiding principles (see below), HANYS evaluated 10 well-known hospital report cards to determine which ones are most credible and, therefore, useful for consumers. What they found was that two of the most popular, *U.S. News & World Report* and *Consumer Reports*, had the lowest scores, while the highest ranking belonged to the much lesser known "The Joint Commission Quality Check."

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Bottom Line

There's clearly an unmet need here – a need that will only grow in size now that more and more consumers will have to actively and intelligently search for any and all information that can help them get the best value for their health care dollar. Much like the price transparency issue, payers and providers can ignore the need and hope it goes away, or they can figure out how to take the lead. Why not actively encourage customers to rate your organization? Why not promote the ratings tools that are most useful to consumers? Granted, this will not be an easy lift. However, the upside could be significant as it creates an opportunity for engendering strong brand affinity and, therefore, warrants serious consideration.

A CLOSER LOOK

HANYS' Guiding Principles for Hospital Report Cards

Building on academic research and the recommendations of the National Priorities Partnership convened by the National Quality Forum (NQF), HANYS developed a set of guiding principles to which report cards should adhere. They include the use of:

- ✔ a transparent methodology
- ✔ evidence-based measures
- ✔ measure alignment
- ✔ appropriate data source
- ✔ most current data
- ✔ risk-adjusted data
- ✔ data quality
- ✔ consistent data
- ✔ hospital preview

Opportunities for Payers and Providers

BE THE CONSUMER

Those payers and providers that embrace price and quality transparency will immediately see the benefits of thinking in terms of customer needs. Of course, these are broad concepts that have enterprise-wide implications and must be broken down into tactical initiatives in order to be implemented. Where to start? Think like a consumer and how she'd want to be treated at every stage and step in the process.

The simplest way to **"be the consumer"** is to start by putting a name and a face to each of your customer segments.

Step 1: Know thy customer

Call it the buyer's journey, touch point mapping or whatever you like. The simplest and best way to assume the role of the consumer is to start by putting a name and a face to each of your customer segments. Consider this a black and white sketch and just the beginning. Now, think about how to fully colorize this image. Here are some steps to consider:

- **Start with the basics**. This should include demographics such as gender, age, family structure, income, etc. Ideally, it should include information on the types of health care services they're responsible for purchasing and/or their level of influence if they're not the final decision-maker.
- **Append what's missing.** After you've defined each segment in basic terms, think about ways to add depth and color. For example, what can you find out about their media preferences, their digital footprint and their shopping/buying habits?
- **Get inside their head.** Perhaps the most important part of building a true customer persona is to interview actual customers. Doing so will not only humanize these people (versus "segments") but it will help put you in touch with the kinds of thoughts and insights that can't always be gleaned from raw data.

Step 2: Walk in her shoes

Once you know who you're trying to sell to, you can start to simulate what her experience might be across the entire continuum, and you can think of ways to make it as positive, convenient and easy as possible.

- **Awareness ("Who are you?") –** It's important to recognize that the consumer shopping experience starts with a need or desire that the consumer has. It's not about you, the seller, which is a good thing

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CONTENT MARKETING DEFINED

According to the Content Marketing Institute, **content marketing** is the art of communicating with customers and prospects without selling. It is non-interruption marketing. Instead of pitching your products or services, you are delivering information that makes your buyer more intelligent. The essence of content strategy is the belief that if you deliver consistent, ongoing and valuable information to buyers, you will be rewarded with their business and loyalty:

Keys to Success

- Define your objectives upfront.
- Establish a game plan for implementation.
- Set up metrics and monitor carefully.
- Be consistent.
- Be timely, relevant and interesting.
- Know that curation is as important as creation.

to keep top of mind through the entire process. At this stage, the objective is to get on the consumer's radar with the hope of making it to her consideration list. One of the best ways to do this is through content marketing (see sidebar), which if done properly will increase the likelihood that a consumer will find you when she searches via Google or some other search engine. This is critically important since, according to the Pew Research Center, 77 percent of online health seekers say they started with a search engine.

Far too many payers and providers pay too little attention to content marketing and other tactics, such as paid search, that will enhance their "findability." This is a big mistake.

- **Exploration ("Tell me more.") –** The importance of content marketing continues during the exploration phase of the shopping experience. The key reason for this is that most consumers do their shopping before the seller even knows they're interested. That means sellers have to be sure they're providing all of the information that is needed to help a consumer make a good decision and, preferably, one that points her to your organization. Bear in mind that the mantra for content marketing is "Tell, Don't Sell!" so you need to strike the proper balance between what matters to consumers and what you feel compelled to say about yourself.

- **Purchase ("I'm ready to buy!") –** As noted above, the first time you meet a prospective customer might be when she's ready to "hit the buy button." This happens frequently for items like computers and TVs. In the case of health care services, however, this is less likely to be the case. Being "ready" doesn't necessarily mean that the consumer will pull the trigger without having a discussion with someone within your organization. As such, you need to be sure that your "front line" is properly trained to serve the needs of the consumer at this particular stage. Do they have the knowledge they need? The demeanor? The sales skills? Are they a good reflection of your brand? If you make a mistake here, you may never see the potential customer again.

- **On-board ("So how will this work?") –** One of the biggest mistakes made by sellers of all types is to assume that once a sale is made you can "count that chicken" and move on to the next. In reality, the on-boarding process is critical since it sets the tone for what the consumer, now customer, can expect. It's the beginning of the "customer experience," which will determine if she becomes a repeat customer and, better still, an enthusiastic advocate. As such, both payers and providers need to be very thoughtful about what's happening in these early days. At a basic level, you need to make sure that you meet each

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1/3
of consumers
said they would be willing to switch their health insurance or health care provider if another company offered a more
ideal experience.

and every promise or expectation that was set before the customer decided to buy. Even better, you should think about ways to go beyond those expectations to make the first impression as favorable as possible.

- **In-flight ("Are you a great copilot?") –** So the relationship is now underway. Are you there for your customers at all the right times and all the right places – be it in person, on the phone, online or via mobile? Establishing a good first impression is a great way to start – but it's just that. You need to be prepared to deliver at or above that same level throughout the relationship. The importance of this cannot be overstated. According to a 2012 study from PwC's Health Research Institute, "When it comes to interacting with a hospital, doctor's office or other health care provider, consumers are nearly twice as likely as those in the airline, hotel and banking industries to say that staff friendliness and attitude dictate whether the experience was positive or negative. One-third of consumers said they would be willing to switch their health insurance or health care provider if another company offered a more 'ideal' experience."

For payers and providers alike, there is room for significant improvement. In fact, here's where you could stand out if you're fully committed to price and quality transparency.

For example, a payer might implement a system through which members could easily see the costs and ratings of all providers in their network. Likewise, a provider might implement a system through which all patients are asked to provide a review of their most recent experience – reviews which would then be made available to the public.

These are just the tip of the iceberg, and they may sound like heresy. However, if you spend some thoughtful time wearing the shoes of your customers (while setting aside outmoded precepts), you'll be able to envision a level of customer service that is – as Nordstrom has often been described – "legendary" and differentiating.

- **Repurchase ("Let's do this again sometime.") –** One of the best pay-offs you can get for investing in customer experience is repeat business from existing customers. In many ways, this is what branding is really all about. Real branding goes beyond the veneer of what a brand looks like or sounds like. It gets into real substance and considers every customer interaction at every touch point. This is especially true for businesses that are as hands-on and service-oriented as payers and providers.

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You need to be targeted – continually testing and learning from what you do through response-tracking and analytics.

- **Referral ("I want to tell everyone to buy from you, too!") –** This is another important payoff for delivering an outstanding customer experience. Most of the time, this happens on its own. But don't be afraid to ask for referrals as well.

Step 3: Be intentional and targeted

For most payers, marketing directly to consumers is breaking new ground. Unless (and even if) you've been selling Medicare Advantage Plans or Managed Medicaid Plans, there's a good chance that most of your customers have come through employer groups. And while it's likely that you've done some brand advertising intended to make consumers feel good about being offered one of your plans, you haven't engaged in the hand-to-hand combat that comes with selling to consumers one at a time.

As a result, you need to shift gears – and fast. Using what you learn in steps 1 and 2, you need to adopt a "direct-to-consumer" (DTC) mind-set, somewhat akin to the approach taken by pharmaceutical companies and reverse mortgage providers. You need to be targeted, and you need to continually test and learn from what you do. This will likely require a new level of commitment to response-tracking and analytics.

For providers, the situation is somewhat different. For the most part, hospitals and physician groups have used various forms of mass media to sell their services, so they're familiar with one-to-one selling. But, for many, this has been more about branding than hard-core, measurable DTC. To be truly effective and efficient, providers should also adopt a DTC mind-set, which will require being much more intentional and targeted.

Bottom Line

Even if part of your marketing strategy has always included detailed assessment of the customer experience throughout your process, it's time to look at it with fresh eyes. At this moment in health care, the consumer need is not only dramatically different from what it was even six months ago – it's also not entirely defined. This makes it especially important for marketers to keep an eye on the buyer's journey from awareness through renewals and revisits, and to use tools like content marketing to provide information, build trust and empower consumers to make decisions. Learning to be direct, agile and innovative will be the keys to marketing success for payers and providers.

CLOSING THOUGHTS

It's only a matter of time before the new health care consumer, who is presently flailing, actually becomes an empowered shopper and buyer. And when it comes to shopping and buying, Americans are hard to beat. There's no doubt that this will create significant challenges for payers and providers (especially providers!). But for those willing to disrupt themselves, change their mind-sets and lead the way, there are significant gains to be made.

Hopefully, you've found this paper to be interesting and thought-provoking. If you have any comments or would like to discuss it further, please feel free to contact the author via email at dschultz@mlinc.com.

About the Author

David Schultz, founder and president of Media Logic, has been working with payers and providers for more than 20 years and, with the help of colleagues, has consistently launched innovative and award-winning marketing strategies. David has studied PPACA extensively and uses his expertise to frame the law's marketing implications for Media Logic's clients.

About the Company

Media Logic is a proven leader in health care marketing. The Affordable Care Act has completely altered the health care landscape and has had a profound impact on both payer and provider marketing. As a firm with more than 20 years of health care experience, we've helped our clients stay on top of all of the changes – to navigate rough waters and achieve success.

Specialists in marketing for health plans – From corporate branding and open enrollment efforts to product launches and channel marketing to campaigns targeting a range of consumer and employer audiences, we've helped guide our health plan clients through a wide range of marketing challenges. And, every time, we have provided the strategic guidance and breakthrough creative to help them turn these challenges into opportunities.

Specialists in marketing for hospitals and providers – In the current, consumer-centric health care climate, branding is more vital than ever. We have deep experience at helping hospitals identify and articulate a unique selling proposition – and successfully launch their brands. In addition, we have developed powerful marketing programs to drive interest in and preference for key service lines and associated physician practices... leveraging direct marketing, content marketing and more.

To find out more, visit us at www.medialogic.com or on social media:

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