

# FROM THE FIELD

## Tiered Hospital Networks

Reflections from the California HealthCare Foundation/*Health Affairs* Roundtable.

by **Jill M. Yegian**

**ABSTRACT:** As a result of rising health care costs, health plans are experimenting with insurance products that shift greater financial responsibility for medical care to consumers and create incentives for consumers to consider cost differences when choosing among providers. Based on an October 2002 roundtable discussion, this paper discusses insurance product trends, particularly tiered hospital networks. Issues addressed include these product features' potential to reduce system costs, the effect on the hospital–health plan relationship, consumers' ability to consider cost and quality in decision making, and financial barriers to care for the chronically ill.

AS HEALTH CARE COSTS INCREASE, health plans and employers are shifting more of the financial responsibility for medical care to consumers and designing insurance products that encourage consumers to consider cost differences when choosing among providers.<sup>1</sup> One such development, the creation of hospital “tiers,” imposes different cost-sharing levels for high- and low-cost hospitals, making cost differences among hospitals more transparent to consumers and allowing consumers to decide whether a high-cost facility merits additional out-of-pocket spending. Tiering and other changes in product design raise complex questions concerning these product features' potential to reduce system costs, consumers' ability to understand the cost and quality implications of their decisions, and financial barriers to care for the chronically ill.

In October 2002 the California HealthCare Foundation (CHCF) and *Health Affairs* held a roundtable event, *Product Trends in Health Insurance: Benefits, Risks, and Implications*. This roundtable, the sixth in a series, brought

together twenty-five leaders from insurance, clinical, purchaser, consumer, and regulatory entities to examine the causes and consequences of changes in the insurance market for patients, providers, and the health care system.<sup>2</sup> This paper summarizes the discussion at this event and provides further analysis of the issues at stake.

### Experimentation Is The Rule Of The Day

As health care costs continue to rise, insurance product features aimed at “buying down” premium increases have proliferated. Benefit design trends include movement from fixed-dollar copayments to percentage coinsurance, increased use of deductibles and service-specific deductibles (such as for maternity), and adoption of tiered pharmaceutical benefits, whereby consumers pay more for brand-name drugs than for generics.<sup>3</sup> Participants anticipated substantial increases in consumer cost sharing in future years. Indeed, one of the remarkable features of the past year is that employers have continued to finance most of the

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rapidly increasing health insurance premiums, even in a recessionary economy, rather than making dramatic (as distinct from incremental) shifts toward thinner benefits and higher coinsurance.

Anchored by the paper by James Robinson, “Hospital Tiers in Health Insurance: Balancing Consumer Choice with Financial Incentives,” which accompanies this report on the *Health Affairs* Web site, much of the roundtable discussion focused on network design features. Hospital costs—long the largest component of health spending—overtook pharmaceuticals as the fastest-growing component in 2002.<sup>4</sup> In addition, attention has recently focused on cost variation among hospitals.<sup>5</sup> Over the past year in California, three of the largest health plans—PacifiCare, Blue Shield of California, and Health Net of California—have rolled out tiered hospital networks, wherein hospitals are grouped into categories based on cost and consumers pay more for services from higher-cost hospitals (Exhibit 1). To date, Blue Shield of California is the only plan to incorporate quality considerations into tiering: Hospitals can offset higher prices to a limited degree

through participation in the Patient Evaluation of Performance in California (PEP-C) or Leapfrog Group quality initiatives. Although tiered hospital networks exist in other parts of the country—Tufts Health Plan in Boston is one example—the approach seems to have more momentum in California than elsewhere in the country.

Some roundtable participants saw tiered networks as a brief stop on the way to “narrow” networks, closed panels of providers reminiscent of the era of tightly managed care. As Robinson describes, Highmark Blue Cross Blue Shield offers multiple network options, with products based on the narrower networks charging lower premiums while offering richer benefits than those based on the broader network. In California, PacifiCare recently announced the rollout of its narrow Value Network, projected to produce premium savings of 6–16 percent; providers were selected based on a cost threshold and several quality measures.<sup>6</sup> In an era of steeply increasing costs, other health plans may see an opportunity to appeal to the market segment interested in trading broad choice for lower

**EXHIBIT 1**  
**Characteristics Of Tiered Hospital Networks Offered In California**

	Start date	Additional cost per day for high-tier hospitals	Product feature	Number of tiers	Incorporate quality?	Percent of hospitals in high-cost tier	Enrollment
PacifiCare	January 2002	\$100–\$400	Option for HMO products for 50+ employers	2	No	50	20,000
Blue Shield of California	April 2002	\$100/10% (employer market), \$150/10% (individual market)	Mandatory for all products in individual market and employers up to 300	2	Credit for participation in PEP-C and/or Leapfrog Group	15	1 million or more
Health Net of California	November 2002	+\$100–\$750	Option for HMO products for 2+ employers	3	No	30	Not available

**SOURCES:** Cheryl Randolph, PacifiCare, personal communication, 12 December 2002; Ken Wood, Blue Shield of California, presentation to the California HealthCare Foundation, 18 July 2002; and Brad Kieffer, Health Net of California, personal communication, 12 December 2002.

**NOTES:** HMO is health maintenance organization. PEP-C is Patient Evaluation of Performance in California.

premiums and fewer out-of-pocket costs. The private health insurance market may divide itself into four quadrants, with products featuring broad networks and low cost sharing available for those willing to pay very high premiums, products featuring narrow networks and high cost sharing for those able to pay only very low premiums, and a mix of both available at intermediate premium levels.

Tiering of medical groups was briefly discussed as a logical next step in the progression from pharmaceuticals to hospitals but was seen to be even more complex and logistically challenging than hospital tiering is. Tufts Health Plan charges its members more to see a specialist than a primary care physician, but a more refined form of physician-level tiering that incorporates both practice efficiency and quality outcomes was deemed unrealistic in the short term.

### Will It Work?

Reflecting the broader societal debate, a central question for roundtable participants was whether tiering would actually reduce system costs or just shift them to consumers or among payers. It is too early to know whether tiered hospital networks will generate broad interest or move market share among hospitals; among workers covered by employment-based insurance, 5 percent of those in health maintenance organizations (HMOs) and preferred provider organizations (PPOs) were enrolled in tiered provider arrangements in 2002.<sup>7</sup>

The following considerations were raised for discussion: (1) Some hospitals may find that they receive higher overall revenues by continuing to post high prices and thereby losing some volume as a result of tiering, compared with what they would receive from lower prices and higher volume. (2) Cost-increasing trends in the health care economy, including medical technology and an aging population, are likely to overwhelm any cost

reduction associated with tiering. (3) Design features that are broadly targeted, such as hospital tiering, will have a limited effect on system costs because of the concentration of health spending: In 1998, 10 percent of the employment-based population accounted for 58 percent of the spending.<sup>8</sup> (4) While much of the current industry effort focuses on the demand side, some observers believe that the real cost containment potential lies on the supply side, with efforts that coordinate care, manage

resources on a population basis, and target high users through disease management.

**“A central question was whether tiering would reduce system costs or just shift them to consumers or payers.”**

### Relationships Realigned

Hospitals have reacted negatively to the introduction of tiered networks.<sup>9</sup> Academic medical centers (AMCs), in particular, have

questioned the appropriateness of tiering based on cost alone, citing the high cost of their teaching and research mission and the complex, high-risk patient populations that they tend to attract. Anticipating this objection, Blue Shield of California's tiering methodology stratifies hospitals by AMC status, comparing teaching hospitals with other teaching hospitals and community hospitals with other community hospitals. By design, of course, some hospitals in each group end up in the high-cost tier. For example, Stanford University Hospital and the University of California teaching hospitals at the University of California, Los Angeles, and University of California, San Francisco, are in the low-cost tier, while the teaching facilities at Lucile Salter Packard Children's Hospital (affiliated with Stanford University) and Cedars Sinai Medical Center are in the high-cost tier.<sup>10</sup> According to market logic, that is appropriate; tiering makes cost differences among hospitals more transparent to consumers and allows them to decide whether to pay more for a high-cost facility. However, AMCs raise a valid—and familiar—question about the sustainability of their burn units, trauma services, and twenty-four-hour

“standby” capabilities in an era of declining public reimbursement.<sup>11</sup>

As relationships between health plans and hospitals have deteriorated, health plans and medical groups have become more aligned. This may be attributable in part to the shared experience of struggling against hospitals’ increasing market power; some medical groups have seen shared risk pools drained by large hospital per diem charges.<sup>12</sup> However, other aspects of the plan–medical group relationship are genuinely positive: The recent Robert Wood Johnson Foundation/CHCF initiative, Rewarding Results, has contributed to a number of collaborations between health plans and medical groups. The Pay for Performance effort in California has gained momentum, with participation from six major health plans serving eight million HMO members. For some health plans, this collaborative approach to working with medical groups is a distinct shift in approach from previously combative relations.

### **Complexity Creates Challenges For Consumers**

An insurance product with a tiered hospital network groups the hospitals into different tiers and charges more for higher-cost hospitals. How much more? It depends on the plan and the product. Some have two tiers, while others have three. Some products feature copayments, while others feature coinsurance. The tiers are generally updated every six months or so, and some hospitals will move between the levels. Applied to an HMO product, consumer cost sharing can be straightforward: Blue Shield of California has structured its tiering so that the hospital copayment for the high-cost tier (“Affiliated”) is \$100 per day more than the copayment for the low-cost tier (“Choice”) for enrollees with employer-based coverage. However, consumers are much more likely to be confused by the point-of-service (POS) product: It has three levels (HMO network, PPO network, and out of network) and sets enrollees’ share of inpatient charges at zero (HMO), 20 percent (PPO), and 40 percent (out of network) for Choice hospitals and 10 percent, 30 percent, and 50 percent for Af-

filiated hospitals.

Compounding the increasing complexity of insurance benefit design for consumers is the lack of easily obtainable information about prices. As health plans increasingly turn from copayments to coinsurance in an effort to hold down premiums, understanding the cost of services becomes more important to patients, who are bearing a larger proportion of the bill. Unlike restaurants and department stores, physician offices and hospitals do not post prices; it can be very difficult for a patient to obtain an estimate of the cost of services in advance of treatment. A key factor is uncertainty regarding the patient’s condition and the extent of treatment that may be needed. Moreover, the hospital and each treating medical professional are generally only loosely affiliated and bill separately for their services. An unintended consequence of the proliferation of complex benefit designs with incentives for consumers to select among providers, at least in California, may be additional business for Kaiser Permanente, where benefits are comprehensive, copayments are easy to understand, and physicians and hospitals are closely linked.

As insurance product designs create incentives for consumers to learn about cost differentials among providers and choose accordingly, health plans have begun to develop efforts to help consumers obtain information about costs and quality. Hospital tiering is one such effort, distinguishing among hospitals based (primarily) on cost. Blue Cross of California (which is affiliated with WellPoint Health Networks and is independent of Blue Shield of California) has taken a different approach: Rather than tier hospitals, the plan offers its enrollees an online rating system that assigns each hospital one to four price tag symbols indicating relative cost. On the quality side, some health plans have contracted for proprietary online decision support for their enrollees who are choosing among hospitals. Public efforts, such as the Pacific Business Group on Health’s Healthscope, offer information that hospitals voluntarily agree to disclose on measures such as patient satisfaction and

procedure volume. While these initiatives provide more information than has been available in the past, they fall far short of integrating cost and quality information in a way that consumers can easily obtain, understand, and apply to their own decision making.

### Empowered Or Overwhelmed?

Much of the rhetoric dominating health policy circles—and the roundtable discussion—revolves around educating consumers about cost and quality and providing incentives for cost-conscious use of services. Many argue that greater financial responsibility for the cost of medical services will facilitate more rational decision making by encouraging consumers, accustomed to paying \$10 for a physician visit or prescription, to view medical care as a finite resource rather than an entitlement.

However, while policy analysts see a declining consumer share of costs over the past thirty years, consumers simply see rising out-of-pocket costs (Exhibit 2). For a population trained by managed care to expect comprehensive benefits for low out-of-pocket costs, the benefit design changes are likely to be perceived as takeaways to be blamed on greedy or wasteful industry and government players.

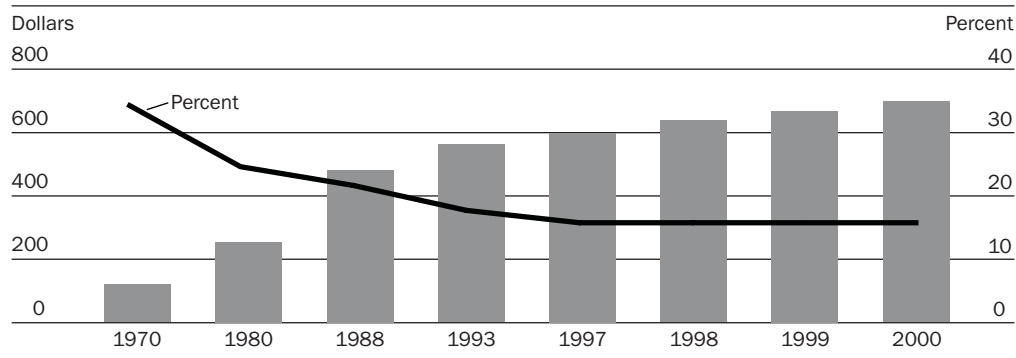
The vision of the rational consumer taking quality and cost into account in making informed decisions about medical care is further

threatened by the lack of consumer demand for quality information. The 1999 Institute of Medicine report on patient safety, *To Err Is Human*, received tremendous media attention publicizing the message that medical care is not uniformly high-quality and error-free, but a recent Harris Interactive survey found that quality ratings of health plans and providers had little effect on consumers' decision making.<sup>13</sup> The complexity of the issue is likely to be a major contributing factor; identifying, comprehending, and applying currently available information to individual decisions is a daunting task. Consumers may not perceive sufficient value in incorporating quality considerations into selecting plans and providers when they are well, and they may find the prospect overwhelming when they are sick.

### Isolating The Sick And The Poor

Current product trends raise broad questions about the deterioration of the social contract ensuring that healthy members of society contribute to the costs of caring for the sick.<sup>14</sup> As insurance product designs increasingly trade premium costs for cost sharing at the point of service, people who use medical care disproportionately will experience increased financial burden. Concern emerged at various times throughout the roundtable discussion regarding the implications of current product

**EXHIBIT 2**  
**Out-Of-Pocket Spending, Per Capita And As A Percentage Of National Health Care Spending, Selected Years 1970–2000**



**SOURCE:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.  
**NOTES:** Selected rather than continuous years of data are shown prior to 1997.

**EXHIBIT 3**  
**Consumers' Responses To Increasing Copayments, By Income And Health Status, 2002**

	Total	Household income		Health status	
		<\$50,000	>\$50,000	Chronically ill	Not chronically ill
In response to increase in prescription drug copayment					
Requested generic	37%	47%	34%	39%	36%
Did not fill prescription	11	16	7	13	9
In response to increase in physician visit copayment					
Postponed visit	24	25	24	29	21
Skipped visit	13	16	10	22	7

**SOURCE:** Harris Interactive, Strategic Health Perspectives, 2002.

trends for the chronically ill, particularly for those with low incomes. A 2002 survey of the public conducted by Harris Interactive suggests that increasing copayments for prescription drugs and physician visits may differentially affect the behavior of the low-income and the chronically ill (Exhibit 3). Any link to health status, the key outcome of interest, is unclear; the RAND Health Insurance Experiment, now more than twenty years old but still the gold standard, found that increased cost sharing reduced use of services but did not have a clear effect on health status.<sup>15</sup>

Several roundtable participants expressed the view that without major redirection, the health care system will move inexorably toward greater government involvement to ensure access to medical care. After two years of reductions, the proportion of the population without health insurance resumed its upward trajectory this year, reaching 41.2 million people and 14.6 percent of the population.<sup>16</sup> This is not solely a problem of the poor and unemployed. The fastest-growing segment of the uninsured in 2001 was upper-income Americans (households earning at least \$75,000); according to the Employee Benefit Research Institute, job-based coverage fell in 2001 for the first time since 1993.<sup>17</sup> Discussion of universal coverage, a political third rail for years after the defeat of the Clinton plan, has recently re-emerged at both the national and the state levels.<sup>18</sup> The only safe prediction is that experi-

mentation will continue in an effort to reach a sustainable level of social investment that meets the medical care needs of all Americans.

*The author thanks Jamie Robinson for his review and helpful comments. The views presented here are those of the author and do not necessarily reflect those of the California HealthCare Foundation.*

**NOTES**

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