

Tiered Networks for Hospital and Physician Health Care Services

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Issue Brief

- The purpose of this *Issue Brief* is to provide an understanding of tiered provider networks and the issues involved, with an emphasis on tiered hospital networks. Under a tiered provider network benefit structure, employees pay different cost sharing rates for different tiers of providers.
- Tiered provider networks are essentially a variation of a long-standing practice of providing one level of benefits to employees who use in-network providers and another level of benefits for use of out-of-network providers. The introduction of tiered provider networks is part of a larger movement to sensitize employees to the real cost of health care. For tiered provider networks to drive lower cost and better quality, consumers will need to be more knowledgeable about various aspects of health care and health insurance.
- Employers and insurers are particularly interested in tiered networks to control spending on hospital services. As of 2001, Americans spent \$1.4 trillion on health care services, \$451 billion of which was for hospital care. While the growth rate for spending on hospital care services was only 8 percent in 2001, compared with 16 percent for prescription drugs, hospital care services accounted for 32 percent of all spending and 30 percent of the growth in spending.
- Tiered provider networks allow employers and insurers to include all or most hospitals and health systems in their plan, thereby allowing them to move away from limited provider networks that are characteristic of many traditional health maintenance organizations.
- By being exposed to higher out-of-pocket expenses, health plan participants will have more of an incentive to become engaged in the process of provider and treatment selection. This may provide additional pressure on hospitals and physicians to disclose information about costs and performance. However, while there is little evidence that tiering has had an effect on consumer choice between in-network and out-of-network physician care and prescription drug choice, it is unknown how large the difference in out-of-pocket payments would need to be before a significant number of consumers factor price into their hospital choices.
- The difference in out-of-pocket payments may need to be substantial to generate changes in consumer behavior because inpatient services tend to be price inelastic, although employers may realize some savings even if only a few consumers change their behavior and choose lower-cost providers. Tiered networks may also increase the amount of uncompensated care that is provided by hospitals.
- Tiered provider networks may result in providers renegotiating contracts if they are sensitive to being in the highest-cost tier. Some providers may view being in the higher-cost tier as driving patients to lower-cost providers and may take steps to renegotiate contracts to become lower-cost providers. Other providers may view being in the higher-cost tier as an indication that they are a high-quality provider and may use that to differentiate themselves from lower-cost providers.

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Introduction

Since 2000, annual health insurance premium increases in the United States have averaged more than

10 percent, causing many employers to re-think their approach to managing employee health benefits (Fronstin, 2002). Employers are generally thinking about ways in which they can introduce various aspects of “consumerism” into their benefit programs so that employees are treated more as *direct purchasers* of health coverage and health care services rather than as the *indirect beneficiaries* of purchases made by the employer. Consumerism generally means that employees have a greater role in choosing health care providers, health plans, and benefit packages, while assuming greater financial risk at the point of service (Gabel, Lo Sasso, and Rice, 2002). A primary goal of “consumerism” is to increase employees’ satisfaction with their health benefits by shifting decision-making power (and, incidentally, costs) onto them, rather than having someone else make those decisions for them. Many employers expect (or at least hope) that increased consumerism will also lead to a reduction in the cost of providing health benefits to employees, as employees become more knowledgeable of health care costs and careful about their resource use.

Employers are interested in increased consumerism in health benefits for a number of reasons. First, and most important, employers continually look for more cost-effective ways to provide health benefits for their employees, and are concerned about continued cost increases. Second, some employers have been concerned that the public and political “backlash” against managed care will result in new restrictions or laws that will entangle them in litigation over the health benefits they voluntarily provide; employers could distance themselves from potential liability for health care coverage decisions by limiting their role only to the contribution amount for health benefits and not to the actual coverage or delivery of the health care services. Third, employers may be able

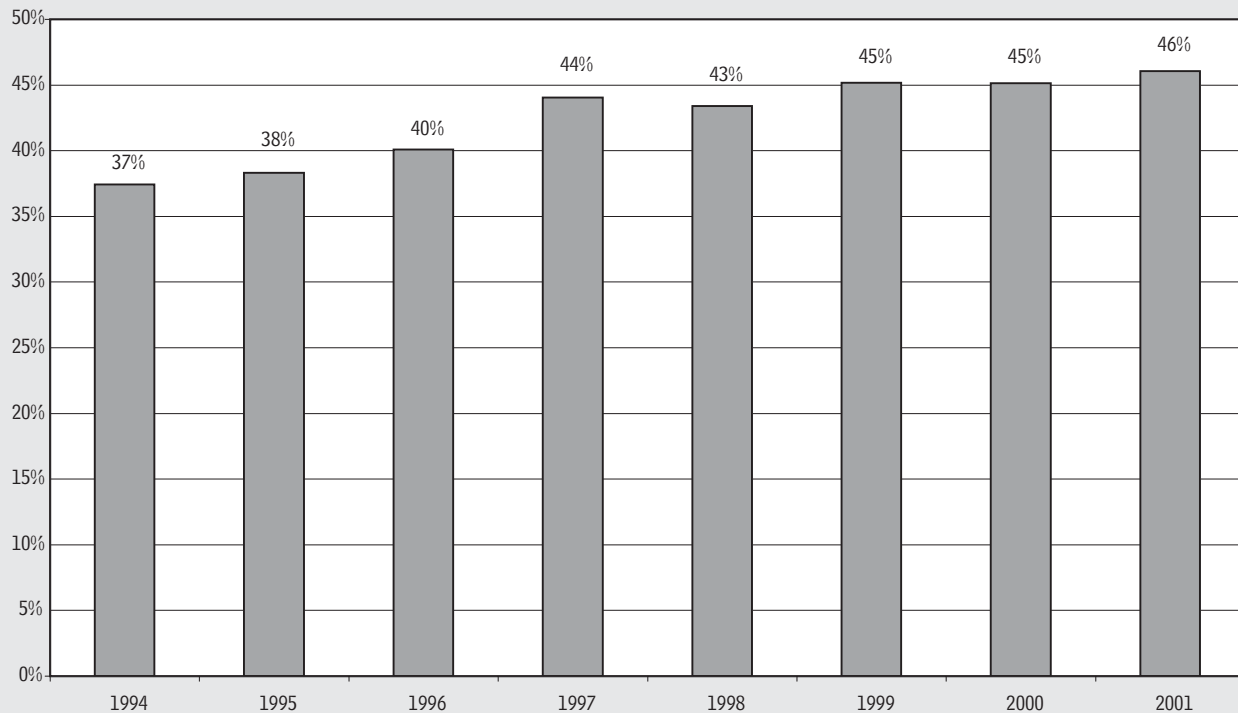
to provide workers more choice, control, and flexibility through these arrangements.

To give employees more choice among types of health benefit arrangements and health care services, while at the same time exposing them more directly to the cost of those benefits and services, a few employers have turned to, and many others are considering, tiered networks for hospital and physician services. After a couple of years of experience with tiered co-payments and networks for prescription drug benefits, insurers and employers have begun to see the value in tiered networks for physician and hospital services as well. The impetus for tiered hospital networks came from the increased bargaining power that hospitals gained as the number of hospitals and hospital beds declined and the patient population grew. According to Robinson (2003), some hospitals are now willing and able to walk away from contracts with insurers unless reimbursement rates are increased and utilization review constraints are decreased. In fact, according to the American Hospital Association, the average number of managed care contracts per hospital declined between 1997 and 2001.

Under a tiered provider network benefit structure, employees pay different cost-sharing rates for different tiers of providers. For example, a provider may be in the lowest-priced tier if it is the lowest-cost provider, and may be in the highest-priced tier if it is the highest-cost provider. Tiers could also be assigned based on the size of the discount obtained from the provider. Quality measures may also be used to assign providers to various tiers. Tiered provider networks are essentially a variation of a long-standing practice of providing one level of benefits to employees who use in-network providers and another level of benefits for use of out-of-network providers. Tiers make cost differences among providers more transparent to consumers and are a way to expose consumers to the actual cost of services, allowing them to decide whether a higher-cost provider merits the additional out-of-pocket expense (Yegian, 2003).

Insurers and employers can use tiers to distinguish among different types of hospitals or providers. Providers could be tiered according to the prices that they

Figure 1
PERCENTAGE OF HOSPITALS THAT ARE PART OF A LARGER HOSPITAL SYSTEM



Source: American Hospital Association. Hospital Statistics, 1999 and 2003 editions.

charge or the quality of care that they provide. One advantage of such an approach is to make employees more aware of the cost and quality implications of their decision to use providers in the various tiers. A disadvantage of this approach is that employees may choose the lowest-cost tier even when they may get better-quality health care services in a more costly tier.

The purpose of this *Issue Brief* is to provide an understanding of tiered provider networks and the issues involved, with an emphasis on tiered hospital networks. Previous EBRI research has already examined the emergence of defined contribution health benefits (Fronstin, 2001) and the spectrum of various consumer-driven health benefit options (Fronstin, 2002). The first section of this report discusses recent trends in the hospital industry. The next section discusses how tiered provider networks operate and is followed by a section on some of the associated issues. The next section summarizes plan information for various insurers that offer tiered provider networks, and the section after that discusses what is known about how consumers have responded to other types of tiered benefits. Before presenting the conclusions, the report discusses what is known about how consumers use health plan and provider performance data and related issues.

Consolidation of Hospitals

Hospital merger activity has increased dramatically in recent years in many parts of the United States. In 2001,

46 percent of hospitals were part of a larger hospital system, up from 37 percent in 1994 (Figure 1). The wave of mergers was a reaction to a competitive managed care environment that had been placing greater emphasis on controlling costs and forcing high-cost providers out of the market (Goldberg, 1999).

The evolution of the insurance market helps explain the hospital consolidation movement. As managed care companies expanded to increase their leverage, so did hospital systems. Evidence suggests that, more recently, hospitals have been able to leverage their consolidated positions and negotiate for better reimbursement rates from insurers. In Miami, FL, key hospitals, such as those that are considered to be “must-have” in a network, were able to obtain more profitable contracts from insurers, in some cases by threatening to drop out of in-plan networks if their demands were not

met (Mays et al., 2001). Hospital systems in Miami were also able to replace unprofitable risk contracts with more favorable per diem payment arrangements.

In Cleveland, OH, after two for-profit hospital systems departed the market, the two leading local systems were able to control 68 percent of the area's hospital beds (Christianson et al., 2000). The two systems have been able to negotiate higher reimbursement rates from insurers and eliminate risk contracting. And in Lansing, MI, one hospital system, accounting for more than 60 percent of the hospital market, has been able to secure small payment increases, and was expected to have more leverage in future negotiations with insurers (Devers et al., 2001).

This is not to say that hospitals have needed to consolidate all over the country to gain market share and to increase leverage with insurers. In October 2000 in Syracuse, NY, for example, insurers appeared to have more leverage than hospitals. At that time, Excellus Blue Cross Blue Shield controlled about 40 percent of the Syracuse health insurance market (Katz et al., 2001). However, none of the major hospitals in the Syracuse area have initiated efforts to increase market share, revenue, or clout since 1998. Instead, they have focused mainly on controlling costs, although past experience with lower-than-average increases in insurance premiums are no longer being realized because of a tight labor market and because there is still a strong leaning toward indemnity coverage in the community. Syracuse employers historically have not taken an active role in shaping the local system and have shown little interest in quality improvement initiatives. In fact, while in the past insurers and employers were able to leverage their purchasing power to eliminate excess supply of hospital beds, the apparent shortage of beds and nurses, at least in some regions, has had the effect of increasing hospital purchasing power. Hospitals in the Syracuse area have also differentiated their services, and physicians tend to have particular affiliations, which also means they are less likely to be excluded from a network.¹

What Are Tiered Provider Networks?

Rather than threaten to exclude a hospital entirely from its health benefits

program, an employer can offer tiered provider networks as a “next-generation” way to leverage favorable cost experience from hospitals. Since employees have the option to use the more expensive hospitals and providers (albeit under less favorable payment conditions for the employee), this type of approach may cause less friction with employees and providers than entirely excluding providers from a plan. Under a tiered provider network benefits package, health care providers are typically separated into different tiers, with the tiers being based on some combination of cost and quality.

For instance, under one scenario, tier 1 providers, thought to have the lowest cost and highest quality, would have the lowest cost sharing (by employees) for health care services, while tier 2 would have much higher cost sharing. Differences in cost sharing could be applied to either per-day or per-visit copayments, overall coinsurance, or even deductibles. For example, with hospital tiers, employees may face a \$0 per day copayment for tier 1 hospitals and a \$200 per day copayment for tier 2 hospitals. Alternatively, employees may face 10 percent coinsurance for tier 1 hospitals and 30 percent coinsurance for tier 2 hospitals, or they may face no deductible for tier 1 hospitals and a \$1,000 deductible for tier 2 hospitals.

The tiered provider network concept is relatively new for hospital services, but many employees are already familiar with it, especially in preferred provider organizations (PPOs) and point-of-service (POS) health plans, which subject them to lower out-of-pocket expenses when they choose in-network doctors (or hospitals) over out-of-network doctors (or hospitals).² However, from the point of view of insurers and employers, tiered provider networks are fundamentally

Figure 2
NATIONAL HEALTH EXPENDITURES, 2001

	Total Spending (billions)	Distribution of Spending	Growth Rate	Share of Increase in Spending
Total	\$ 1,425	100%	9%	—
Hospital care	451	32	8	30%
Physician services	314	22	9	22
Nursing home care	99	7	5	4
Prescription drugs	141	10	16	17
Program administration	90	6	11	8
Other	331	23	7	19

Source: Katharine Levit, Cynthia Smith, Cathy Cowan, Helen Lazenby, Art Sensenig, and Aaron Catlin. "Trends In U.S. Health Care Spending, 2001," *Health Affairs*, Vol. 22, no. 1 (January/February 2003): 154–164.

different from the combined in-network and out-of-network benefit structures. Under a tiered provider network, all providers can have a contract with the insurer or health plan. The terms of the contract may differ depending upon the cost of providing care and other factors. In contrast, under a PPO or POS plan with out-of-network benefits, out-of-network doctors do not have a contract with the insurer or employer. This means that payers are billed at and responsible for paying prevailing charges at different benefit levels.

Employers and insurers are particularly interested in tiered networks to control spending on hospital services. As of 2001, Americans spent \$1.4 trillion on health care services, \$451 billion of which was for hospital care (Figure 2). While the growth rate for spending on hospital care services was only 8 percent in 2001, compared with 16 percent for prescription drugs, hospital care services accounted for 32 percent of all spending and 30 percent of the growth in spending. It may be easier to implement hospital tiers than physician tiers because there are many fewer hospitals than physicians with which to negotiate contracts.

National spending on hospital services has increased for a number of reasons. Both the cost and utilization of services have been increasing (Robinson, 2003). While for many years hospitals had a major surplus in the number of available beds, today there is much less excess capacity because of consolidation, fewer hospitals, fewer beds, and population growth. As noted above, hospital bargaining power over prices has increased, resulting in higher costs to insurers and employers, and, ultimately, higher premiums. Some hospitals have used their clout, especially those in small markets dominated by a single facility or in large markets dominated by hospital systems, by threatening

to walk away from contracts with managed care plans (Robinson, 2003).

Tiered provider networks allow employers and insurers to include all or most hospitals and health systems in their plan, thereby allowing them to move away from limited provider networks that are characteristic of many traditional health maintenance organizations (HMOs). In the 1990s, employers attempting to attract and retain workers in a tight labor market characterized by increasing wages moved away from relatively more restrictive to less restrictive managed care plans. Since tighter-managed HMOs had to compete against more flexible PPOs, many of the more tightly managed plans opened their networks to more providers. In many areas, distinctions between plans could no longer be made by comparing the selection of providers in each network, since providers were contracting with nearly every network. Tiered provider networks are one way to make distinctions between providers when all or most have network contracts.

Similarly, tiered provider networks could also allow employers and insurers to address their concerns about any-willing-provider (AWP) laws. In a number of states, providers cannot be prohibited from joining a network if they are willing to accept the terms of the network. Tiered provider networks would allow employers and insurers to make distinctions between providers in states that have AWP laws.

Tiered provider networks can also benefit consumers by giving them more choice of providers, especially when it comes to hospital care. Hospitals formerly not in a network may now be included in the offering, but at higher cost sharing. In fact, one goal of tiered provider networks is to allow consumers to see any provider that they chose, with their out-of-pocket costs determined by

The introduction of tiered provider networks is part of a larger movement to sensitize employees to the real cost of health care.

their choice of provider.

In some sense, tiers build upon the selective contracting foundation of managed care and HMOs. One of the distinguishing features of a network of providers is the way the network selects its providers. Some networks evaluate candidates against a set of predetermined

selection criteria. In the early HMO and managed care models, providers that met the predetermined selection criteria were able to be part of the network. Today, with tiered provider networks, all providers can be part of the network, but within the network, the predetermined selection criteria can be used to determine the providers' tier and, therefore, the consumers' cost sharing.

The introduction of tiered provider networks is part of a larger movement to sensitize employees to the real cost of health care. Many employers expect that consumerism generally will result in a decrease in their own health benefit costs.³ However, it is unrealistic to expect a decrease in health care costs to occur immediately. Twenty percent of the population accounts for 80 percent of the spending (Fronstin, 2002), and new benefit designs will need to focus on the highest-cost users to have an impact in the short run. It may be found that the tiered hospital network is better than other benefit package changes at controlling costs and utilization in the short run because it targets high-cost users more than it targets the general population. However, as mentioned above, modest out-of-pocket payment differences between tier 1 and tier 2 hospitals may have very little, if any, impact on consumer behavior. In the long run, data and information on prices and quality should be more readily available to the general population, and should begin to affect other aspects of health care utilization.

Consequences of Tiered Networks

The extent to which tiering incentives will impact consumers' behavior is still unknown. It is clear that one of

the goals of tiered provider networks is to provide financial incentives for consumers to use lower-cost and/or higher-quality health care providers. By exposing members to higher out-of-pocket expenses, they will have more of an incentive to become engaged in the process of provider and treatment selection. This may provide additional pressure on hospitals and physicians to disclose information about costs and performance. However, while there is little evidence (as discussed below) that tiering has had an effect on consumer choice between in-network and out-of-network physician care and prescription drug choice, it is unknown how large the difference in out-of-pocket payments would need to be before a significant number of consumers factor price into their hospital choices (Robinson, 2003). In fact, the difference in out-of-pocket payments may need to be substantial to generate changes in consumer behavior because inpatient services tend to be price inelastic, although employers may realize some savings even if only a few consumers change their behavior and choose tier 1 providers. Consumers may be constrained by factors other than price from using certain hospitals. They rely heavily on their physicians for treatment advice and may be unwilling to use a hospital in a different geographic region, where their physician does not have admitting privileges, to save a modest amount of money.

It is also unknown how tiering will impact the behavior of providers. Tiered provider networks may result in providers renegotiating contracts if they are sensitive to being in the highest-cost tier. Some providers may view being in the higher-cost tier as driving patients to lower-cost providers and may take steps to renegotiate contracts to become tier 1 providers. Other providers

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may view being in the higher-cost tier as an indication that they are a high-quality provider and may use that to differentiate themselves from tier 1 providers. Tiered networks for hospitals, if associated with quality information, may also result in increasing physician knowledge about hospital quality differences, which may affect physician affiliations and recommendations of hospitals, thereby improving quality.

Tiered networks may also increase the amount of uncompensated care, such as bad debt and charity care that is provided by hospitals. In 1999, hospitals incurred \$20.8 billion in costs for uncompensated care (Hadley and Holahan, 2003). Some of this uncompensated care was due to insured persons not making their out-of-pocket payments.⁴ As consumers' out-of-pocket expenses increase, there may be an increase in bad debt in the form of uncompensated care. Providers, especially hospitals, may look at ways in which they can collect a patient's out-of-pocket payment at the time of service. Hospitals and physicians may respond by reducing the amount of charity care that they provide in order to offset the increase in bad debt.

There may also be less integration of health care for consumers in tiered networks. Presumably, consumers will "shop" based on cost and quality. In some cases, this will mean that consumers will move among providers to contain their costs. This may increase total spending if, for example, consumers do not bring their medical records and the results of prior tests to new providers and those providers request new tests. Health spending may increase and quality of care may decrease if patients have less attachment to providers, and providers either do not know or have a history of a patient's total care and either request new tests or simply need more time to educate themselves about their new patients.

Finally, tiered networks may have unanticipated effects on academic medical centers (AMCs). AMCs provide medical education and training and conduct

research on new medical practices and technologies. AMCs also provide health care services to the poor and medically indigent. This care is financed through cross-subsidies from private- and public-paying patients, and is also subsidized by state and local governments. AMCs have

in the past provided twice as much uncompensated care (as a percentage of revenue) as nonacademic medical centers (Reuter and Gaskin, 1998). As a result, AMCs are usually the most expensive source of health care and are unable to compete on price. Tiered networks based on cost will likely place AMCs in the higher-cost tier. This will drive private-pay patients toward lower-cost nonacademic medical centers. In turn, AMCs will see an increase in bad debt and charity care (as a percentage of revenue) and may put pressure on policymakers to increase public sources of financing. Tiered networks that essentially steer private-pay patients away from AMCs may therefore have the effect of increasing taxes, increasing the use of tax revenue for hospital services (at the expense of other services), or causing fewer uninsured patients to receive care, which may cost society more money in the long run.

*Examples of
Tiered Provider
Networks*

A number of papers and resources have provided information on the insurers that are offering tiered provider networks

and on the types of benefits being offered. Iglehart (2002) and Robinson (2003) report that Blue Shield of California, Humana, PacifiCare Health Systems, Tufts Health Plan, and United Health Group all currently offer some form of tiered hospital network. Iglehart also reports that CIGNA and HealthNet were planning to offer tiered

hospital benefits in 2003. PacifiCare and Blue Shield of California have already introduced tiered benefits for physician services. Blue Cross of California had originally announced that it would also offer tiered hospital benefits but quickly reversed course. Other insurers to offer tiered benefits include Fallon Community Health Plan in Massachusetts and Blue Cross Blue Shield in Wisconsin.

Various features of selected tiered plans for both hospital and physician services are presented in Figure 3. In most cases, employers can voluntarily offer these plans, although Blue Shield of California mandates the tiered hospital plan for small and mid-sized groups, as well as for the nongroup market. Among the insurers offering tiered provider networks examined in this study, anywhere from 15 percent to 50 percent of the providers were assigned to the high-cost tier.

Copayment levels and differences in those levels by tier varied considerably for the plans examined. Some plans had very little, if any, cost sharing for health care services obtained from tier 1 providers. However, there are plans, like the one offered by Blue Shield of California, that have a \$200 tier 1 copayment for individuals in the small-group market HMO and 20 percent tier 1 coinsurance for individuals in the small-group market PPO. Tufts has a \$350 copayment for tier 1 hospitals. Out-of-pocket payment differences for tier 1 hospital services varied from \$100 (Blue Shield of California and Health Net of California) to \$1,325 (Blue Cross Blue Shield of Wisconsin).

Health plans are much more likely to be using cost over quality to assign providers into tiers. While a number of plans, most notably Blue Shield of California, are taking quality into account in designing networks, they are at best only using participation in quality initiatives and are not yet taking actual performance into account.

Employers may soon take a more active role in promoting tiered networks as well. Recently, CalPERs, the second-largest purchaser of health care in the United States behind the federal government, announced that it

would begin concentrating its purchasing and/or its members' choices among the most clinically and cost-effective providers through the use of tiered networks, selective or exclusive contracting, and/or individually selected provider choice.⁵ CalPERs is often seen as an indicator of industry trends.

Consumer Experience With Tiered Benefits

Employees have had many years of experience with various types of tiered benefits. For example, many employees have

enrolled in or can choose to have benefits from a PPO. A PPO is a panel of health care providers who individually contract with an insurance company and/or employer to offer health care benefits to plan members. PPO network physicians generally do not assume financial risk for the provision of health care services. Typically, PPOs reimburse their physicians on a negotiated fee schedule or a discounted fee-for-service basis. PPO plans choose physicians to meet geographic and specialty needs, often in response to employer requests. Enrollees can receive health care services from PPO (or in-network) providers, and they usually have the option of choosing non-PPO (or out-of-network) providers, but they face higher cost sharing requirements when receiving care from a non-PPO provider.

As mentioned above, one difference between a PPO and a tiered provider network is the way in which the insurer or employer contracts with providers. Under a tiered provider network, insurers and employers could have a contract with each provider from which plan members are eligible to receive health benefits. Employee cost sharing will be higher for higher-cost, lower-quality providers. Under a PPO, only in-network providers will have a contract with the insurer or employer. Out-of-network providers are not constrained

Figure 3
FEATURES OF VARIOUS TIERED-PROVIDER NETWORKS

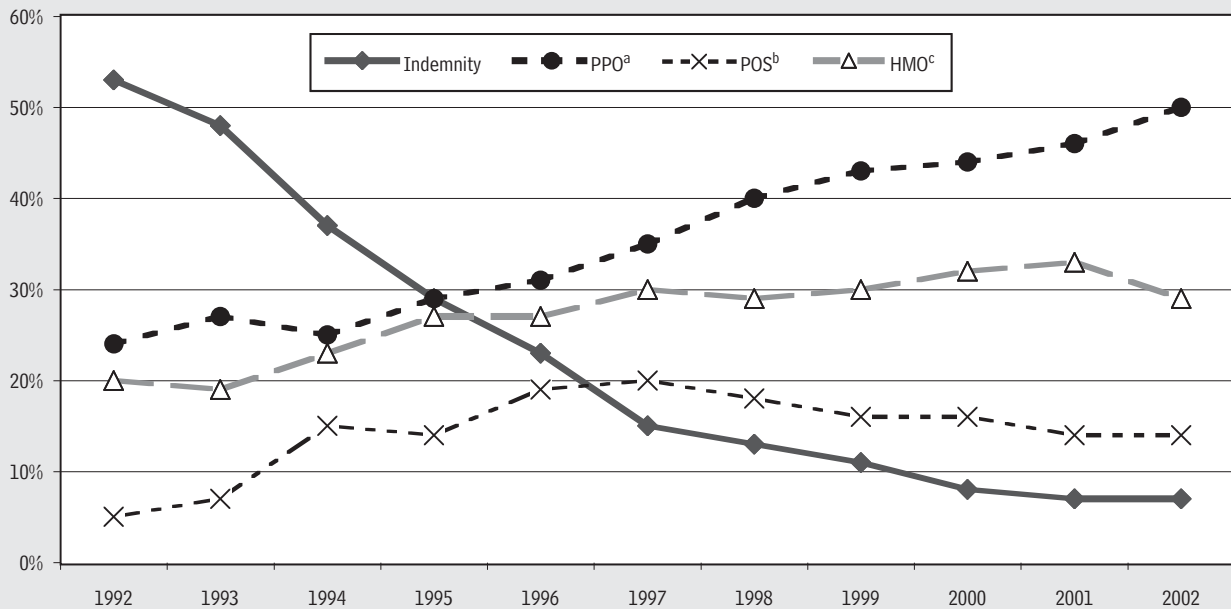
	Date	Market or Product Feature	Percentage of Providers in High-Cost Tier	Tier 1 Copay	Tier 2 Copay	Quality Indicators
Blue Shield of California	April 2002 for hospital services	Mandatory for individual, small group, mid-sized up to 299; voluntary for large groups	15%	Individual Market: HMO ^a : \$0; PPO ^b : 30% coinsurance.	Individual Market: HMO ^a : \$150; PPO ^b : 40% coinsurance.	Patient's Evaluation of Performance in California and the Leapfrog Group
				Small Group Market: HMO ^a : \$200; PPO ^b : 20% coinsurance.	Small Group Market: HMO ^a : \$300; PPO ^b : 30% coinsurance.	
PacifiCare	January 2002 for hospital services	HMOs ^a for employers with 50 or more employees	50%	Inpatient: \$0. Outpatient surgery: \$0.	Inpatient: \$100–\$400 Outpatient surgery: \$50–\$200	Leapfrog Group
	January 2003 for physician services	Mid- and large-sized employers in 8 counties	50%	n/a	n/a	Quality index
BlueCross & BlueShield of Wisconsin	January 2003 for hospital services	Voluntary for small, mid-sized and large employers	44%	Mid-sized and Large Groups: Inpatient: \$0 Outpatient surgery: \$0 ER: \$25	Mid-sized and Large Groups: Inpatient: \$50–\$375 Outpatient surgery: \$25–\$325 ER: \$100	
				All Groups: Inpatient: \$0 Outpatient surgery: \$0 ER: \$25	All Groups: Inpatient: \$700–\$1,325 Outpatient surgery: \$650–\$1,275 ER: \$100	
Fallon Community Health Plan, Worcester, MA	July 2002 for physician services in HMO ^a product	Voluntary for small, mid-sized and large employers	This plan is not a tiered network, but a tailored one. Employers or employees choose between the limited (tier 1) or broad (tier 2) network.	Office Visit: \$5 ER: \$25	Office Visit: \$10 ER: \$50	
Tufts	January 2002 for Hospital services	Voluntary for small, mid-sized and large employers	15%	\$350	\$600	
Health Net of California	November 2002 for hospital services	HMOs ^a for employers with 2 or more employees	30%		\$100–\$750 per day	

Source: *Managed Care Outlook* (various issues); James C. Robinson, "Hospital Tiers in Health Insurance: Balancing Consumer Choice With Financial Incentives," Health Affairs Web Exclusive, March 19, 2003: W3–135–146.; Jill M. Yegian, "Tiered Hospital Networks: Reflections from the California HealthCare Foundation/Health Affairs Roundtable." Health Affairs Web Exclusive, March 19, 2003: W3–147–153.

^a Health maintenance organization.

^b Preferred provider organization.

Figure 4
NATIONAL EMPLOYEE ENROLLMENT, BY PLAN TYPE, 1992-2002



Source: Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans* (New York: Mercer Human Resource Consulting, various years).

^a Preferred provider organization.

^b Point-of-service plan.

^c Health maintenance organization.

by negotiated fees or discounted prices. Employee cost sharing will be higher for out-of-network providers than for in-network providers.

Some HMOs, known as POS plans, also allow participants to choose a provider from outside the network. A POS plan is similar to a PPO except that the in-network portion of the plan looks and feels like an HMO. In other words, when using in-network providers, enrollees are required to select a primary care physician, who then acts as a gatekeeper, essentially controlling referrals to in-network specialists. However, employees can choose to go out-of-network without a referral, paying higher cost sharing.

Use of PPOs and POS plans is widely prevalent today. In 2002, 50 percent of the population insured through employment-based health plans were enrolled in PPOs, while an additional 14 percent were enrolled in POS plans (Figure 4). The research literature suggests that PPO and POS users may in fact be responding to higher cost sharing requirements for out-of-network providers by using in-network providers. Smith (1997/98) found that approximately 2 percent of claims within PPOs were for payments to non-network providers.⁶ Wong and Smithen (1999) found that 12 percent of all claims, accounting for 9 percent of the dollar value of the

claims, were for out-of-network care. Forrest et al. (2001) also found a very low rate of visits to out-of-network providers. Between 0.2 percent and 1.8 percent of enrollees in the plans that Forrest et al. examined self-referred to an out-of-network specialist. In fact, Kapur et al. (2000) did not find any evidence that physician expenditures were higher in a POS plan than in an HMO, and concluded that direct patient access to specialists does not necessarily result in higher provider expenditures. The results may also suggest, as others have shown, that choice of provider at the time of enrollment in a health plan is more important to workers than choice at the point of service (Ullman et al., 1997).

Prescription drug benefits are another area in which employees have experience with tiered benefits. Many employers offer plans in which drugs are categorized according to tiers, and employees pay higher amounts for higher-tier drugs. Employers and insurers expect that tiered prescription drug benefits will encourage employees to purchase drugs that are in the lowest-cost tier. Under a tiered pharmacy benefit, plan members typically pay less for less expensive drugs. Plan members are often encouraged to fill prescription drugs through a mail order pharmacy rather than through a retail pharmacy. Copayments are usually lower when

Figure 5
DRUG PLAN INCENTIVES, BY PLAN TYPE, FIRMS WITH 1,000 OR MORE EMPLOYEES, 1998–2001

	Indemnity			PPO ^a			POS ^b			HMO ^c		
	1998	2000	2001	1998	2000	2001	1998	2000	2001	1998	2000	2001
Generic Incentive												
Lower copayment	34%	41%	52%	45%	56%	65%	49%	61%	72%	41%	56%	66%
No deductible	2	2	<1	1	<1	<1	1	2	n/a	n/a	<1	n/a
Higher coinsurance	7	5	5	10	7	6	4	2	2	1	1	<1
Pay difference between generic and brand name	4	9	10	6	12	10	11	14	11	4	4	3
Mail-Order Incentive												
Lower copayment	23	35	46	31	47	55	37	50	60	11	23	30
No deductible	16	15	12	12	12	10	7	8	4	1	<1	<1
Higher coinsurance	22	20	16	21	18	14	12	12	9	1	1	1
Combination of Generic and Mail-Order Incentive												
Lower copayment	28	41	50	32	47	56	30	44	56	6	16	21
Higher coinsurance	n/a	<1	n/a	1	1	1	<1	<1	<1	n/a	<1	n/a
Pay difference between generic and brand name	1	3	2	2	3	3	2	4	3	<1	<1	<1
No Generic or Mail-Order Incentive	34	28	22	22	14	10	22	13	9	51	34	25

Source: Hewitt Associates, LLC, *Salaried Employee Benefits Provided by Major U.S. Employers* (Lincolnshire, IL: Hewitt Associates, LLC, various years).

^a Preferred provider organization.

^b Point-of-service plan.

^c Health maintenance organization.

the mail order pharmacy is used (Figure 5).

Employers have generally used both two-tier and three-tier pharmacy copayment systems, although some have even used four-tier systems. Employers have generally structured three-tier plans for prescription drug benefits in the following way:

- The lowest copayment for generic drugs (tier 1).
- The second-highest copayment for preferred brand drugs (tier 2).
- The highest copayment for nonpreferred or nonformulary drugs (tier 3).

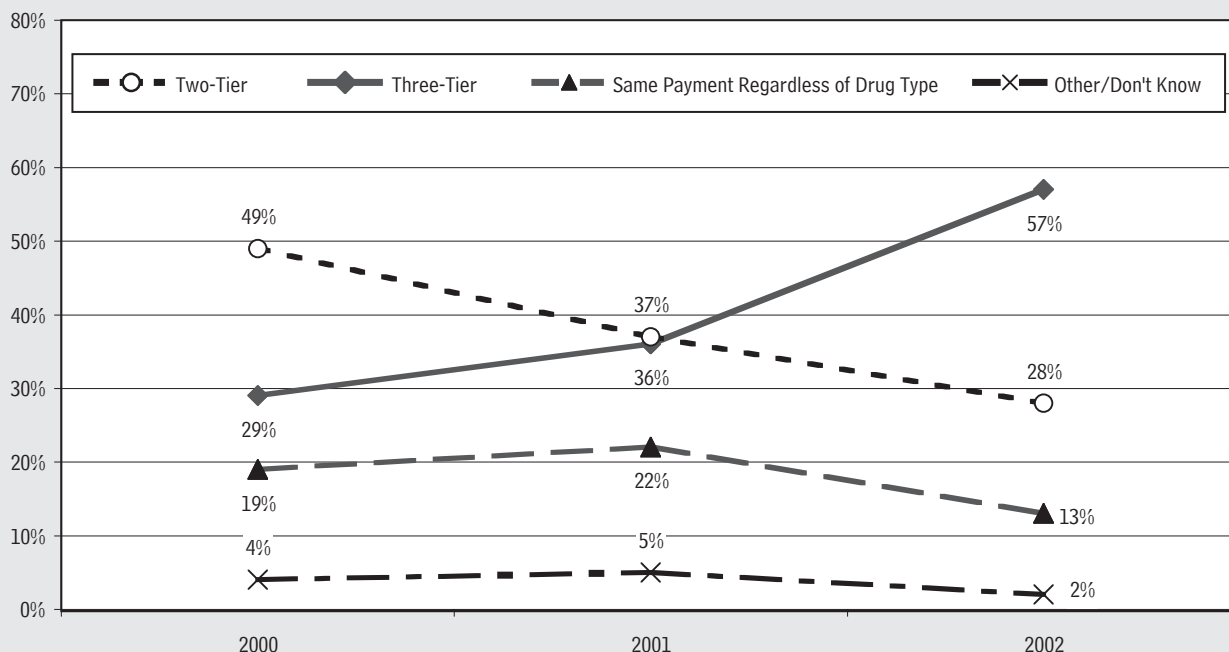
In 2002, 85 percent of covered workers had either a two-tier or three-tier pharmacy plan, up from 78 percent in 2000 (Figure 6). The movement toward three-tier plans has been strong, with 57 percent of covered workers in them in 2002, up from 29 percent in 2000. Copayments have averaged \$8 for tier 1 drugs, \$14–\$17 for tier 2 drugs, and \$16–\$26 for tier 3 drugs (Figure 7). Tiered plans allow employees to choose among drug therapies (when a choice is available) if they are willing to pay for that choice.

Studies have generally found that the introduction of tiered prescription drug benefits has reduced utilization of prescription drugs in general, or has reduced use

of more expensive classes of drugs. Motheral and Henderson (1999/2000) found that the introduction of a closed formulary (an exclusive list of drugs for which a health plan will pay) was associated with significantly lower increases in use and spending. Nair et al. (2003) found that shifting individuals from a two-tier plan to a three-tier plan increased formulary compliance rates by 5.6 percent. This study also found that generic use rates had increased, but they also increased among individuals who did not shift from a two-tier to three-tier plan. This effect may be due to the general increase in copayment levels for all plans. More recent data continue to support the finding that generic drug use is increasing relative to other drugs, which in part explains why growth in prescription drug spending for some employers slowed from 16.9 percent in 2002 to 11.3 percent in 2003.⁷

...it may be an enormous challenge to engage consumers in thinking about cost and quality information for health care services.

Figure 6
PERCENTAGE OF COVERED WORKERS FACING DIFFERENT COST SHARING FOR PRESCRIPTION DRUG BENEFITS, 2000-2002



Source: Erin Holve et al., *Employer Health Benefits: 2002 Annual Survey*. (Menlo Park, CA: The Henry J. Kaiser Family Foundation, and Chicago, IL: Health Research and Educational Trust, 2002).

Employee Education

For increased consumerism generally and tiered provider networks specifically to drive lower cost and better

quality, consumers will need to be more knowledgeable about various aspects of health care and health insurance. Under tiered hospital networks, employees must decide whether the features of the tier 2 (or higher-cost) hospital are worth the additional cost. Such features may include a favorable geographic location, admitting privileges for a preferred physician, or an affiliation with an academic medical center, to name a few. Presumably, employees will be able to compare and evaluate health care quality and the associated costs.

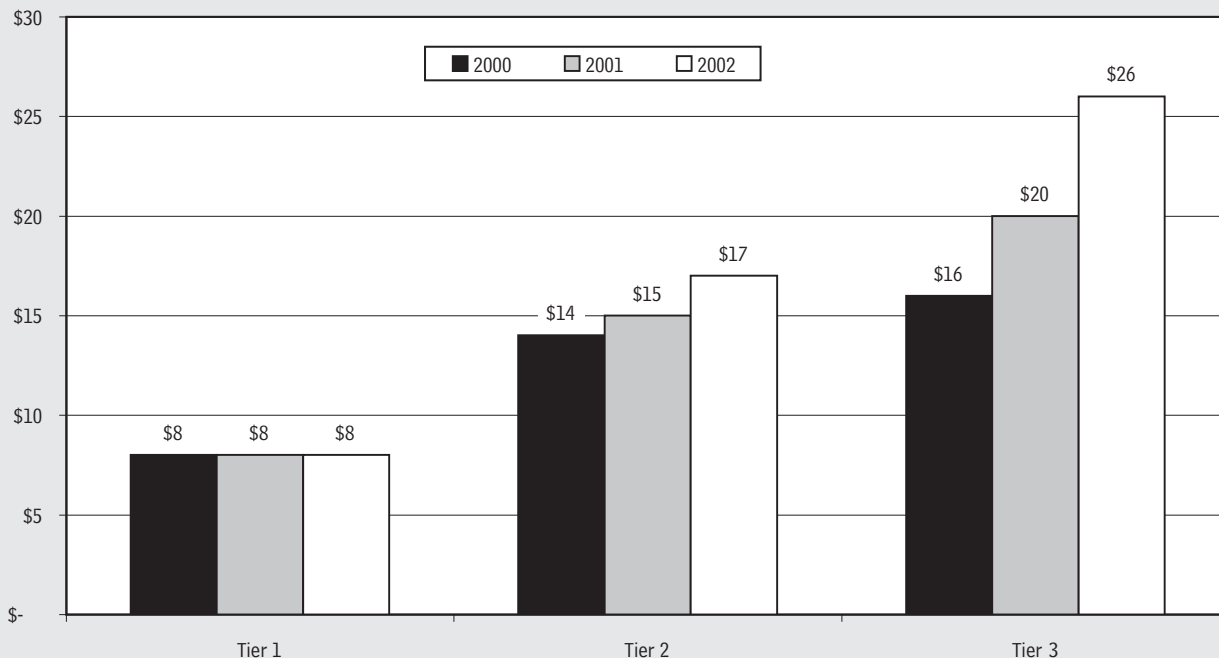
However, recent research suggests that in the short term it may be an enormous challenge to engage consumers in thinking about cost and quality information for health care services. Two recent studies found that, over the course of one year, 38 percent of adults sought health information (RAND Health, 2001; Tu and Hargraves, 2003). This estimate may or may not be a cause of concern. It is well known that 20 percent of the popula-

tion accounts for 80 percent of health care spending. In fact, 50 percent of the population is very healthy and generally does not need health care services. As a result, a significant portion of the population would not be expected to be searching for information on health care. However, Tu and Hargraves also found that between 42 percent and 45 percent of the population with a chronic condition searched for information on health care. They also found that a person's level of education was by far the most important factor affecting whether people are likely to seek health information, with information-seeking rising sharply as the level of education increases.

Schultz et al. (2001) examined whether consumers used "report cards" that provided information on service quality and satisfaction at the provider group level. Data were collected by telephone from more than 1,900 employees in companies that were aligned with the Buyers Health Care Action Group (BHCAG) in Minnesota. BHCAG distributes a report card that gives enrollees information on patient satisfaction and service quality of health care systems.⁸ Schultz et al. (2001) provides detailed information on how the data were collected for the report cards.

The designers of so-called "consumer-driven

Figure 7
AVERAGE COPAYMENTS FOR VARIOUS TIERS OF PRESCRIPTION DRUG BENEFITS, 2000-2002



Source: Erin Holve et al., *Employer Health Benefits: 2002 Annual Survey* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, and Chicago, IL: Health Research and Educational Trust, 2002).

benefits,” including tiered provider networks, assume that the financial incentives that are built into these plans will motivate consumers to use quality information to become more engaged in health care decision making. However, even if consumers do not use information, the availability of the information may still change the way providers practice medicine and ultimately have a positive impact on health care quality. Chassin (2002) examined how providers in New York responded to the publication of data on risk-adjusted mortality following coronary artery bypass graft surgery (CABG). He found that providers made specific improvements in the way they treated CABG patients because of the public availability of the data. The changes took place despite the fact that patients did not avoid high-mortality hospitals and insurers did not use the data to reward better providers or steer patients to them.

While there is little information about the quality of health care providers and little research on how consumers use that information, there is a fairly large and growing body of research that examines how consumers use information about health plans. Spranca et al. (2000) used a controlled experiment setting to examine how health plan quality information as measured by the Consumer Assessment of Health Plans Study (CAHPS) affects health plan selection. The Agency for

Healthcare Research and Quality (AHRQ) led the development of CAHPS and describes it as “an easy-to-use kit of survey and report tools that provides reliable and valid information to help consumers and purchasers assess and choose among health plans.”⁹ Prior to CAHPS exposure, Spranca et al. found that 86 percent of consumers preferred higher-cost comprehensive plans. The introduction of CAHPS ratings showing that some less-expensive, less-comprehensive plans provided higher quality resulted in only 59 percent of consumers preferring the more-expensive plan that was more comprehensive.

Farley et al. (2002) found that health plan performance information does influence plan choice, but only when the information was read by consumers. In addition, according to Hibbard et al. (2002), the way in which information is presented to consumers affects how it is interpreted and how much weight is placed on the information in choosing from among health plan options. The study discusses the literature which shows that health plan performance reports are not used by consumers, possibly because the information is difficult to use and understand. Furthermore, the provision of visual cues (e.g., “four-star” ratings) in the presentation of health plan performance data resulted in more selections of the higher-performing plans, even though those plans

*...for tiered
hospital
networks to drive
down costs and
increase quality,
consumers will
need to be more
knowledgeable
about health care
and health
insurance.*

cost more. Those who are developing data to support decision-making in an increasingly “consumer-driven” environment should take note of these findings from the research literature on health plan and provider performance data.

Employers may be the ultimate hurdle between their employees and consumer-driven health benefits. Employers have adopted many tools to improve purchasing decisions but continue to feel that information regarding quality of health care providers is inadequate (Hargraves and Trude, 2002). In addition, many employers are skeptical that tiered-network products are practical for their work force, questioned their employees’ ability to access and understand information about choices and costs, and questioned the feasibility of administering these benefit designs (Mays et al., 2003). Health plans such as those that utilize health reimbursement accounts or tiered provider networks essentially require employees to make more of their own decisions regarding the consumption of health care services. Employers may be slow to move toward these plans until they feel comfortable that sufficient tools and resources are available to enable their employees to make informed decisions.¹⁰

Conclusion

After a couple of years of experience with tiered copayments and networks for prescription drug benefits and in-

network and out-of-network benefit schedules for physician services, and in some cases hospital services, employers and insurers are turning their attention to tiered networks for hospitals. In some cases, attention is also focused on tiered networks for physicians. Under tiered arrangements, employees face different levels of

cost sharing, depending on the provider tier from which they choose to obtain health care services. Providers are tiered according to the prices they charge, but can also be tiered by the quality of care that they provide. Tiered benefits make cost and quality differences among providers more transparent to consumers; however, employees may choose the lowest-cost tier even when they might get better

quality health care services from a more costly one.

Employers and insurers are particularly interested in tiered benefits in order to control spending on hospital services. Tiered hospital networks are a way of focusing cost containment efforts on the highest-cost users. Hospital care accounts for 32 percent of all national health care spending and 30 percent of the growth in spending, and is often associated with other health care services, such as office visits prior to an inpatient stay and prescription drugs. Since 20 percent of the population accounts for 80 percent of the spending, changing incentives and providing tools and resources about quality to the 20 percent of the highest-cost users may have the greatest potential to increase efficiency in the delivery and financing of health care.

However, for tiered hospital networks to drive down costs and increase quality, consumers will need to be more knowledgeable about health care and health insurance. Recent evidence suggests that, in the short term, it may be an enormous challenge to engage consumers to think about cost and quality in health care, but it is expected that, in the long run, cost and quality information will be readily available to the general population; consumers will frequently base their health care and purchasing decisions on this data, which will drive changes in the practice of medicine; and providers will adjust their practice patterns according to what they learn themselves from cost and quality data collection and dissemination initiatives.

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Endnotes

¹ Personal communication, Sally Trude, Center for Studying Health System Change, May 2003.

² Traditional HMOs also provide a form of tiered benefits. HMOs typically provide very comprehensive coverage when employees use in-network providers. In contrast, there are usually no benefits when employees use unapproved out-of-network providers.

³ Mercer Human Resource Consulting (2002) reports that about one-half of employers responding to a recent survey reported that lowering health benefit costs was an important objective for offering a consumer-driven health plan.

⁴ Approximately 20 percent of uncompensated care is associated with privately insured individuals, while another 10 percent is associated with individuals covered by public insurance programs (Hadley and Holahan, 2003).

⁵ See www.calpers.org/whatshap/calendar/board/hbc/200305/strategicplan/AStratPlan01.doc (last reviewed June 2003).

⁶ Smith (1997/98) examined data from 1987–1990. This time period of first-stage PPO models may not be representative of today's experience with PPOs.

⁷ See www.corporate-ir.net/ireye/ir_site.zhtml?ticker=ESRX&script=410&layout=-6&item_id=418146 (last reviewed June 2003).

⁸ The study found that consumers who change care systems are more likely to use report cards, and have found them to be very helpful. However, consumers who are pleased with their care system tend not to use report cards.

⁹ www.ahrq.gov/qual/cahpfact.htm (last reviewed April 2003).

¹⁰ Even after favorable IRS guidance regarding health reimbursement accounts (HRAs) in June 2002, less than 1 percent of all employers offered HRAs in 2002, although 7 percent of trend-setting jumbo employers (20,000 or more employees) offered them (Mercer Human Resource Consulting, 2002). Fifteen percent of jumbo employers are very likely to offer such a plan within the next two years. Some would view this trend as a step in the right direction, but others may view it as disappointingly slow, and it may indicate that employers will be slow to move toward increased consumerism before they are comfortable that tools and resources are available to employees.



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