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Hospital Tiers In Health Insurance: Balancing Consumer Choice With Financial Incentives

The health economy will not sustain permanent double-digit cost inflation, and the health polity will not abide heavy-handed restrictions on consumer choice.

by James C. Robinson

ABSTRACT: Variations in efficiency and market power are generating wide variations in the prices charged by hospitals to health insurance plans. Insurers are developing new network structures that expose the consumer to some of the cost differences, to encourage but not mandate differential use of the more economical facilities. The three leading designs include hospital "tiers" within a single broad network, multiple-network products, and the replacement of copayments by coinsurance in HMO as well as PPO products. This paper describes the new network designs and evaluates the challenges they face in influencing consumers' behavior, incorporating information on clinical quality, and supporting medical education and uncompensated care.

THE IRRESISTIBLE FORCE has collided with the immoveable object. Health care cost inflation is surging as hospitals flex their bargaining leverage for higher prices and fewer constraints.[1] Meanwhile, consumers, purchasers, and regulators are digging in and saying no to health plans that seek hospital discounts via threats of network exclusion.[2] Caught in the middle, the insurance industry is developing network designs that seek to accommodate consumers' demand for choice by including most providers but attenuate the inflationary spiral by increasing consumers' exposure to price differences among hospitals. The geographic and organizational diversity of the nation is permitting experimentation with three distinct network design strategies, including tiers of hospitals, each with a different admission copayment, within one all-inclusive network; the combination of multiple hospital networks, each with a different consumer premium contribution, within a single insurance product; and the replacement of fixed-dollar copayments by percentage coinsurance, which automatically tiers providers according to price. Each of the new experiments contrasts with the standard health maintenance organization (HMO) benefit and network design, which imposes small copayments that do not vary among hospitals and seeks to hold down hospital prices by excluding some facilities from the network and demanding volume discounts from the others.

The emerging tiered-network, multiple-network, and coinsurance-based network designs extend to the hospital sector some of the principles developed by insurers for their pharmaceutical benefit coverage, where the patient's share of the cost is linked to the price

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of the product chosen. The patient now frequently pays less for an off-patent generic than for an on-patent brand-name drug, less for an on-formulary than for an off-formulary product, and less if the prescription is filled by a mail-order house than if filled by a retail pharmacy.[3] However, it is much more difficult to categorize hospitals by relative price and efficacy than to do so with drugs, and it is far from clear that the contemporary wave of network experiments will add more in transparency and incentives than it subtracts in heightened complexity. Three sets of questions need to be addressed. First, how effective will the new network designs be in influencing patients' choices and, indirectly, providers' price strategies? Second, how will differences among hospitals in clinical quality, medical education, and uncompensated care be factored into network designs? Third, what influence will the trend toward provider-specific copayments exert on the cross-subsidies between healthy and sick citizens that are created by insurance?

"It is far from clear that the contemporary wave of network experiments will add more in transparency and incentives than it subtracts in heightened complexity."

This paper analyzes the contemporary redesign of health insurance networks, highlighting efforts to promote price-conscious demand by consumers and price-conscious supply by hospitals without the limited provider relationships characteristic of traditional HMO products. The principles underlying tiered-network, multiple-network, and coinsurance-based network designs are illustrated with examples from Blue Shield of California, Tufts Health Plan, Highmark BlueCross BlueShield, and WellPoint Health Networks. All of the new designs suffer from major limitations, but each offers a mechanism through which consumers can reduce their out-of-pocket costs through a judicious choice of providers. As such, the contemporary experiments constitute part of a larger transition in the health care system toward greater reliance on information and incentives for individual patients. No one knows what the future will bring, but everyone knows what it will not. The health economy will not sustain permanent double-digit cost inflation, and the health polity will not abide heavy-handed restrictions on consumer choice.

Hospital Network Tiers

The proximate source of the contemporary proliferation of network designs is the rapid increase in inpatient and outpatient hospital costs, which outstripped prescription drug spending as the greatest contributor to overall health care cost inflation in 2001.[4] Hospital costs are accelerating as a result of increases in unit prices and rates of utilization for both inpatient and outpatient services. For twenty years the hospital industry suffered from a surplus of beds, which occurred when the capacity expansions driven by Hill-Burton subsidies and cost-plus Medicare reimbursement were followed by utilization declines driven by managed care and prospective Medicare reimbursement. This excess gradually has been sweated out of the system, as some facilities have closed, many have reduced staffed beds, and the population has grown. Hospitals now are willing to walk away from managed care contracts unless prices are raised and utilization review constraints are lowered, with the most effective demands occurring in small markets dominated by a single facility or in large markets dominated by hospital chains. Hospital costs also are driven by underlying increases in spending for nursing staff, inpatient pharmaceuticals, regulatory compliance, clinical equipment, and information technology. Tiered network designs respond to cost variation among hospitals, and hence in bargaining power, rather than to factors that affect the costs of all hospitals equally.

Vertically integrated health plans, each with exclusive or quasi-exclusive networks of

hospitals, would charge premiums that reflect the costs of their hospitals and hence obviate the need for hospital tiers within their networks. But most health insurers have divested their exclusive (staff-model) delivery systems, and most hospital systems have divested their in-house HMO products, as both have learned that health insurance and health care are subject to very different economies of scale and scope. As purchasers increasingly contract with a single health plan, they pressure these plans to include most, if not all, hospitals in their contracted networks, achieving through market forces what "any-willing-provider" initiatives would have achieved through legislation. While enabling consumer choice among all facilities, the principle of network inclusivity undermines health plans' ability to hold down costs by threatening network exclusion to facilities that do not discount their prices. It also undermines the ability of preferred provider organization (PPO) and point-of-service (POS) plans to channel patients to contracted hospitals, since few facilities fall outside the contractual network.

Tiered network products establish two levels of consumer cost sharing for hospital services, depending on whether the patient uses a facility in the core (low cost sharing) or premium (high cost sharing) tier. For PPO products with coinsurance provisions, this can be as simple as retaining a 20 percent coinsurance rate for facilities in the core tier and increasing it to 30 percent for facilities in the premium tier (with 40 percent or 50 percent for out-of-network facilities). For HMO products, tiered network designs typically are structured as differences in dollar copayments per admission or per patient day (per procedure for outpatient services). Cost sharing for hospital services is a recent addition to many HMO benefit designs, which once restricted copayments to physician office visits and ancillary services. The coinsurance and copayment differences typically do not capture all, or even most, of the differences in costs across hospital tiers. As such, they do not mimic balance-billing insurance principles, according to which the health plan pays a defined amount toward the hospital bill and the patient pays the remainder, which makes the patient fully responsible for the price differences across facilities (as the payment by the insurer never exceeds the cost of the low-cost facilities). The tiered designs are not conceptualized as a means to insulate the health plans from hospital cost variation but, rather, as a means to inform and sensitize the patient, who previously was insulated from and indifferent to the cost implications of hospital choice.

Individual hospitals can be assigned to the core and premium tiers using any of numerous criteria, including unit prices (for example, per diem rate), average costs (both unit prices and service intensity), structural characteristics of the hospital (for example, teaching status, sole community facility), indicators of quality, or the outcome of negotiations (for example, a chain may insist that all of its facilities be in the same tier). Tiers can cover all services but typically exclude emergency admissions and may be used in different ways for routine hospital services than for tertiary services that are available only in selected facilities. Hospital tiers may be used for some or all insurance products (HMO, PPO, POS) and for some or all customer segments (individuals and small firms, large accounts, or Medicare risk products), and they may be optional or mandatory (purchasers may be offered tiered and nontiered variants or solely a tiered network). The effect of tiering on product premiums will depend on the criteria used to define tiers, the cost-sharing differential that encourages patients to economize, and the effect of tiering, if any, on the mix of enrollees in tiered and nontiered products. Tiered network products have been developed by national and regional health plans, including United, Humana, CIGNA, HealthNet, and PacifiCare.[5]

Insurance Products With Multiple Networks

Insurance firms typically are born as single-product entities, either broad-network indemnity carriers, narrow-network HMOs, or, in the contemporary environment, high-deductible medical savings account (MSA)

products layered over a PPO network.[6] Consumers vary widely in their preferences and willingness to pay for different configurations of network breadth, benefit coverage, and premium payment, which causes fundamental problems in a market where most private insurance is purchased on a group, rather than an individual, basis. To accommodate diverse employee preferences in a world of single-network products, employers would need to contract with multiple plans, as embodied in the principles of managed competition.[7] Most large private firms and almost all small and midsize firms prefer to contract with a single carrier, however, to reduce administrative costs and avoid the possibility of risk selection among competing carriers.[8] Health plans have responded by diversifying into multiple products, each of which may come with a partially distinct provider network.[9] Indemnity networks include all licensed providers, PPO networks include most providers, and HMO networks include a subset based on either organizational form (for example, group practice) or willingness to discount prices. Insurance entities now frequently sell one "total replacement" product (or metaproduct) comprising multiple insurance options (HMO, PPO, and MSA). Employees choose among multiple offerings from a single carrier rather than among multiple single-product carriers.

During the prosperous years of the late 1990s many consumers expressed a desire for unimpeded choice of providers through broad network access, and many health plans added physicians and hospitals to their networks. As the economy has faltered and health care cost inflation has returned, the market may experience a renewed willingness to purchase narrow-network products if they come at a premium much lower than those for insurance products with broader networks. However, when one purchaser selects a product for a large group or self-insured corporation, narrow networks are shunned in favor of broad-network alternatives. Many insurers differentiate their HMO and PPO networks according to physician but not hospital participation. HMO networks can include many fewer physicians than PPO networks do without creating major geographic access barriers, but they cannot exclude many hospitals without creating access barriers for at least some services. In these contexts, HMOs and PPOs manifest similar hospital networks but differentiated physician networks. In the face of substantial consolidation and pricing leverage by hospitals, however, the inclusion of all facilities in all networks undermines insurers' ability to price one product well below another, in turn eviscerating the value of multiple-product offerings. In these contexts, designing insurance networks explicitly to include different numbers or types of hospitals becomes attractive.

Coinsurance And Hospital Auto-Tiering

Managed care lowered patients' financial barriers to access by almost eliminating cost sharing at the time of care, compared with the status quo before managed care took hold. Whereas traditional indemnity and Blue Cross insurance imposed a deductible for the first services used, layered percentage coinsurance above the deductible, and excluded many preventive and behavioral services altogether, the typical HMO product imposed no deductibles, replaced percentage coinsurance with modest fixed-dollar copayments, and extended coverage to many new forms of care. Even PPO products, which were constructed on an indemnity rather than an HMO platform, often replaced coinsurance with copayments and extended coverage in a manner similar to that of their HMO competitors (while retaining a deductible). As a result of these benefit changes, the percentage of health care costs paid directly out of pocket by patients declined by 20 percent during the 1990s.[10] This reduction in cost sharing contributed to the resurgence of cost inflation, as would be predicted by the research literature on moral hazard.[11] More generally, lower cost sharing and richer benefits fostered an entitlement philosophy according to which considerations of cost should be excluded altogether from health care decision making. This philosophy, when combined with rising expectations, a li-

tigious culture, and new clinical technologies, now renders difficult any discussion of limits, trade-offs, and priorities in American medicine.

Cost inflation and the backlash against managed care are reversing the trend toward richer benefits and prompting an increase in deductibles and the replacement of copayments with coinsurance in PPO and some HMO products.[12] Depending on how they are structured, deductibles and coinsurance sensitize the patient not merely to the average cost of the services they use but to the cost variation among providers. Deductibles and coinsurance differentiate providers automatically, without the need to establish formal tiers, allocate particular providers among them, and modify copayment levels according to each consumer's choice. Deductibles expose consumers to cost differences among providers for services incurred until the threshold has been reached, which can exert a strong financial effect as deductibles are raised from nominal levels to $1,000, $2,500, or more. Coinsurance exposes consumers to a percentage of the cost of services incurred above the deductible and, as such, to a percentage of the variation among providers in both unit prices and service intensity. Even a standard 20 percent coinsurance rate generates considerable financial liability for hospitalized patients in a world where costs can vary among facilities by more than $1,000 per day and $5,000 per admission. Newer benefit designs, with coinsurance rates as high as 40 percent for hospitalization and 50 percent for selected outpatient services, assign even more of the cost differences among providers to the patient making the choice. In contrast with dollar copayments, percentage coinsurance automatically increases enrollees' financial responsibility, as health care costs rise over time.

Experiments In Network Design

■ **Blue Shield of California.** Blue Shield of California developed its hospital tiers in response to the increasingly successful leverage of bargaining power by individual hospital facilities and by hospital chains. Average costs per day in 2001 ranged from $1,600 in the competitive Los Angeles metropolitan area through $2,200 in the more consolidated San Francisco region to $3,200 in the Sacramento market, which is characterized by cartels. Within each region, costs varied from lowest to highest by 600 percent across community facilities and 150 percent across tertiary care facilities. Hospitals were using bottlenecks on inpatient bed capacity to leverage price increases for outpatient services even where freestanding outpatient alternatives were available.

The Blue Shield tier structure is designed to influence the variation in costs not across geographic areas but within them. Moreover, the plan seeks to promote cost-conscious choice among community hospitals and among academic medical centers (AMCs) separately, rather than to create incentives for consumers to select community-based rather than (the invariably more expensive) teaching hospitals. Blue Shield sorted facilities by region and teaching status and computed average cost per inpatient episode and per outpatient procedure for each hospital within each of the groupings. Expenditures for selected services (for example, maternity care, transplants, and emergencies) were removed before the cost averages were calculated. Blue Shield uses costs rather than negotiated prices, as hospitals vary considerably in the manner by which they are paid (capitation, per diem, or case rates), in the number and types of carved-out services paid on a supplemental basis (for example, injectible medications), and in the negotiated trigger points for stop-loss (for example, some hospitals negotiate low triggers that shift half of admissions into stop-loss status). Facilities with average costs (weighted for inpatient and outpatient services) that exceed the average for their regional and teaching status group by a sizable amount are assigned to the "affiliate" tier, with the others remaining in the "choice" tier. Based on these criteria, 85 percent of the contracted hospitals are in the low-copayment tier, and the remainder in the high-copayment tier, with some variation across geographic regions. One major chain negotiated the inclu-

sion of all its hospitals in the choice tier, despite very high costs in some facilities, while the other chains in the state have some facilities in the choice and some in the affiliate tier.

Blue Shield introduced its tiered networks in April 2002 for all products sold to individuals, small groups, and midsize firms (up to 299 employees); it is optional for larger firms. The mandatory use of tiered networks obviates the doubling of options (tiered and nontiered for every product), immediately increases pressure on high-price hospitals by increasing the price-sensitivity of one million members (out of a total of 2.3 million), and eliminates concerns over adverse selection, in contrast to the alternative strategy of permitting purchasers to select between tiered and nontiered products. The cost-sharing differences between choice and affiliate tiers are modest (and do not apply to emergency admissions and procedures). In the individual market, use of a choice hospital has no admission copayment in the HMO and 30 percent coinsurance in the PPO, while use of an affiliate hospital imposes a $150 admission copayment in the HMO and 40 percent coinsurance in the PPO. (Individual-market products also are subject to deductibles: $1,500 for the HMO and a range of $500–$2,000 for the PPO). In the small-group market, use of a choice hospital requires a $200 admission copayment in the HMO and 20 percent coinsurance in the PPO, while use of an affiliate hospital requires a $300 copayment in the HMO and 30 percent coinsurance in the PPO. These consumer cost-sharing differences fall well short of the total cost differentials between choice and affiliate hospitals, and Blue Shield continues to share responsibility for the economic consequences of its enrollees' hospital selections.

Blue Shield views its tiering methodology as one component of a larger effort to position itself as an entity that informs and supports consumers' health care choices instead of limiting them. As such, it is unwilling to rely on network exclusion as a mechanism for restraining cost increases, although difficult negotiations with particular facilities sometimes lead to a contract termination. While the Blue Shield HMO contracts on a capitated basis with medical groups and its PPO contracts on a fee-for-service basis with individual physicians, both products use the same inclusive hospital network. Blue Shield includes some quality performance measures in its tiering criteria, beginning with a hospital's participation in the Leapfrog quality improvement program and a facility's scores on patient satisfaction surveys, and will add outcome-based quality metrics as they become available.[13] It also is working on methods to adjust the cost data for severity across facilities. Blue Shield has considered extending tiering principles into its HMO physician network, as the capitated payment rates vary greatly across medical groups, but it faces numerous technical difficulties in adjusting for patient severity, scope of capitated services, and the fact that medical groups have their own contractual relationships with particular hospitals. Tiering principles are applied to inpatient and outpatient hospital services, ambulatory surgery centers, radiation and chemotherapy services in freestanding centers, substance abuse services, and pharmaceutical benefits (generic versus brand-name drugs).

■ **Tufts Health Plan.** The Boston hospital market is dominated by large AMCs, whose cost structures are much higher than those in nearby community facilities, even for secondary forms of inpatient care that are done routinely in all hospitals.[14] The Tufts plan originated as a narrow-network HMO product with a single tertiary care center and multiple community facilities, but it has been forced by consumers' desire for choice to broaden into PPO and POS products and to include all hospitals in all of its networks. It designed a tiered HMO product to support community facilities and reduce its costs by motivating enrollees to use community hospitals when possible. Tufts thus assigned community facilities to the core tier and tertiary facilities to the premium tier, in contrast with Blue Shield of California, which created choice and affiliate tiers for community and tertiary facilities separately. Of the eighty acute care hospitals in Massachusetts, twelve are defined by Tufts as ter-

tiary care facilities, based on their involvement in graduate medical education, clinical research, and provision of specialized services.

The tiered hospital network design was introduced in January 2002 as an option, not a required part of any product, first in the midsize- and large-firm customer segments and then for small groups. Inpatient admission and outpatient surgery copayments are $350 in community facilities and $600 in tertiary centers. Physician visits also are subject to tiering principles, with acute care, physical exams, well-baby care, and obstetrics/gynecology (OB/GYN) visits requiring $15 copayments to see a primary care physician and $35 to see a specialist. The tiered product is offered side by side with the nontiered HMO product, enjoying a modest 5 percent premium advantage, so that employers and employees are not forced to change benefit designs. The initiative's voluntary nature has severely limited its enrollment, however, which after six months accounted for less than 1 percent of the 900,000 plan enrollees. This may grow as hospital tiers are extended into the PPO and POS products, which account for one-third of enrollment, and as more customer accounts come up for renewal.

■ **Highmark BlueCross BlueShield.** Highmark BlueCross BlueShield is the dominant insurer in western Pennsylvania, with 3.4 million enrollees and a 65 percent share of the regional market, plus another 1.7 million enrollees spread across the nation in self-insured corporate accounts. Highmark offers not only the full range of insurance products (indemnity, PPO, POS, HMO, Direct Access HMO) but maintains multiple provider networks to respond to the preferences of its diverse constituencies. Because of its history and special regulatory status as insurer of last resort, Highmark maintains an all-inclusive (participating provider) network open to all licensed physicians and hospitals. This network, called PAR, is used to support indemnity products, which continue to enroll 800,000 members, especially labor union members and retirees. As the Blue Cross plan for western Pennsylvania and the Blue Shield plan for the entire state, Highmark also maintains a broad PPO network to support the national accounts that use the BlueCard program, based on relationships with Blue plans in other states. This network, called Premier, imposes credentialing requirements and extracts modest contractual discounts from providers in exchange for participation. The core of Highmark's commercial and Medicare products, however, is the Keystone network, which was designed to support the HMO product when that was viewed as the future of U.S. health insurance. As consumers and purchasers chafed under network exclusions and limited access to referrals, Highmark expanded the Keystone network as the basis for POS, PPO, and, most recently, Direct Access (no primary care gatekeeper) HMO products.

A single, broad (Keystone) network and uniformly rich benefit coverage left Highmark without a low-premium product able to compete on price with narrow-network entrants into the commercial insurance market. U.S. Healthcare entered Pittsburgh vigorously in the 1990s and was followed by a variety of hospital-based HMOs, each attacking the price-sensitive end of the market. The principal hospital systems, including Allegheny and the University of Pittsburgh Medical Center (UPMC), began to acquire erstwhile hospital competitors and threaten to counter Highmark's market dominance with their own. An ill-fated expansion into Philadelphia knocked the wind out of the Allegheny system, but UPMC developed into an impressive conglomerate of tertiary medical centers, community facilities, outpatient diagnostic and treatment centers, specialty physician services, and primary care practices.[15] UPMC owns seventeen of the eighty hospitals in western Pennsylvania, including two of three AMCs and three of the five principal community hospitals in Pittsburgh. When Highmark decided to launch a narrow-network insurance product, to be labeled Community Blue, it approached UPMC to ascertain whether the system would be willing to discount its rates in exchange for serving as the network core of the new product. The UPMC system had not merged to-

gether to discount rates, however, and Highmark was left to build its new network without the region's most prominent hospital system. UPMC then began to vigorously promote its own HMO product, with a narrow network built around its affiliated hospitals and physicians, in the commercial market.

Highmark's Community Blue network is the reverse image of many insurance networks in offering broad choice of physicians but constrained choice of hospitals. It includes almost all of the region's physicians, with the exception of those who have admitting privileges only at nonnetwork (for example, UPMC) facilities. Highmark has built multiple insurance products, including HMO, POS, and Direct Access HMO, on the Community Blue network chassis. Physicians are paid at the same rate for enrollees in both Keystone and Community Blue network-based products, but the hospitals that participate in the Community network are paid at lower rates for those products than for Keystone products. The premiums charged for HMO, POS, and Direct Access products are approximately 10 percent lower on the Community Blue network than on the Keystone network.

"The emerging insurance designs represent a second-generation initiative to encourage cost-conscious consumer choice."

Highmark is approaching, or has passed, the limit on product diversity and administrative complexity. It offers three Community Blue products (HMO, POS, Direct Access), four Keystone products (HMO, POS, PPO, Direct Access), multiple Medicare products (Medicare HMO and Direct Access on the Keystone network; MediGap on PAR), a variety of indemnity products on the PAR network, plus the national BlueCard product (PPO, with POS under development by the BlueCross BlueShield Association) on the Premier network. Regulatory strictures prevent a blurring of the distinction between indemnity and PPO products, on the one hand, and HMO and POS (for example, gatekeeper) products on the other. Highmark recently signed a ten-year contract with UPMC, ensuring participation and rate predictability for the Keystone network-based products. UPMC continues to be excluded from the products based on the Community Blue network, however, so that Highmark can maintain a low-cost and hence low-premium market position for those products.

■ **WellPoint Health Networks.** WellPoint is one of nation's largest health plans, with 6.6 million enrollees in California, where it does business under the Blue Cross brand, and another 6.4 million in other states under various Blue Cross, Blue Shield, Unicare, and Healthlink brands.[16] Although it offers a range of insurance products across all customer segments, WellPoint's enrollment and expertise traditionally has been concentrated in the cost-sensitive individual, small-group, and midsize-firm markets. The firm has emphasized broad-network PPO products with substantial consumer cost sharing, running against the conventional California wisdom that the future belongs to narrow-network HMO products with rich benefit coverage. After experimenting with fixed-dollar copayments, WellPoint has reemphasized percentage coinsurance for most services in its PPOs and for many services in its HMOs. WellPoint historically has had a contentious relationship with health care providers in California because of its aggressive rate negotiations and has endured major confrontations as the hospitals have consolidated into nonprofit and for-profit chains. Recent years have witnessed highly publicized contract terminations that have forced consumers to switch physicians or insurers. Two years ago WellPoint launched an initiative to improve relationships with medical groups, hospital systems, and individual physicians and hospitals.

The combination of coinsurance-based PPO products and a corporate initiative to improve provider relationships induced WellPoint to be the last to climb on and the first to jump off the train toward tiered hospital net-

works. Tiered networks have been criticized by low-cost facilities that fear being labeled as low quality, by high-cost facilities that fear being labeled as inefficient, and by hospital association leaders averse to any cost transparency for the industry. Of more practical importance, the benefit designs developed by WellPoint already expose consumers to considerable cost differences among hospitals. Whereas tiering permits only two levels of consumer copayment, deductibles and coinsurance tailor each consumer's financial responsibility to each hospital's payment rate and service intensity, which together determine cost per admission. After announcing the development of a tiered hospital network in California, WellPoint pulled back and restricted itself to publicizing relative cost rankings for each hospital, which are especially relevant for enrollees facing percentage coinsurance provisions, on its consumer Web site.

The reliance on coinsurance and deductibles to sensitize patients to the cost implications of their choices is even more evident in WellPoint's products designed for the individual market, the principal sector of health care where the consumer is the direct purchaser. WellPoint features five low-premium PPOs, five moderate-premium PPOs, and two high-premium HMOs. The economical options include a PPO with a $5,000 deductible, 30 percent coinsurance for physician and hospital services, a $1,000 copayment plus 30 percent coinsurance for maternity services, and 30 percent coinsurance for most ancillary services; a PPO with $500 deductible and 20 percent coinsurance for hospital services, plus a separate $5,000 deductible for nonhospital services; and a PPO with a $1,000 deductible, 20 percent coinsurance for hospital services, and no coverage for physician office visits. Moderate-price products include a PPO with a $1,000 deductible, 30 percent coinsurance for hospital services, and 30 percent coinsurance for physician visits; and an HMO with a $1,500 deductible, no coinsurance, and $10 office visit copayments. The highest-price product is a conventional HMO with modest copayments and no deductible. Monthly premiums vary by more than 500 percent from the thin-benefit PPO at the low end to the thick-benefit HMO at the high end. An analogous variety of coinsurance-based benefit designs also is marketed in the small-group segment.

The range of product (HMO, PPO), premium (high, medium, low), and cost-sharing (high, medium, low) options offered by WellPoint is matched to the large and diverse California marketplace, where the firm is the largest and fastest-growing insurer in the commercial and Medicaid sectors. Nevertheless, there is a substantial segment of the population that would prefer to hold down their premiums by accepting a narrow provider network rather than by paying high deductibles and coinsurance. This consumer segment is enrolled largely in Kaiser Permanente, which offers a narrow but well-integrated provider network and imposes only modest cost sharing. WellPoint is considering a narrow, low-cost provider network, drawing on subsets of its commercial and Medicaid networks, to support a new generation of HMO and PPO products that offer rich benefits but limited choice of providers.

Challenges And Opportunities

■ **Uncertain effectiveness of financial incentives.** The emerging insurance designs represent a second-generation initiative to encourage cost-conscious consumer choice at the time of seeking care, moving beyond uniform copayments that do not differentiate among high- and low-cost providers. There exists no evidence to date on how substantial the copayment and coinsurance rates need to be before a sizable number of patients factor price into their hospital choices. Modest cost differences across tiers and networks will be unlikely to precipitate the same changes in behavior produced by tiered pharmaceutical benefits. Unlike generic and brand-name drugs, both of which are available in the same pharmacy, low- and high-cost hospitals may lie at considerable distances from one another. Moreover, many patients rely on their physician to select the hospital, and physicians typically base institutional affiliations and admis-

sions on factors other than cost to the patient. Most importantly, hospitals are multiproduct firms that may be efficient and high-quality providers of some forms of care but inefficient, low-quality providers of others. Tiering of multiproduct hospital organizations rather than of individual hospital services is analogous to tiering of multiproduct pharmaceutical manufacturers rather than of individual pharmaceutical products.

Although the contemporary experiments are likely to exert only modest effects on consumers' choices in the short term, they may have important implications for how the nation balances the costs and benefits of hospital services over the long term. Hospitals now are raising their prices to rebuild balance sheets depleted by the Medicare cutbacks in the Balanced Budget Act (BBA) of 1997, to cover escalating nursing labor and inpatient drug costs, and to finance investments in clinical and information technologies. These are all worthy purposes. Resources are not infinite, however, and the inevitably difficult social trade-offs will be made more effectively if citizens are given incentives and information when making health-related choices.

■ **The role of quality in network design.** Any tiering of hospitals according to cost should be accompanied by information and incentives concerning the quality of care to be obtained in neighboring facilities. Health care lacks reliable comparative data on the quality of care, partly because of the inherent heterogeneity of patients, conditions, and treatments, but also because of the historical dominance of providers over patients in making health care choices. Some patients remain attached to the paternalistic tradition, but others are embracing a more active role in their own care. The health care system is pursuing a wide range of efforts to develop and disseminate better measures of quality. Once the data exist, they can be used not only by patients but also by physicians, purchasers, regulators, and hospital managers themselves. The new network designs increase the demand for facility-specific information on cost and quality, as patients will need to satisfy themselves that lower price does not imply lower performance, and hence mirror efforts to increase the supply of such information. To be effective, incentives need to be combined with information, but information also needs to be combined with incentives.

Quality information can be combined with financial incentives in many ways. Quality could be embedded in the criteria for allocating facilities across tiers, as envisaged by Blue Shield of California. Alternatively, high-quality but high-cost facilities could accept their designation as premium institutions, expensive but worth the added expense. Tufts Health Plan has encountered only minimal resistance from hospitals that were assigned to the high-cost tertiary care tier, as none wanted to be labeled a community organization in a metropolis of AMCs. Nontiered benefit designs favor low-quality, high-cost hospitals, since they can obtain the same payment rates as those with similar quality but lower costs or with similar costs but higher quality. In contrast, tiered designs favor high-quality, low-cost hospitals, as they can attract patients at the expense of high-cost alternatives. The implications of tiered benefits for low-quality, low-cost hospitals and for high-quality, high-cost hospitals are less evident. If good information on quality differences were available, tiering would permit the former to compete for the budget-conscious consumer and the latter to command a premium price for premium service. In well-functioning markets outside the health care sector, there typically exists a range of products with different price and quality characteristics; low-quality offerings survive if they charge low prices and high-quality offerings command high rates. Only in malfunctioning markets, such as those in health care, is there neither a business case for economy nor one for quality.

■ **Individual incentives and social equity.** Tiered network designs inevitably raise concerns over access to high-quality care for low-income citizens. Much of the attention devoted by the journalistic media to network tiers evokes imagery of poor patients who might have chosen a high-quality but high-

cost hospital being induced to settle for a low-quality, albeit low-cost, alternative. In reality, nontiered hospital networks do not subsidize the poor at the expense of the rich. Low-quality hospitals are not typically to be found in high-income neighborhoods, and well-heeled consumers do not drive across town to seek them out. Rather, low-quality hospitals are likely to be located in low-income communities and be used by the citizens who live nearby. In the absence of tiered networks, low-income consumers face the same copayments as do their wealthier counterparts across town. If society wished to equalize health care opportunities, it could supplement tiered network designs with MSAs or other financial subsidies for low-income citizens. Banning network tiers merely forces some enrollees to pay average prices for low-cost care while permitting others to pay average prices for high-cost care.

Some of the price variation among hospitals is due to differences in case-mix severity, medical education, and provision of uncompensated care. Cost-based tiering will tend to shift admissions toward facilities with lower average patient acuity, less involvement in medical education, and fewer uninsured patients. Hospitals historically have relied on implicit subsidies among patients and forms of care, which permit them to pursue their social missions but impede attempts to compare the efficiency by which particular services are provided by particular institutions. It is far from obvious that low-acuity patients should be treated in high-cost AMCs geared toward treating the most severe conditions. The Tufts approach to network tiering explicitly seeks to encourage patients who do not need the specialized services of teaching hospitals to obtain their care from community institutions, analogous to its efforts to have primary care services be obtained from primary care physicians rather than from specialists.

The logic of the marketplace is to flush out implicit subsidies by permitting consumers who are being charged more than cost to switch to services priced at cost. This transparency has the virtue of forcing a reevaluation of implicit subsidies, many of which turn out to favor particularly powerful constituencies rather than particularly needy patients. Explicit subsidies tend to work better than implicit subsidies that are not open to outside examination. Nevertheless, it often is difficult to make the transition to explicit subsidies, and the undermining of implicit subsidies then leads to even more arcane financial transfers or to the elimination of subsidies altogether. Without adequate direct funding for medical education and care for the uninsured, aggressive consumer incentives to avoid high-cost hospitals will generate a political backlash.

The Limits Of Network Design

Network tiers, multiple-network products, and the reversion to coinsurance in health insurance benefits are responses to the cost variation among hospitals, which in turn is driven by consolidation and the reduction in excess capacity. To be effective, tiered products require multiple independent facilities within reasonable travel distance as the basis for cost-conscious consumer choice. The hospital cost problem is most acute, however, in precisely the urban cartel and rural markets that lack those characteristics. Tiering may be most effective in fragmented markets such as Los Angeles, where it is least needed, and least effective in consolidated markets, such as Sacramento, where it is most needed.

The limits on network innovations are severe even in competitive hospital markets, since the main cost drivers are new drugs, clinical equipment, information technologies, labor shortages, and regulatory requirements, which affect all hospitals in an area with approximately equal force. Tiered hospital benefits can stop growth in these costs no more effectively than tiered pharmacy benefits can halt spending on newly available pharmaceutical and biotechnology products. In this sense, tiered benefits offer no more than one-time savings, thereby following numerous public and private initiatives that moderated but did not master the inflationary gradient.[17] The temporary nature of any savings to be had from the recent experiments in network design is

not, however, a conclusive argument against them. In fact, there exists no conclusive solution to health care cost inflation, reflecting as it does new technological opportunities and rising consumer expectations.[18] All that public and private initiatives can expect to achieve is a never-ending series of one-time savings, steps backward on the upward escalator, that allow the citizenry to spend at least some of its money on something besides medicine.

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NOTES

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