Tiered Hospital Plans

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Insurers look at new ways of holding down rising health insurance costs. One such approach is called tiered hospital plans. According to the BLS Employment Cost Index, employer health care costs rose 11.4 percent between June 2001 and June 2002. This compares with a 4.0-percent rise between June 1998 and June 1999. With such rising health care costs in recent years, insurers are looking at alternative ways of designing health plans. One such recent alternative, *tiered hospital plans*, has attempted to hold down hospital costs. In fact, the tiered approach to hospital charges is not really "new" because it is modeled on tiered drug plans. Under tiered drug plans, enrollees pay different amounts per prescription based on the cost of the drug. The individual pays less for lower cost generic drugs than for higher cost brand-name drugs. A similar concept applies to tiered hospital plans.

Under the tiered hospital programs, the insurer groups together hospitals based on their cost of care. The hospitals would then be categorized, for example, as "lower tiered" and "higher tiered." The enrollees would be required to pay more for the higher tiered hospitals. For example, individuals might have to pay $50 per day in lower tiered hospitals and $200 a day in higher tiered hospitals. A tiered program may also operate by having the insurer pay 80 or 90 percent in a low-cost hospital and 60 or 70 percent in a more expensive hospital. In addition, the more expensive hospital may also require the enrollees to pay a specific dollar amount per day.

The concept of tiered hospital programs is different from preferred provider organizations (PPOs). Under the tiered approach, the insurer and the hospital negotiate the cost levels at the hospital. The insurer then determines the benefit provisions for hospitalization based on the cost level of the specific hospital. The insurer will designate hospitals as lower tiered and higher tiered. There may be additional tiered options predicated on the cost of the hospital. All of the hospitals are still within the insured network, but the coverage will differ based on the expense of the hospital. For PPOs, on the other hand, insurers and hospitals negotiate together the benefit provisions of hospital care. Coverages for PPOs will differ based on whether the enrollee uses an in-network hospital or an out-of-network hospital.

Tiered hospital plans first became popular in California when PacifiCare and Blue Shield of California launched programs early in 2002. Other health insurers, including Health Net and Blue Cross of California also introduced tiered plans during 2002. PacifiCare first instituted their program in January 2002 by offering it to the mid-size and larger employers. Under the plan, members can use a "Select Hospital" or another hospital within PacifiCare's network. If the members choose a Select Hospital, hospitalization benefits are paid in full; if they go to another hospital, they must pay $100, $250, or $400 per hospitalization, depending on the hospital's cost.[1]

The main criticism leveled at tiered programs thus far comes from some hospital officials, who say the tiered approach emphasizes cost savings without regard to both the quality of and scope of services provided in the hospital.[2] They fear that charging enrollees in the plan a higher amount for the more expensive hospitals may lead some individuals to ignore potentially better hospitals in terms of quality and breadth of services for the sake of lower cost. "To get the highest quality," says Jan Emerson, speaking for the California Healthcare Association, which represents hospitals throughout the State, "you sometimes have to get the costliest services." Ms. Emerson then goes on to say that "new systems that improve quality aren't coming cheap and those prices are reflected in rates that hospitals charge health plans."[3]

Recently, Blue Shield of California announced that starting October 2002, quality measures and patient experiences would be used as factors in determining how their tiered hospital program works. "Adding quality and patient experience data will help educate our members on how to make the right decisions concerning their own health care, and will continue to reinforce our hospitals partners' commitment to quality care," says Eric Brook, chief medical officer at Blue Shield.[4]

Current Data Capture

The BLS National Compensation Survey no longer identifies plan types--PPOs, HMOs, traditional fee-for-service plans. Instead, health plans are categorized by the type of funding arrangement--indemnity and prepaid. The survey has three questions on restrictions imposed on enrollees. The first question asks whether the plan restricts the providers an enrollee may see. The next question asks whether the enrollee can go outside of the network of providers at a higher cost, for plans that do restrict providers. The third question describes the medical services that would be provided at a better benefit if the enrollee stayed within the network.

Tiered hospital options can be part of either a prepaid or indemnity plan. Currently, most tiered hospital programs are part of prepaid plans. Such programs would be identified as restricting providers and allowing enrollees to go outside the network for hospital room and board benefits.

Under both prepaid and indemnity plans, the enrollee would receive better benefits by selecting the lower tiered hospitals rather than the more expensive hospitals. For data capture, the current policy is to classify prepaid plans with a tiered hospital product as allowing enrollees to obtain care outside the plan network. Such plans are referred to as *prepaid plans with a point-of-service option*. An indemnity plan with a tiered option would be classified as restricting providers and allowing enrollees to receive better benefits if they stay within the network. In prior surveys, this type of plan was designated as a PPO.

Future Data Capture

Tiered hospital programs can be considered both a new kind of "hybrid plan" and a managed-care feature. The goal of tiered plans is to help keep hospital costs down and to allow consumers to choose among various hospitals within the insured network on the basis of cost. In other words, tiered programs give the enrollees the option of determining whether or not they want to pay more for higher cost hospitals. Tiered hospital products are part of prepaid or indemnity plans.

If tiered hospital plans become more prominent in the future, BLS can identify these features among other managed-care features within the plan. Like tiered drug plans described earlier, tiered hospital programs focus on just one medical service and therefore are not of themselves a type of a plan. Adding a question to identify tiered hospital programs as a managed-care feature would allow BLS to report on the prevalence of these features separately, independent of the type of plan.

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Notes

1 For more information on this topic, see PacifiCare News Release, November 1, 2001; also, John Carroll, "Hospital Copayments: At What Cost," *Managed Care*, May 2002, on the Internet at http://www.managedcaremag.com/archives/0205/0205.tiers.html (visited August 22, 2002); and Johanna Bennett, "Insurers Push Higher Copayments For Treatment At Pricey Hospitals," *Wall Street Journal Online*, June 6, 2002, on the Interent at http://www.legacyalliance.net/inthenews.html (visited September 2, 2002).

2 For more information on this topic, see Lisa Rapaport, "CalPERS Eyes Tiered Rates: More Expensive Hospitals Would Cost Patients More," *The Sacramento Bee Online*, August 17, 2002, on the Internet at http://www.sacbee.com/content/business/story/4016543p-5042009c.html (visited September 23, 2002); also, John Carroll, "Hospital Copayments."

3 John Carroll, "Hospital Copayments."

4 "Blue Shield Factors Quality Measures Into Tiered Plans," *Employee Benefit News*, September 10, 2002, on the Internet at http://www.benefitnews.com/detail.cfm?id=3443 (visited September 11, 2002).