The Erosion Of Health Insurance: The Unintended Consequences Of Tiered Products By Health Plans

Hospital tiering could have unintended consequences for the health of the public—and the health of our fragile health care system.

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ABSTRACT: When properly structured, consumer-driven health care may provide gains to both patients and the delivery system. However, the current approach by health plans could result in real harm to patients and to an already fragile health care delivery system. While health plans are presenting tiered products as a necessary mechanism to control rising hospital expenditures, this paper explores the real drivers of the rising cost of health care, including utilization, increased demand for advanced medication, and new technology. Left unchecked, such benefit designs could have dangerous public policy implications and consequences, including the further erosion of the basic tenets of health insurance.

The paper by James Robinson describes the contemporary redesign of health insurance networks, as well as the theory and rationale behind the introduction of new product designs by health plans. In doing so, it suggests that such products add value to health care purchasing decisions, improve access to health care, and provide useful information to consumers. Although there is much to be gained from consumer-driven health care, which when properly structured may act as a useful tool to control health care spending, the underlying assumptions, rationale, and implementation of these products are seriously flawed. The implications of the current approach by health plans could result in real harm to the chronically ill and patients who require costly acute treatment, and to our fragile health care delivery system.

For this commentary I use hospital network tiers to illustrate the broader concerns about these products; similar problems exist with other consumer-driven benefit designs. First, hospital tiering is presented to the public as a necessary response to rising hospital spending, as if the increases were being driven by the hospital industry itself. In reality, hospitals are the point in the delivery system at which the real, powerful drivers of the rising cost of health care are being played out most visibly. For example, nearly two-thirds of the increase in 2001 hospital costs is attributed to increased utilization and intensity of services as a result of the aging population, increased demand for advanced medications, and new technology. Further, the structural shortages of qualified personnel, additional administra-
tive costs for hospitals and health plans associated with the current system, and the rising cost of meeting government regulations are also reflected in higher spending for hospital services.2

Second, hospital tiering begins with the assumption that products produced by various hospitals are largely the same (as is the basis for pharmaceutical tiering) and that differences in costs among hospitals are largely attributable to their relative efficiency in producing the same product. Nothing could be further from the truth. Health plans may argue that unless there is a measured difference in quality, they should not pay more for the same clinical service at inherently more expensive hospitals, such as academic medical centers (AMCs). However, these assumptions ignore the real drivers in the differences in costs between hospitals that are determined by factors beyond the narrow issue of efficiency of care. In fact, institutions that are higher in overall cost may be more efficient and effective in treating patients.

Real Drivers Of Health Care Costs

The following factors delineate the real determinants in the differences in costs among hospitals, ordered by the degree of impact on the cost structure of a hospital.

■ Organizational mission. The first factor is the question of the organization’s mission. Is the hospital engaged in teaching and research activities, and to what degree? AMCs create technological breakthroughs, train future physicians and caregivers, and conduct research to identify breakthrough treatments and more cost-effective ways to treat disease. Even among AMCs, hospital-based costs for academic and research operations vary considerably by the source and amount of funding, including whether such payments are from government or private sources.

■ Services offered. The second factor is the volume, scope, and depth of services offered. The broader and greater the array and volume of high-complexity, high-cost, technologically advanced services, the greater the organization’s overall cost structure. Also, the greater the volume and scope of community benefit activities, such as free/partial payment clinics and trauma services, the greater the overall costs.

■ Public-pay patients. The third factor is the number of Medicare and Medi-Cal patients treated by an organization. To the extent possible, institutions absorb underpayments for treating government patients as part of their community benefit mission, along with free and partially paid care. The shortfall in government payments is reflected in part in the payments negotiated for commercially insured patients.

■ Practice style. The fourth factor is the medical practice style in the institution, which drives such factors as length-of-stay and use of ancillary services, including the use of highly sophisticated treatments, devices, and medications, which may be more costly but are also more effective.

Only after adjusting for all of the factors above does one begin to address differences in the relative efficiency, effectiveness, and coordination of care during a hospital stay. Although differences in costs among hospitals do exist, they are usually associated with differences in the organizations’ missions, or the type and mix of services offered. Thus, relative efficiency has little impact on cost differences among hospitals.

■ Capital. Other factors, such as depreciation related to capital expenditures, also have a sizable impact on the differences in costs among hospitals. Where an organization is in its capital replacement cycle to maintain facilities and equipment will be reflected in the hospital’s cost structure, and ultimately its payments negotiated with health plans.

■ Profit. The final factor affecting health cost differences among hospitals may be the level of operating profit generated by the facility, which will vary from year to year.

For all of the reasons listed above, tiered hospital products, even within peer groups, are flawed, given the variation in these and other key factors. Proponents of tiered benefit designs argue that these new products are required for plans to gain bargaining power over
selected institutions. Yet the health plans cannot demonstrate that the market leverage of these institutions play a major role in driving up the cost of health care, especially when compared with other factors previously discussed. Additionally, there is no meaningful discussion regarding the key fact that most commercial health plans are public companies driven to maximize returns to shareholders.\(^3\) However, the vast majority of hospitals that provide care in California are nonprofit or government-sponsored institutions driven by a community service and public benefit mission.

**The Health Care System At Risk**

The current approach by health plans in fact places the health care delivery system at great risk. Today more than half of the hospitals in California are losing money on operations. Notwithstanding the expressed concerns about the market leverage of certain institutions, the few “successful” hospitals have operating margins of no more than 3–4 percent. Further, most hospitals are not generating enough cash to meet their current capital needs, replace facilities and equipment, and meet seismic retrofit requirements.

The unintended consequences of tiered hospital benefit designs are too great. The health care delivery system is a complex web of interdependent public, private, teaching, and community hospitals reflecting decades of policy decisions intended to fund vital public programs such as indigent care, medical education, and research. The current payment system reflects a patchwork of pricing mechanisms as health care financing policy has evolved. In short, the introduction of tiering into hospital–health plan pricing represents a form of price manipulation in one segment of the market without due consideration to the existing cross-subsidies and interdependencies between the private and public sectors that are assumed or demanded of our current delivery system.

Finally and most importantly, there is no justification for putting patients in the middle of such a major public policy issue regarding health care financing. Patients now face the difficult choice of having their provider (doctor or hospital) relationship interrupted or bearing an economically and socially unfounded financial penalty. Through the introduction of these health benefit plans, the private sector is inappropriately making important public health policy decisions without public awareness or participation.

**The Quality Of Quality Information**

In addition to the flawed assumptions behind tiered products, the practice of disseminating so-called quality information associated with value purchasing is also unsound. Under the guise of providing consumers with information about hospital quality, many health plans are developing quality rating services. Purchasers and providers should be as concerned about the quality of quality information as they are about the quality of medical care. Instead of the current approach by health plans to create and disseminate their own proprietary sets of questionable quality indicators, all stakeholders should demand the development of an agreed-upon set of meaningful quality measures for use by private and public payers throughout the health care system. Rather than placing precious resources in additional administrative costs associated with the hodgepodge of measures, these pooled resources could be redirected to actually improve the quality of care and the quality of information given to consumers.

**The Future Left Unchecked**

Without intervention, the current benefit designs pose unintended, harmful conse-
quences to the system, including the disruption of patient care and higher costs to providers and payers alike. The following are likely consequences of the current environment.

Hospitals will adjust and decrease prices for consumer-sensitive services, such as outpatient care. Nevertheless, because the total cost of operating these facilities will not be reduced, inpatient prices will increase at a greater rate. At the same time, the number of ambulatory, boutique, and specialty hospitals will increase, eroding the presence of commercially insured patients in the hospital setting. These specialty hospitals often crop up when market opportunities arise to “carve out” selected specialty services, which are financially lucrative under the current payment systems. Such specialty hospitals will price their services below those of full-service hospitals. The specialty facilities will add new fixed costs to the system and exacerbate industry salary inflation as a result of the structural personnel shortages. Given the private ownership structure of the new facilities, there will be little incentive to examine the appropriateness of care being rendered, which is commonly recognized as the most effective way to control health care costs. Use of health care services will likely increase, particularly among commercially insured patients. Concurrently, health plans will realize even greater hospital costs as hospitals struggle to offset an increasing percentage of underfunded government-paid patients.

In response, health plans will apply the actuarial consequences of these forces to their insurance products, resulting in several troubling implications for individuals, purchasers, and national public health policy. Total health care costs will rise even further, but for all of the wrong reasons. People with chronic diseases, those who choose to receive their care in an AMC, and those who require complex and costly care will be required to pay much more out of pocket for all of the wrong reasons. This will also contribute to the further erosion of health insurance as we know it, resulting in the swift, predictable, and legitimate response by the public.

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NOTES
2. Ironically, another implication of consumer-driven health plans for all hospitals will be additional administrative expenses. As hospitals move from operating in the wholesale model of insurance of the past to the underinsured retail model of the future, there will be the additional admitting, billing, collection, and bad-debt costs.
3. Notable exceptions are Kaiser Permanente and Blue Shield.