

**“AMERICAN MEDICINE AND ITS PATIENTS PUT COLLECTIVELY AT RISK:
IMPLICATIONS FROM TIERED BENEFIT PRODUCTS”**

Tiered benefit products place a greater share of the healthcare dollar, and more responsibility for healthcare decisions, on consumers.

Tiered benefit plans have the potential to produce major changes in whether, when, from whom, and at what price patients access healthcare.

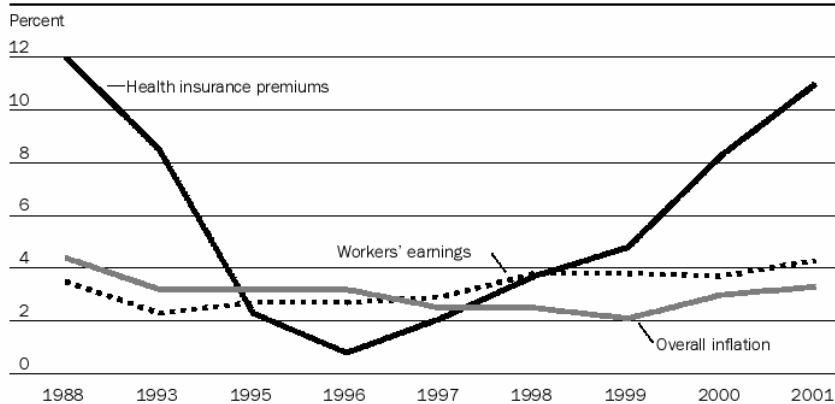
Tiered benefit products will be advantageous for some health systems and academic medical centers, and disadvantageous for others.

There are steps that can be taken to evaluate the impact of tiered benefit products and respond to new market dynamics.

PROBLEM DEFINITION

The average increase in healthcare premiums charged to America’s employers has risen since 1996 and exceeded 11% in 2001. Premium increases are predicted to average 15% in 2002. While increases of this magnitude might be acceptable, they are certainly not sustainable.

Health Insurance Premium Increases Compared With Other Indicators, 1988-2001



SOURCES: Kaiser/Health Research and Educational Trust (HRET) Survey of Employer-Sponsored Health Benefits, 1999, 2000, 2001; KPMG Survey of Employer-Sponsored Health Benefits, 1988, 1993, 1995, 1996, 1997, and 1998-2001; and Bureau of Labor Statistics, 2001.
NOTES: Estimate is statistically different from the previous year for 1997-1998, 1998-1999, 1999-2000, and 2000-2001 ($p < .05$). No tests were done on years prior to 1997 or for workers' earnings or overall inflation. Sample included firms with 200 or more workers only.

EXPLOSION IN TIERED PRODUCTS

Employers and purchasers are pursuing strategies to influence health plans and regain control of runaway healthcare costs. Tiered benefit products were timidly rolled out in a few selected markets in 2001 with mixed results, but are now growing very rapidly in

many markets throughout the country. Based on a survey of national health plans by BDC Advisors, LLC:

- All health plans surveyed believe that something has to be done to address double-digit premium increases and rising medical costs
- 90% believe that hospitals still have costs that can be reduced
- 70% are working on product designs that shift an increasing portion of the healthcare dollar onto members
- 70% indicate they are working on product designs that will expose hospital costs (“cost transparent”), and link increasing member costs to the use of higher cost hospitals (“consumer-directed”)

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TIERED BENEFIT DESIGN

There are four principal ingredients in tiered benefit plans:

- *Tiered prescription benefits*, which are not a new concept;
- *Tiered hospital benefits*, where patients are charged significant co-pays for accessing more expensive hospitals (e.g. several hundred dollars per inpatient day) or ambulatory centers (e.g. \$25 to \$100 per clinic visit or per procedure);
- *Tiered physician benefits*, where patients are charged significant co-pays for accessing physicians believed to be more expensive than his or her peers; and
- *Tiered employee fringe benefit accounts*, where patients are invited to accept a fixed amount of cash, place it in a medical savings account, and spend it on healthcare or other benefits. Unspent balances are paid to the employee, in exchange for being at risk for paying excess costs and/or delaying diagnosis or treatment.

MARKET OBSERVATIONS

Although their introduction is early in most markets, there are emerging lessons about tiered benefit products.

- *Lower market premiums.* If health plan enrollees currently have access to most physicians and hospitals through most health plans in a market, tiered co-pays require consumers to limit their own access or pay more. As a result, these products are often being priced below prevailing HMO products in order to attract enrollment. This serves to lower the dollars available to physicians and hospitals in the market overall.

- *Drop in primary care visits.* We are observing major falloffs in primary care visits within tiered benefit products. Not surprisingly, tiered fringe benefit accounts are particularly popular with those employees who have enjoyed relatively good health.
- *Discounting.* Health plans may give higher-cost hospitals the opportunity to reduce their rates in order to change their position among tiers which further erodes physician and hospital reimbursement long-term.
- *Steerage.* The success of these products is predicated on their ability to both pull patients (i.e., using the tiered co-pay) and push patients (i.e., medical management) into lower cost hospitals. Medical management and incentives among providers need to be clearly delineated.
- *Performance / benefit dichotomy.* Tiered benefit plans seem to only work in markets where there is excess capacity for the benefits being tiered. For example, lower-cost hospitals should benefit from increased patient volume under these products. If these hospitals are at capacity, however, volume is unlikely to move to them.

IMPLICATIONS

There are many implications from tiered-benefit products on health systems and academic medical centers.

- *Evaluation.* If a health system is lucky enough to have “strategic indispensability”, or if the local market lacks excess capacity, an organization may be able to refuse participation in tiered benefit plans. In our opinion, this is a dangerous strategy for all but a few health systems and academic medical centers.
- *Market structure and product participation.* Health systems may have the ability to alter their approach to participation in the market. A strategy should be developed which addresses shifting financing mechanisms and managing product offerings and participation.
- *Competition and customer expectations.* Health systems will need to work harder to attract and retain customers to the extent that health plans emphasize choice and access. Health systems will need to do a better job of understanding customer expectations and expanding consumer-directed technologies.
- *Health system optimization.* Organizations should reconsider how best to use your system’s member hospitals and ambulatory centers by type of illness, type of payor, overhead structure, and other criteria; and how best to deploy physicians by studying their cost per illness, use of ancillaries, and prescribing habits.
- *Focus on quality.* Health systems and academic medical centers should bolster all quality programs and further increase patient satisfaction.
- *Co-payment and collections procedures.* With a greater share of the healthcare dollar being collected at the time of procedures, health systems will need to

- upgrade their co-payment and collections procedures in outpatient and inpatient settings.
- *Union and healthcare leadership campaigns.* Health systems may want to lobby with unions in opposition to tiered benefit product designs. Unions are often vehemently opposed to these kinds of products which are viewed as a reduction in benefits.

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BDC Advisors, LLC would be pleased to assist you and your organization with an analysis of tiered products in your marketplace, how your organization is positioned, and what can be done to optimize your performance. If you should have any questions, please contact Richard E. Wesslund, Managing Director at (415) 247-1030.