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HEALTH INSURANCE

Management Strategies Used by Large Employers to Control Costs





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**Health, Education, and
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The Honorable James M. Jeffords
Chairman, Committee on Labor and
Human Resources
United States Senate

Dear Mr. Chairman:

At your request, this report examines the strategies of large, innovative purchasers who have attempted to stem the rapid escalation in health insurance costs while maintaining or enhancing the quality of care for their employees. A better understanding of the strategies and tools adopted by such purchasers should assist the Congress in reforming public health insurance programs and in identifying potential areas for coordinated approaches by government and private sector purchasers.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will make copies available to interested parties on request.

If you or your staff have any questions, please call me at (202) 512-7114. Major contributors to this report are listed in appendix V.

Sincerely yours,

A handwritten signature in cursive script that reads 'William J. Scanlon'.

William J. Scanlon
Director, Health Financing and
Systems Issues

Executive Summary

Purpose

After several years of double-digit increases in the cost of employee health insurance, the nation's larger firms, employer coalitions, and even state governments entered the 1990s with an aggressive approach to rein in employee health insurance costs. The recent downturn in health insurance premium growth—in which some large employers actually experienced premium declines—is attributable, at least in part, to some of these efforts. Spending pressures in public programs like Medicare and Medicaid also slowed, though not as markedly as for most private purchasers.

A better understanding of the strategies and tools adopted by large, innovative purchasers should assist the Congress in reforming public health insurance programs and in identifying potential areas for coordinated approaches by government and the private sector. For this reason, the Chairman of the Senate Committee on Labor and Human Resources asked GAO to examine the strategies of large purchasers that have attempted to (1) stem the rapid escalation in health insurance costs and, at the same time, (2) maintain or enhance the quality of care for their employees. The sample included 25 private firms, purchasing coalitions, and state governments. (App. I contains details about the sample.)

Background

Employers have an important stake in the cost, structure, and quality of their employee health benefit programs. Private business expenditures for health services—dominated by health insurance premiums for workers—now account for more than 5 percent of total employee compensation compared with about 2 percent in 1970. Clearly, the incentive for constraining the growth in health care costs has intensified over the past few decades. Moreover, employers recognize the pivotal role that health benefits play in attracting and retaining employees and in maintaining productivity. More recently, this mixture of cost and workforce concerns led employers to advocate health care delivery systems with better-integrated care and to play a more active role in managing their health benefit programs.

Results in Brief

Several dominant themes emerged from GAO's examination of the health benefit purchasing strategies of 25 large purchasers: (1) an emphasis on the delivery of services by better-integrated managed care plans; (2) a focus on measuring and improving the quality of the services provided; (3) a transition to the sharing of costs, responsibility, and information with employees; and (4) a greater reliance on competitive market principles. Large purchasers use their size and/or reputations—which gives them

flexibility—to fashion health care purchasing strategies responsive to their own needs. Some choose to adopt strategies that respond to specific differences in the structure of health plans or employee characteristics at their various locations across the country. Others choose a more uniform approach at all or most of their key locations. Flexibility with regard to timing permits some large purchasers to choose between a radical but quick transformation or the adoption of a more gradual transition. Strategies are also fashioned to respond to constraints such as unions or contract rules and strengths like a younger, healthier workforce or market presence in terms of a large number of employees at a particular location.

The size of a workforce in a specific market can translate into market leverage. Large purchasers do not hesitate to use their market power to make demands of potential health insurers or to influence provider behavior. Among the requirements that a large purchaser can establish are that health plans justify and substantiate premiums, submit performance and quality data, and offer broad provider networks. While market leverage is not necessarily viewed as the most important or only dimension of a health care purchasing strategy by large purchasers, they recognize that their size makes a broader range of specific tools available in formulating their overall strategy.

The specific tools used by large purchasers in implementing their strategies vary considerably but fall within three broad categories: (1) health plan evaluation criteria, including techniques to assess premiums and foster competition among plans; (2) incentives to sway employee behavior; and (3) overt marketing strategies to influence employees' choice of delivery systems and of specific plans. By no means is there unanimity on the use of evaluation criteria. Many large purchasers GAO interviewed recognize the shortcomings of the cost, quality, and access criteria that have been developed so far. Despite their shortcomings, these criteria are of growing importance: first, they provide purchasers with data that can be used to persuade often skeptical employees about the quality of the health plans offered; second, the criteria require competing health plans to demonstrate to equally skeptical purchasers that managed care is indeed a cost-effective choice.

Most purchasers are convinced that providing an incentive for employees to be cost-conscious in their selection of plans and use of health care is a key component of an effective purchasing strategy. They also recognize that lower copayments and deductibles coupled with a richer set of benefits are probably insufficient incentives in terms of achieving

significant increases in the number of employees who choose a managed care option. Directly tying the employee's share of the premium to the cost of a health plan can become a much more powerful incentive for employee choice and insurer behavior when the differences are large enough to affect market share. For the purchasers in GAO's sample, however, introducing effective and reasonable financial incentives was perhaps the most difficult aspect of implementing a proactive purchasing strategy. Factors that limited purchasers' flexibility in this regard included unions or the corporate culture's perspective on employee cost-sharing.

Principal Findings

Purchaser Flexibility Is Key to Evolution of Effective Health Care Purchasing Strategies

Large employers have made dramatic changes in the way they purchase health insurance. These changes, as well as the variations in the approaches taken, are a testament to the flexibility of the private sector—a characteristic that state governments appear to share. Some large employers have ceased to offer a fee-for-service indemnity product or have significantly increased the share of premium for employees who insist on greater freedom in choosing their own doctor, the hallmark of such a health plan. Others have substituted point-of-service (POS) plans that resemble a health maintenance organization (HMO), but also allow access to other providers outside of the HMO network. POS plans are seen by some purchasers as a way to transition employees from the substantially free choice of indemnity coverage to the more restrictive world of HMOs. Most employers have become selective about the HMOs they offer and are focusing greater attention on persuading employees that such health plans are a smart choice. Often employers' decisions about the type and mix of options are influenced by the differences in the markets where they purchase coverage or in the characteristics of their workforces. An employer's freedom to change the number and mix of health plans, however, is not without constraint. For example, unions and corporate culture can undermine the consistency among the elements of a firm's purchasing strategy.

Market Leverage Is a Useful, Though Not Essential, Component of Market Strategies

Size can translate into influence and leverage in the marketplace. However, the market power of large private sector employers is often exaggerated. While a purchaser may be able to exert leverage over health plans in a few local markets because of a relative concentration of

workers, the number of employees and covered lives often masks the geographic fragmentation of the workforce. For example, one firm GAO interviewed has approximately 250,000 employees eligible for benefits who are distributed across 19,000 zip codes. The largest number of employees in any one location is only about 5,000. Such fragmentation was sometimes accentuated by allowing different divisions of a corporation to purchase HMO coverage separately. To enhance their leverage, some firms have formed purchasing coalitions, reduced the number of plans offered, consolidated HMO purchasing at a central office, and relied on their national reputations to attract health plans. In markets with little managed care penetration and a relatively small number of employees, some firms choose not to devote resources to developing an effective purchasing strategy. The number of employees simply does not justify the effort and cost involved. States as purchasers of health care, on the other hand, have substantial buying power. For several years, the California Public Employees' Retirement System has used the market power of the state and local governments' almost 1 million covered lives to demand HMO rate reductions.

Purchasing Criteria Used to Justify and Limit Number of HMO Options

In the past, many large employers offered a choice between a standard company indemnity product and a variety of HMOs. Some firms told GAO that HMOs were selected without any specific criteria or coordination on a company-wide basis. Nor were HMOs held accountable for actually managing care, the presumptive benefit of such a delivery system. Moreover, since employers were not advocating HMOs, choice and quality were not major issues with their employees in selecting participating plans. Today, many large firms have established criteria to help them decide with which HMOs to contract. Generally, the effect of these criteria is to limit the number of HMOs offered. For example, some firms require that an HMO seek accreditation from the National Committee for Quality Assurance and be able to report data on customer satisfaction and service delivery. However, employers suggested that measures of quality are imperfect at best and require some subjective judgment. Most have pointed out the need to develop a consistent set of outcome-oriented measures.

For many firms, a key criterion in selecting HMOs is cost. While the debate continues over the degree to which large employers' contracting decisions are or should be influenced by cost, there is general agreement that enhancing competition is key in a health care system that looks increasingly to managed care to help moderate premium growth. In the

past, rather than obtaining HMO premiums through marketplace competition, large firms were frequently price takers—that is, they often paid the “sticker price” rather than shopping for a lower or the best price. HMOs practiced shadow pricing, that is, they simply tracked the costs of alternative plans and set the rates slightly lower to retain a competitive edge. Though often less expensive than indemnity coverage, HMOs had little incentive to keep prices down.

Today, most firms use a variety of techniques to obtain the best price possible from HMOs. Plans are asked to submit sealed premium bids with the understanding that not all bids will be accepted and that justification of and negotiation over increases is to be expected. Health plan bids are carefully scrutinized and analyzed, sometimes with the assistance of outside consultants. Employers recognize, however, that it is difficult to determine the true cost incurred by managed care plans because of inadequacies in the data currently available from such plans. During negotiations, plans are often informed of their standing relative to competing plans and of the impact of a proposed premium increase on the employee contribution. While purchasers stress that giving employees an incentive to be cost-conscious in selecting a health plan fosters a competitive framework, they do not believe that the resulting competition reduces the importance of or eliminates the need to negotiate.

Access objectives, a final criterion used by many purchasers to select HMOs, may actually work at cross-purposes with the goal of selecting the most cost-efficient or highest-quality plans. Employers recognize that very broad networks affording the greatest choice of physicians are generally not the most efficient and may lack the management features that are the purported hallmark of a managed care delivery system. Because of the limited availability of managed care in some markets, particularly rural areas where a managed care option may not even exist, some employers continue to offer indemnity-type products.

Financial Incentives and Information Used to Advocate HMO Enrollment

Purchasers also phased in or incorporated financial incentives to encourage employees to transition from high- to lower-cost products. Relatively few of the purchasers in GAO’s sample have tied their contribution to a low-cost HMO, requiring the employee to pay the difference for a higher-cost alternative. Most employers fall somewhere in between the adoption of a low-cost formula and one that provides no incentive to be cost-conscious. Whatever the formula, however, purchasers generally now ask employees to contribute more to the cost of

coverage, particularly for those who choose an indemnity option. On the other hand, a few firms use incentives to encourage employees to enroll in the indemnity plan if demographics suggested a lower use of health care services. Such firms contend that HMOs can be more expensive for healthy workers because under capitation, services must be paid for even if they are never used.

Because union agreements or corporate culture may impede the use of such financial incentives and because of what purchasers referred to as a constant stream of negative publicity ranging from gag rules to maternity stays, information on the advantages of managed care has assumed even more importance in influencing employee health benefit decisions. Firms have become advocates for managed care by stressing the differences between indemnity and managed care products—no claim forms, better preventive care services, increased continuity and coordination of care, and lower out-of-pocket costs. Before implementing its current managed care strategy, one firm only provided the names and phone numbers of available HMOs. Now this firm provides considerable information to employees on HMOs and, in fact, emphasizes HMOs in its open enrollment literature. During open enrollment, some purchasers now routinely provide comparative information on the managed care plans they offer, including (1) basic information on the network such as size, participating hospitals, and percentage of physicians accepting new patients; (2) the results of customer satisfaction surveys; and (3) data on the delivery of preventive services such as immunization or mammography screening rates. As reflected by the prominence of such data in the information provided to employees, access is the single most important issue for employees.

Recommendations

GAO is making no recommendations in this report.

Comments From Purchasers

The purchasers in our sample commented on a draft of this report. They generally agreed with our presentation of the information and our observations. They also provided technical suggestions, which we incorporated where appropriate.

Contents

Executive Summary		2
Chapter 1		10
Introduction	What Is an “Active” Purchasing Strategy?	10
	Active Purchasing Shaped by Employee Perspective	11
	Managed Care Comes in Many Varieties	12
	Transition From Payers to Purchasers	16
	Objectives, Scope, and Methodology	17
Chapter 2		20
Flexibility and Leverage: Attributes of Large Private and Public Purchasers	Flexibility: The Foundation of an Active Purchasing Strategy	20
	Importance of Market Leverage Often Overstated	29
Chapter 3		33
Purchasers Use Evaluation Criteria to Pursue Price, Quality, and Access Goals	Tension Between Need for and Adequacy of Evaluation Tools	33
	Price: Tools Used to Evaluate Premiums and Enhance Competition	34
	Quality: Some Employers Hesitant About Using Quality Criteria	48
	Access: Employers Accommodate Employee Concerns About Choice	52
	Application of Criteria Varies	54
Chapter 4		57
Plan Options, Incentives, and Marketing Used to Sway Employee Behavior	Evolution in Employee Benefit Options	58
	Developing Financial Incentives Poses Challenges for Purchasers	61
	Firms Try Marketing to Overcome Resistance to Managed Care	70
Chapter 5		74
Observations	Advocacy of Managed Care	74
	Competitive Market Principles	74
	Influencing Employee Behavior	76
	Common Elements, Yet Diversity of Approaches	76

Appendixes	<p>Appendix I: Characteristics of Purchasers in GAO Sample 78</p> <p>Appendix II: Background on HEDIS and NCQA Accreditation 80</p> <p>Appendix III: Summary of Southern California Edison Performance Measures 82</p> <p>Appendix IV: Changes in HMO Enrollment, Plan Options, and Financial Incentives 83</p>
Major Contributors to This Report	86
Tables	<p>Table 1.1: Employer-Employee Perspectives on Managed Care 12</p> <p>Table 4.1: HMO Enrollment for Purchasers in GAO Sample Before and After Changing Purchasing Strategy 57</p> <p>Table 4.2: Health Care Options Available 59</p> <p>Table 4.3: Hypothetical Firm-Employee Contribution Options 62</p> <p>Table 4.4: Financial Incentives Adopted by Purchasers 63</p> <p>Table I.1: Characteristics of Private Firms 78</p> <p>Table I.2: Characteristics of Private Purchasing Coalitions 79</p> <p>Table I.3: Characteristics of State Government Programs 79</p> <p>Table II.1: Status of NCQA Accreditation Reviews as of December 1996 81</p>
Figures	<p>Figure 1.1: Change in Employer-Sponsored Managed Care Enrollment From 1987 to 1996 13</p> <p>Figure 1.2: Spectrum of Health Care Plans 14</p>

Abbreviations

BHCAG	Buyers' Health Care Action Group
CalPERS	California Public Employees' Retirement System
HEDIS	Health Plan Employer Data and Information Set
HIPC	Health Insurance Plan of California
HMO	health maintenance organization
IPA	independent practice association
NCQA	National Committee for Quality Assurance
OSC	organized system of care
PBGH	Pacific Business Group on Health
PCP	primary care physician
POS	point-of-service
PPO	preferred provider organization
RFP	request for proposal

Introduction

Large private sector purchasers we interviewed suggest that the double-digit increases in the cost of health insurance common just a few years ago have been controlled considerably in the last 2 years—a development they attribute, at least in part, to their more active management of employee health benefit costs. Virtually every study of health care cost trends since 1990 corroborates the dramatic slowdown in health care inflation. For example, surveys of private employers reported 1995 increases of 2.1 percent and 1996 increases ranging from 2.5 percent to only .5 percent.¹ According to a Peat Marwick survey, health maintenance organization (HMO) premiums experienced the least fluctuation, growing by only four-tenths of a percent in 1995 and followed by a decrease of the same magnitude the next year. It was the second straight year, the survey reported, that the rate of increase in premiums was less than the growth in three key indicators: (1) overall inflation, (2) inflation in the health care sector, and (3) growth in workers' earnings.² Moreover, some large purchasers have reported HMO premium decreases for several years. While Medicare and Medicaid have also experienced a slowing of cost growth, these public programs have not been as successful as the private sector in subduing program cost growth. What remains uncertain is whether this tempering of the rate of health care inflation is a short-lived aberration or is due, at least in part, to tangible changes in the way private and some state purchasers shop for and offer health benefits to employees.

In order to understand how changes in health benefit purchasing strategies have contributed to cost control, we examined the experience of a group of 25 large health insurance purchasers—private firms, purchasing coalitions, and state governments. Many of these entities have opted for an approach to purchasing that demands more analysis on the part of the buyer. They have developed and applied criteria in a competitive environment to assist them in the selection of health plans. Finally, they have restructured their benefit programs to encourage employees to choose less expensive or more efficient health care options.

What Is an “Active” Purchasing Strategy?

The approach adopted by some large employers can be characterized as an “active” purchasing strategy. It is a systematic way of identifying and offering a mix of health care options that meet a purchaser's expectations

¹Foster Higgins and KPMG Peat Marwick conduct annual surveys of employer-sponsored health benefits. The former includes both large and small employers from the private and public sectors (more than 10 employees), while the latter focuses on firms with 200 or more workers.

²Inflation is measured by the Consumer Price Index.

in terms of access, quality, and price. Large purchasers use different terms to describe what is essentially a similar approach. For some, the concept of a “purchasing strategy” is synonymous with “managed care”—a delivery system that some believe has the potential to be more efficient than traditional, noncoordinated indemnity coverage. Others describe their strategies as “managed competition,”³ a blending of the competitive and regulatory approaches that have coexisted for many years in the U.S. health care system. Traditional economic theory suggests that market forces are capable of promoting efficiency and responsiveness. To advocates of this strategy, however, managed competition connotes a needed rationalization of the health care marketplace intended to encourage cost-consciousness on the part of both health plans and employees. Finally, some describe their purchasing strategy as “competitive” or “market-oriented,” that is, harnessing choice among plans vying for market share to promote greater efficiency in the delivery of health care. Whatever the terminology, these purchasing strategies have one point in common—active intervention on the part of buyers to encourage the development and acceptance of more cost-effective health care delivery systems. Two natural attributes of the large purchasers in our sample assisted their transition to active purchasing: (1) the flexibility to adapt their benefit programs to individual markets and other circumstances and (2) the ability to harness the market leverage conveyed by their size.

Active Purchasing Shaped by Employee Perspective

An integral component of an active purchasing strategy is responsiveness to employee concerns about managed care. Benefit managers we interviewed believe that this delivery system offers the best value for the benefit dollar. They also recognize that workers are generally skeptical about managed care and about the motivation for adopting a benefit management strategy that professes the compatibility between efficiency,

³The economist Alain Enthoven proposed “managed competition” as a way of addressing recognized flaws in the health insurance market, a market in which purchasers lack the data necessary to make informed decisions and in which health plans have an incentive to avoid enrolling sicker and more costly individuals. His concept advocates the establishment of sponsors, sometimes referred to as health insurance cooperatives or purchasing coalitions, to act as buying agents for participating firms and individuals in each market area. Just as most large employers do today, the cooperative would enforce the participation rules for both enrollees and health plans. The rules would include guaranteed access, risk-adjustment of premiums, community rating, and standardized benefits/coinsurance. Enrollees would be offered a variety of health plans that compete not only on price but also in terms of quality. Thus, the cooperative would be responsible for distributing standardized quality and outcomes data on participating plans. Enrollees could choose any plan during an annual open season, but to encourage price sensitivity, an employer’s contribution toward premiums would be limited to the cost of the lowest-price health plan. Enthoven and others have refined and rearticulated the concept since it was first introduced in the late 1980s. Without embracing Enthoven’s entire construct, some large purchasers have adopted important elements of his managed competition theory.

as reflected in lower premiums, and quality. Employees, we were told, are usually aware of the cost issues underlying employer decisions about health benefits. Moreover, purchasers cited the constant barrage of negative publicity as a reinforcer of employee anxiety about managed care—publicity that one benefit manager described as focusing on single anecdotes to characterize the total picture. The negative publicity often suggests that managed care

- promotes efficiency by denying needed services and
- impinges on the doctor-patient relationship.

Table 1.1 characterizes the different viewpoints that sample employers and their employees bring to the issue of managed care.

Table 1.1: Employer-Employee Perspectives on Managed Care

	Employer perspective	Employee perspective
Choice	Choice means choice of a plan or a delivery system.	Choice means “I can continue to see my current doctor.”
Quality	A delivery system that actually manages care is more likely to result in an efficient and high-quality product.	Quality resides in ability of employee to shop freely for the “best” provider; restrictions inherent in managed care are a threat to quality.
Price	Most cost-effective delivery system may be one that limits choice; low cost may reflect greater efficiency rather than poor quality.	Managed care sometimes saves money by rationing services; employees are skeptical that lower cost equates to higher quality.

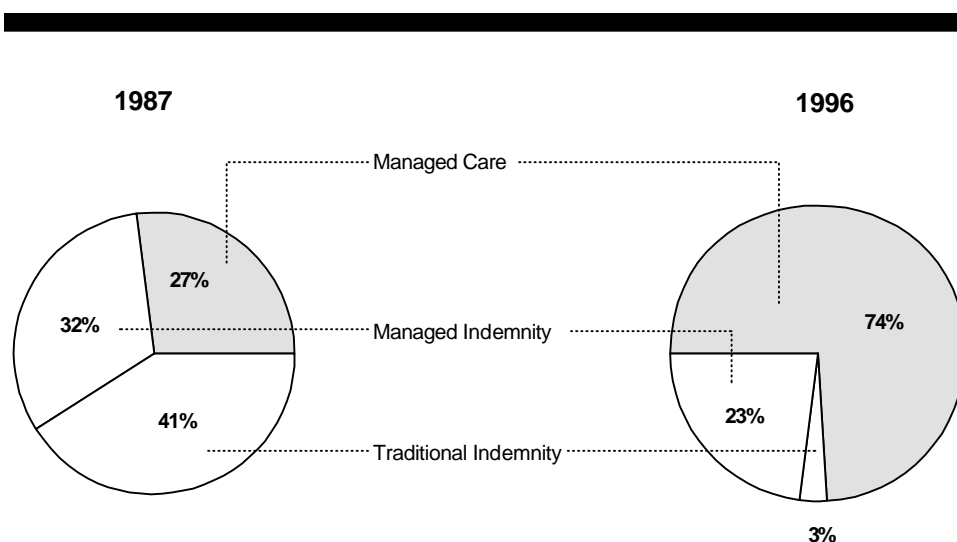
These differing perspectives have helped shape the benefit management strategies adopted by the employers in our sample. Though they remain convinced that managed care has the potential to deliver higher quality at a lower price, purchasers understand the employee retention value of competitive health benefits. They recognize the need to implement changes in ways that maintain good employee relations, protect their ability to recruit workers, and enhance productivity. The attempt by purchasers to respond to concerns about limited choice and poor quality are evident in (1) the articulation of criteria designed to help evaluate health plans, (2) the mix of plans actually offered to employees, and (3) the marketing strategies used to address negative employee perceptions about managed care.

Managed Care Comes in Many Varieties

Because of the different types of managed care plans available to employers, managed care is perhaps most clearly defined by its opposite,

traditional indemnity coverage. In contrast with managed care, traditional indemnity coverage allows a free choice of providers and reimburses physicians and hospitals with limited or no review of the appropriateness of the services rendered.⁴ On the basis of a 1996 survey of health benefits offered by firms with 200 or more workers, only 3 percent of employees are enrolled in such a traditional indemnity program. Another 23 percent are in managed indemnity plans that require precertification for inpatient services and other forms of utilization controls. And the remaining three-quarters are enrolled in a variety of managed care plans, including (1) several different types of HMOs, (2) preferred provider organizations (PPO), and (3) point-of-service (POS) plans.⁵ The rise in managed care enrollment has been swift. Figure 1.1 shows that since the late 1980s, managed care enrollment has nearly tripled.⁶

Figure 1.1: Change in Employer-Sponsored Managed Care Enrollment From 1987 to 1996



Despite the variety of managed care plans, most include one or more of the following common cost-control features: (1) physician and hospital networks with explicit criteria for inclusion, (2) alternative payment methods and rates that often shift some financial risk to providers, and

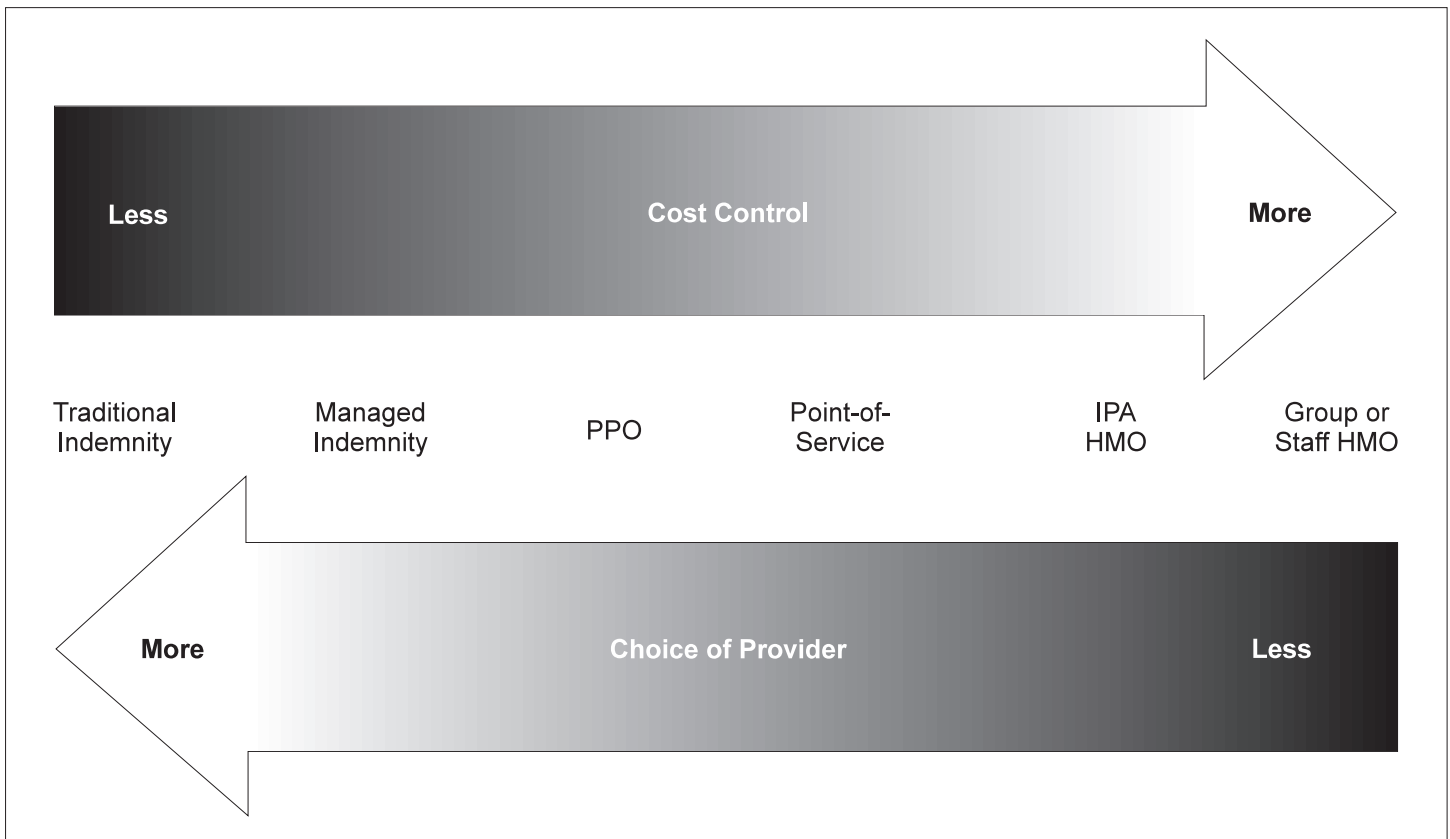
⁴Another characteristic of traditional indemnity coverage is its use of the fee-for-service payment mechanism to reimburse providers. Fee-for-service is also used in PPOs and to some extent in POS and HMO plans. For example, an HMO may pay fee-for-service for some highly specialized procedures.

⁵KPMG Peat Marwick, *Health Benefits in 1996* (Vienna, Va.: Oct. 1996).

⁶1987 employer survey conducted by the Health Insurance Association of America.

(3) utilization controls over hospital and specialist physician services.⁷ A managed care plan's potential for savings depends on the stringency of its cost-control features. In general, HMOs tend to use more stringent controls than PPO or POS plans (see fig. 1.2). However, there is variation within the different types of managed care plans, and as a result, some HMOs have weaker controls than PPO or POS plans.

Figure 1.2: Spectrum of Health Care Plans



⁷For a description of the evolution and use of the term managed care, see *Managed Health Care: Effect on Employers' Costs Difficult to Measure* (GAO/HRD-94-3, Oct. 19, 1993). The traditional distinctions among managed care plans are becoming outmoded as plans rapidly evolve in response to marketplace demands. For example, Kaiser, a group-model HMO, now offers a POS product in certain markets and sometimes contracts with non-Kaiser hospitals. Moreover, the broadening of HMO provider networks in some markets is contributing to a blurring of the difference between some HMOs and PPOs.

- **HMO:** There are several types of HMOs. Staff- and group-model HMOs are the most tightly controlled managed care plans. The former hires physicians directly, while the latter contracts with one or more large physician group practices. Most physicians serve HMO enrollees exclusively, often practicing in clinics owned by the plan. Physicians are either paid a salary or a fixed amount per enrollee, a practice referred to as capitation, for providing comprehensive health services. A patient's care, especially referrals to specialists and hospitalization, is typically coordinated by a primary care physician. A third type of HMO, the independent practice association (IPA), consists of networks of individual physicians that also serve non-network patients covered by other insurance. Typically, IPAs contract with a large number of physicians, and their enrollees represent only a small portion of each physician's practice. As a result, IPAs generally have less leverage over physicians' use of services than do staff or group model HMOs. About as many IPA model HMOs reimburse their primary care physicians under a fee-for-service payment schedule as use capitation. By 1996, about 33 percent of insured employees were enrolled in HMOs.⁸
- **PPO:** To compete with and provide an alternative to HMOs, insurers and employers began offering PPOs during the early 1980s. PPOs retain many elements of indemnity coverage but provide enrollees a financial incentive—lower cost-sharing (copayments)—to receive care from a network of providers that are normally reimbursed at a discounted fee-for-service rate. PPOs vary in the size of their networks and in whether they employ a gatekeeper—a physician who controls referrals to specialists. By 1996, about 26 percent of insured employees were enrolled in PPOs.⁹
- **POS:** POS plans are a hybrid combining features commonly associated with HMOs, PPOs, and, in some instances, indemnity coverage. As denoted by the term, the condition under which medical services are provided is determined by the enrollee each time care is sought. The HMO option often includes a gatekeeper. The PPO option has higher cost-sharing but a larger network of providers. Some POS plans even have a third option—free choice of providers with the employee responsible for paying an even larger share of the cost. By 1996, about 16 percent of insured employees were enrolled in POS plans.¹⁰

⁸KPMG Peat Marwick, p. 23.

⁹KPMG Peat Marwick, p. 23.

¹⁰KPMG Peat Marwick, p. 23.

Although the United States has had network-based managed care plans since the 1940s,¹¹ much of the growth and development of such plans has occurred more recently. During the 1980s, sharply rising health care costs encouraged rapid HMO enrollment growth and the emergence of new types of managed care plans, including PPOS and POS plans. The most rapid growth in managed care enrollment has been in IPA-model HMOs, PPOS, and POS plans. Enrollment in staff- and group-model HMOs, the managed care plans that most experts consider to have the greatest potential to control cost growth, has been relatively flat since the late 1980s.

Transition From Payers to Purchasers

In the past, large purchasers offered only indemnity coverage—the pinnacle in terms of enrollee freedom of choice—and, at the time, the solitary option for firms choosing to provide health insurance as an employee benefit. Several factors contributed to the decision by purchasers to add a managed care option if an HMO was available. First, federal legislation enacted in 1973 required employers who provided health benefits, paid the minimum wage, and had 25 or more workers to offer a federally qualified HMO if one was available in the employer’s geographic area.¹² Second, employers in some markets found that HMO costs were somewhat lower than the costs of their traditional indemnity plans. Third, in some markets with higher managed care penetration, workers asked for HMO options. As noted earlier, other types of managed care plans were subsequently developed with employer encouragement as alternatives to HMOs.

By the 1980s, some firms offered a dozen or more HMOs, especially in markets like California’s. They believed that offering a large number would contribute to price competition that would in turn stimulate greater efficiency. Purchasers assumed that a broad choice of HMOs would also serve as an inducement for employees to enroll.¹³ Purchasers in our sample acknowledged, however, that they lacked a systematic approach to or criteria for evaluating and selecting HMOs. Some firms did not even

¹¹Kaiser-Permanente, a group-model HMO, began in California, Washington, and Oregon in 1942.

¹²The HMO Act of 1973, P.L. 93-222. To be federally qualified, an HMO was required to provide comprehensive benefits, community-rated premiums, and an annual open enrollment period. Subsequently, these requirements were amended to provide federally qualified HMOs with additional rating flexibility. The HMO requirement was designed to promote the growth of such plans as a way of improving the capacity and efficiency of the health care system. This law was repealed effective October 24, 1995 (see P.L. 100-517, sec. 7(b)).

¹³James C. Robinson, “Health Care Purchasing and Market Changes in California,” *Health Affairs*, Vol. 14, No. 4 (1995), pp. 119-20.

coordinate their purchasing, resulting in a lack of consistency across the company. Moreover, since firms were not advocating HMOs, choice and quality were not major issues with their employees in selecting participating plans. Managed care was simply seen as an additional option that saved some money and expanded employees' choice. The only selection criteria noted during our interviews were price and expressions of employee interest in joining a specific HMO.

Between 1970 and 1990, employer expenditures on health benefits climbed from 2 to 5.2 percent of total compensation and was still growing. Moreover, by the late 1980s, employers were experiencing double-digit growth in indemnity premiums. While HMOs in developed markets were somewhat less expensive than indemnity coverage, their premium increases mirrored indemnity cost growth. Because of shadow pricing—the practice of pegging premiums to just below the cost of alternative plans—switching to an HMO might result in initial, one-time savings followed by rapidly growing health care costs in future years, although the premiums would be somewhat lower than those for indemnity coverage. The combination of spiraling indemnity costs coupled with HMO shadow pricing contributed to the widespread belief that a different approach to selecting and offering HMOs was needed. The advent of this active purchasing strategy coincided with a period of increased competition among HMOs for market share.

Objectives, Scope, and Methodology

To better understand how large, innovative purchasers have redesigned their health benefit strategies to foster cost control, the Chairman, Senate Committee on Labor and Human Resources, asked us to examine (1) the design features of purchasing strategies that encourage price competition among health plans, (2) the influence of different health care markets on those strategies, (3) the efforts by purchasers to ensure that quality is not sacrificed in order to achieve cost-containment, and (4) the incentives used to encourage enrollment in less expensive or more efficient health care options. We focused on large purchasers because they are credited with helping to slow down the rate of health care inflation and with increasing health plan accountability. Moreover, their experience is frequently cited as an alternative for reforming publicly funded health benefit programs such as Medicare or Medicaid. We believe that a clear and objective understanding of the cost-control strategies of large purchasers will be useful to policymakers in assessing reform proposals.

The Washington Business Group on Health helped us identify large, innovative purchasers of health care from different sectors of industry. The firms selected (1) operate in a number of different states and (2) offer workers a choice of different types of health plans. In addition to firms recommended by the Washington Business Group, we identified others through a literature review and made selections with the goal of obtaining adequate geographic representation. Predicated on earlier work, we also included a number of recognized private sector purchasing coalitions in our sample; these coalitions, with the pooled resources of member firms, have significant purchasing power in some major markets.¹⁴ Finally, we selected several innovative public purchasers—government agencies that are responsible for managing the health benefits of state employees; county, municipal, and other public employees; and sometimes other groups. State purchasers often surpass the private sector in terms of purchasing leverage and are second only to the federal government in their ability to influence the evolution of health care delivery in the United States. Our sample is judgmental and was not intended to be representative of the health care purchasing activities of large employers, coalitions, or state governments. However, we believe that the selection criteria enabled us to capture the experience of a group of purchasers that has the most direct relevance to policymakers seeking to reform Medicare or other publicly funded health insurance programs.

In total, we visited and collected data on the health benefit management strategies of 15 firms, 4 coalitions, and 6 state government agencies.¹⁵ Appendix I identifies the purchasers we interviewed and their approximate size in terms of employees eligible for health benefits (in the case of firms) and covered lives (in the case of the coalitions and state purchasers). Using a standard interview protocol, we met with the health benefit manager or other appropriate staff for each purchaser to gain insights on the evolution of its management strategy. In addition, we examined pertinent material relating to each purchaser's health benefit program, such as requests for proposal, published performance standards, employee benefit handbooks, annual open enrollment material, and report cards on HMO performance provided to employees.

¹⁴Access to Health Insurance: Public and Private Employers' Experience With Purchasing Cooperatives (GAO/HEHS-94-142, May 31, 1994).

¹⁵One of the firms in our sample, Mervyn's, is a division of another employer we interviewed, Dayton Hudson. Although they were not formally a part of our sample, we included pertinent information on the Medicaid purchasing strategies of Arizona and Florida, two state governments that have incorporated competitive market principals into their programs.

We also provided a draft of this report to the purchasers in our sample, who generally agreed with our presentation of the information and our observations. They provided us with technical suggestions, which we incorporated where appropriate. Our review was conducted between January and December 1996 in accordance with generally accepted government auditing standards.

Flexibility and Leverage: Attributes of Large Private and Public Purchasers

Propelled by the dramatic rise in the cost of providing health coverage, the large firms and state governments in our sample have (1) revamped their benefit programs and (2) placed greater emphasis on managed care in the mix of health plans they offer to employees. While their particular situations varied considerably, these purchasers shared two natural attributes that played a key role in their transformation from passive payers to active purchasers of managed care products: flexibility and leverage. These attributes have served as a foundation for launching benefit management strategies aimed at increasing the accountability of managed care plans for the cost and quality of the services they deliver.

Benefit managers we spoke with stressed the value of flexibility in developing and implementing an effective health benefit management strategy. The term flexibility conveys a mix of nimbleness, latitude, and adaptability in that a purchaser is able to (1) incrementally or suddenly change the mix and type of health plan options, (2) create employee incentives within its benefit system, and (3) implement a strategy either uniformly or differently in the various markets in which it operates. In our sample, the private sector demonstrated the broadest flexibility. That flexibility, however, is not without bounds. On the other hand, the state purchasers we interviewed appear to have more flexibility than that normally associated with the public sector, a latitude some have used to fashion innovative health benefit strategies.

Leverage is a concept that may be more easily described than flexibility, but in our sample, it was less clearly demonstrated. Also called “market power,” it relates to a purchaser’s ability by virtue of size or reputation to exert anticompetitive pressure on health plans to obtain a desired outcome. Large purchasers can also take advantage of the economies of scale conveyed by their size, a factor that should translate into lower administrative costs for operating their benefit programs. While private firms demonstrated the value of their size, it was not something they were able to exercise on their own in many locations. In contrast, state governments in our sample seldom had to rely on purchasing coalitions to establish or augment their already considerable market power.

Flexibility: The Foundation of an Active Purchasing Strategy

Purchasers we interviewed believe that flexibility is key to revamping both the way they purchase managed care products and the operation of their benefit programs. The variation in the approaches taken reflects the ability of large purchasers to make changes where and when they believe it is appropriate. Such flexibility, however, did not always translate into

wholesale, dramatic changes. Instead, flexibility allowed firms to make changes that were either incremental or limited by geographic, organizational, and even demographic boundaries. While flexibility is generally assumed to be an inherent private sector trait, the firms in our sample were not always completely free to exercise it. These firms were constrained by a variety of factors, such as labor agreements; paternalistic corporate cultures that limit the extent of employee cost-sharing; or a disinclination to alienate employees skeptical about managed care, especially those plans with a more limited choice of providers.

**Flexibility Permits
Dramatic Change, but
Some Purchasers Choose
Incremental Strategy**

Many purchasers in our sample have redesigned their health benefit programs to encourage employee migration into managed care plans. Some employers made significant changes over relatively short time frames, such as introducing new delivery systems or altering the components within an existing system, such as incentive structures. In some cases, the purchaser believed rapid change was necessary because of its own poor financial performance or that of its self-funded indemnity plan; others made changes in response to what they viewed as failures in the local health insurance marketplace. Some purchasers, however, chose to implement changes incrementally, recognizing that they could not implement a managed care strategy overnight.

In 1989, Southern California Edison abandoned its fee-for-service indemnity health plan and embarked on a well-publicized new strategy involving considerable infrastructure investment. Edison established a PPO wholly owned and managed by the company. Just 6 years later, Edison discontinued the PPO plan and turned over the operation of its network of clinics to a medical group. The PPO was replaced with a self-insured POS option and some HMOs. Several state governments in our sample also made rapid and dramatic changes in their health benefit programs. Both Wisconsin and Missouri adopted a managed competition system in 1983 and 1994, respectively. In Wisconsin, the impetus was the imminent bankruptcy of the state's self-funded indemnity plan; the Missouri change was prompted by a series of deficits in its indemnity option. In both states, the employee contribution for indemnity coverage jumped considerably with the introduction of a contribution formula based on the lowest-cost plan. The result was a dramatic increase in HMO enrollment. Private sector firms we interviewed have also relied on financial incentives to encourage migration to more efficient/lower-cost plans. Over the course of a year, one firm eliminated the subsidy for its indemnity plan, which, along with utilization-based increases, resulted in more than a 250-percent increase in

the cost of the employee contribution. This change contributed to a significant drop in the number of employees opting for indemnity coverage and an increase in HMO enrollment from about 30 percent to 60 percent. This firm plans to eliminate the indemnity option in 1997 in areas where no POS plan is available.

The structure of a particular market can also encourage large purchasers to make dramatic changes. Concern over consolidation, overlap in networks, and shadow pricing by managed care plans in the Minneapolis health care market led the Buyers' Health Care Action Group (BHCAG), a purchasing coalition, to make a significant change.¹⁶ BHCAG decentralized the management of care for its members by dropping the PPO model originally offered in 1992 and contracting with 15 individual "care systems"—groups made up of medical practices, clinics, and hospitals. Enrollment in the new care systems began in January 1997. With this new approach, BHCAG members essentially contract directly with providers. Moreover, for the purposes of the BHCAG contracts only, the primary care physicians are locked into exclusive arrangements with one care system. This new approach represents a major change in the administration of benefits and the focus of control for the actual management of care but allows the employees of BHCAG firms to continue with their current providers almost undisturbed. Although the primary reason state health insurance purchasing agencies have joined private coalitions is to participate in their quality initiatives, the Minnesota Department of Employee Relations—the state's health benefit administrator—is exploring the possibility with its unions of offering the BHCAG care systems to state employees by 1999. The state's consideration of joint purchasing through BHCAG appears to be motivated by a shared concern over marketplace consolidation.

While many purchasers in our sample want employees to migrate into HMOs, some recognized that they could not implement such a dramatic change overnight. Instead, they chose to make incremental changes to their health benefit programs. Some of these employers told us that they viewed POS plans as a bridge between traditional indemnity coverage and an HMO. (POS plans are essentially HMOs that offer an out-of-network option.) Employers hope that the POS option will allow employees to become familiar and comfortable with managed care, leading to eventual enrollment in an HMO. The incentives—lower copayments, no deductible, and lower limits on out-of-pocket expenses—are designed to attract employees to the HMO network while still offering employees the option,

¹⁶BHCAG has 24 employer members and began joint purchasing in 1992.

albeit a more expensive one, of broader physician choice. One firm that implemented a POS option reported that out-of-network services only accounted for about 10 percent of total plan costs. Surveys, we were told, have shown that most firms implementing a POS plan have had a similar experience. A benefit manager suggested that unlimited choice is frequently desired but infrequently used when accompanied by a higher price tag.

Some firms are deliberately phasing in their managed care strategy. Avoiding use of the term HMO, one purchaser is slowly introducing what it referred to as the next generation of managed care plan.¹⁷ To date, it has only identified nine plans with the potential to meet its criteria for information systems and care management. In many markets, even some with mature HMOS, no such plans are available. Over the long term, however, this purchaser hopes to be able to offer “next-generation” plans to all employees. During the transition, the firm continues to rely on its self-funded PPO as well as existing HMOS to cover the majority of its workers. Another firm has phased in HMOS in four states where such plans already enjoy a relatively high degree of acceptance. This firm plans to add HMOS in other states as managed care capacity in these markets matures.

Regardless of the nature or pace of change, the private firms in our sample often use their innate flexibility to advocate specific delivery systems and occasionally even individual health plans that they believe offer the best value. While some avoided any direct endorsement of a plan, they do provide considerably more information about favored plans than about others that they also offer. One firm developed and implemented a substantial internal marketing strategy to dispel what it believed to be myths about managed care and to encourage employees to enroll in one of the available HMOS.

Flexibility Permits Adaptation to Market Realities and Other Factors

To many of the firms in our sample, flexibility also means being able to adapt the benefit strategy to market conditions and to treat specific groups of employees differently. Such differentiation makes it possible to focus management resources in areas with large concentrations of employees—and where a firm spends a large percentage of its benefit dollars. Differences may also stem from a firm’s decision to manage benefits by division rather than centralizing administrative functions in a single benefit staff. Finally, in some cases, the differentiation takes

¹⁷See cg. 3 for a more detailed description of what this purchaser refers to as organized systems of care.

advantage of a perceived variation in the cost of covering certain demographic groups.

Market conditions often leave a clearly identifiable mark on the benefit strategy of a large purchaser. California purchasers told us that currently there is heightened competition among a large number of undifferentiated managed care plans with broad overlapping networks. This provider overlap led one coalition we interviewed to characterize the state's HMO products as "commodities." Convinced that there is excess capacity and inefficiency in the managed care delivery system, the Pacific Business Group on Health (PBGH), a coalition of 33 West Coast employers, continues to pressure HMOs to lower prices and to justify any increases with demonstrable quality and service improvements. Minnesota, on the other hand, has experienced considerable market consolidation over the past several years. Only four plans control over 80 percent of the market. Managed care plans, we were told, are aggressively buying physician practices. As described above, this apparent march toward monopoly led BHCAG to a dramatic turnaround in its purchasing strategy.

Finally, certain markets have little managed care or are only beginning to see its development. Moreover, purchasers believe that some of these markets are not receptive to the development of HMOs. For example, in some rural markets, providers, especially hospitals, have actively blocked the entry of managed care by refusing to contract with such plans. One purchaser cited the evolution of managed care in Oklahoma City as typical of emerging HMO markets. Several years ago, this market only offered purchasers the choice of an inefficient plan that resembled an HMO. Premiums were high, care was not really managed, and every doctor was in the plan. The entry of two large managed care plans has introduced competition, a development that is helping to transform the local market.

For a variety of reasons, purchasers do not offer HMOs at all operating locations. Thus, some purchasers introduce managed care plans on the basis of the degree of employee concentration or the extent of HMO penetration, or both. In certain markets, they have too few employees to justify the administrative effort. In others, because of the immaturity of the market, HMOs are more expensive than an indemnity product and are not offered. Finally, HMOs are often unavailable in rural areas. Even the state governments in our sample, which generally strive to offer HMOs to all employees, are unable to do so in some rural markets.

A purchaser that adopted extensive quality criteria to screen out unacceptable plans and to monitor performance told us that the administrative burden precludes the firm from applying these criteria in every market where it has employees. Rather, the purchaser focuses its attention on areas with high concentrations of employees. In such markets, it (1) monitors HMO performance against published requirements, (2) works with health plans to build more efficient processes, (3) plans to produce a report card based on the Health Plan Employer Data and Information Set (HEDIS) measurements, and (4) analyzes HMO rates by component. In areas with 500 or fewer employees, we were told, such extensive monitoring is not economical. In these markets, the firm still offers HMOs, but relies on the National Committee for Quality Assurance (NCQA) accreditation as a proxy for health plan quality.

One firm in our sample decentralized management of its benefit program along internal company lines. We were told that creating a single strategy for the firm's separate operating divisions would have been inappropriate given the potential for disruption that would accompany a centralization effort. Lack of profitability in one division led to the adoption of an HMO strategy, but benefit managers were hesitant to adopt this strategy for a different division that was financially strong. According to benefit managers, it was not worth disrupting the workforce at the latter division even if it saved the company money. Consequently, it was possible for employees working in the same state, but in different divisions, to have completely different health care options. On the other hand, another firm is in the process of centralizing responsibility for HMOs in order to introduce greater consistency across its operating divisions for screening and selecting such plans.

Employee demographics can also play a role in designing a health benefit program. Two of the firms in our sample targeted specific coverage options at their younger, unmarried employees. Believing that these employees are generally healthy, these firms wanted to encourage the selection of their self-insured indemnity plan in which the company only pays for the services used, rather than an HMO with a monthly capitation rate that must be paid even if the enrollee is never sick. For example, one firm has an indemnity option called the "Single Person's Plan"; this option is free and pays 100 percent of the first \$600 of covered medical expenses; the employee is responsible for the next \$500 in expenses before cost-sharing kicks in. While this option and others are not limited to younger, single employees, the firm's intent is to encourage those who do not fit this demographic profile to select alternative plans.

State Governments Also Demonstrate Flexibility

Legislatures have frequently given the governing boards and agencies that purchase health care for state employees and other groups wide latitude in designing and managing the benefit program. The authorizing legislation often provides a general framework but leaves important operational decisions to others. In some states in our sample, employee unions also play an active role in defining benefits, incentives, and how the program actually operates.

Many of the state purchasing agencies we visited have the authority to determine the number and type of participating plans and the benefits offered. Moreover, like benefit managers in private firms, they often have the authority to negotiate premiums with participating plans. The legislation establishing the Health Insurance Plan of California (HIPC) is broadly drawn and gives the governing board considerable discretion.¹⁸ The HIPC board initially considered the possibility of severely limiting the number of plans offered; eventually, the board settled on a strategy of offering a large number of competing health plans. In 1987, Minnesota amended authorizing legislation and gave the agency that manages state employee benefits the power to exclude any health plan from the program. Previously, any licensed carrier had to be offered. In some states, the governing board or agency that manages employee benefits has standardized HMO benefits. HIPC's governing board actually designed the benefit package.

In 1992, Missouri passed legislation creating a new public employer purchasing organization known as the Missouri Consolidated Health Care Plan, with a governing board to manage health benefits for state employees and other government entities. The legislation was prompted by deficits in the state's self-funded indemnity plan and by a recognition that purchasing leverage was not being maximized under the current approach. We were told that the authorizing legislation gives the governing board significant flexibility to adapt its health care approach to the continual evolution of the health insurance marketplace. After selling its indemnity plan, the board subsequently included the plan's fee-for-service PPO in a competitive bidding process along with insured HMOs, and instituted a managed competition system. In 1995, the board was also given some negotiating authority with health plans. Flexibility allowed the board to adapt to market conditions in 1995 that resulted in significant reductions in HMO premiums.

¹⁸As part of 1992 insurance market reforms, California established HIPC—the first government-sponsored voluntary purchasing coalition for small employers.

Flexibility Is Not Without Constraints

Looking across our sample, the flexibility of purchasers to develop wide-ranging variations on a health benefits management strategy is clear; the constraints that helped shape each purchaser's strategy are less obvious. Several factors, such as concern about the potential disruption of employees' relationships with their doctors, individual corporate cultures, labor agreements, and the nature of the health care markets in which the firms are located, have limited the degree to which any particular strategy has been implemented.

Purchasers recognize that (1) employees do not necessarily share their enthusiasm for managed care and (2) a managed care strategy could be disruptive to employees' medical care and adversely affect their morale. A variety of approaches have been used to minimize the impact on employees, but in some instances, these approaches may actually be at cross-purposes with the efficiency goal that underlies the adoption of such a strategy. In order to address employee concerns about disturbing existing relationships with physicians, many firms insist that participating HMOs include broad provider networks. At the same time, benefit managers acknowledge that such networks are difficult to manage and are therefore generally less efficient. One firm conducted a "provider disruption analysis" to determine the extent to which employees' physicians participated in the networks of various HMOs. This firm told us that it ended up contracting with two HMOs that were more expensive but that had also scored well in its analysis.

Once a benefit management strategy is adopted, corporate culture and labor contracts may limit a firm's ability to create incentives for employees to move from indemnity to managed care plans. One of the strongest incentives, requiring employees to pay a portion of the cost of the health plans they select, is essentially unavailable to firms that have a history of paying the full cost of coverage or to firms that face stiff competition for employees. One employer told us that it operates under the paternalistic notion that an employee choosing single coverage should not have to contribute to the cost.¹⁹ In other firms, the zero-premium benefits

¹⁹This same paternalism often does not apply to coverage of dependents. Missouri pays about 55 percent of the cost of health benefits for children, but only 28 percent for a spouse and 36 percent for family coverage. These percentages were increased in recent years, utilizing savings realized through the managed competition process adopted for the state employees' health benefit program. Washington offers free coverage for children in all but the most expensive plans, but the employee must always pay for coverage of a spouse. Xerox has adopted a policy of basing total compensation (benefits and pay) less on family status and more on the employee's contribution to the business. As a result, it is gradually increasing its allowance for workers choosing employee-only coverage and decreasing the amount for those selecting family coverage. However, the allowance is still so generous that an employee can purchase full family coverage, including prescription drugs, in an efficient HMO with little or no out-of-pocket costs.

negotiated by labor unions have a spillover effect on the rest of the company. One employer told us that it offers benefits free to nonunion employees so as not to encourage greater unionization of its workforce.

A strong union presence affects not only the cost of health care coverage to employees but also the pace with which changes can be made. Any significant changes in the structure of the health benefits for these purchasers must be included in the collective bargaining process, which may occur only once every 2 or 3 years. The insistence of unions on maintaining a free indemnity option has limited the ability of some purchasers we interviewed, especially those in the private sector, to implement a uniform managed care strategy for their entire workforce. However, two firms in our sample, U S WEST and Southern California Edison, were able to negotiate the substitution of a POS option for more traditional indemnity-type coverage. In the case of U S WEST, the POS plan is free. Two state purchasers we interviewed still offer either traditional indemnity or PPO coverage but have been more successful than the private sector firms in negotiating labor contracts that require employee cost-sharing, that is, targeting the state's contribution to the least expensive managed care plan. The state of California, on the other hand, has been discussing a new cost-sharing formula with its unions since the early 1990s and, as of August 1996, had been unable to reach an agreement with most bargaining units. We were told that agreement on a new cost-sharing formula could enhance the leverage of the agency that manages employee benefits for the state—the California Public Employees Retirement System (CalPERS)—during negotiations with health plans.²⁰

Characteristics of individual markets can also constrain private firms as they attempt to implement new health care strategies. Market-based constraints, in their most basic form, may prevent purchasers from even offering managed care products. For example, few very rural areas are served by HMOs. Market characteristics may also dictate the type of benefits an employer offers. One firm in our sample said that the structure of benefits first popularized by the automotive industry in the metropolitan Detroit area makes it difficult to retain employees without offering first-dollar coverage. That is, most services are provided with no or minimal copayment or deductible.

²⁰Since 1967, other public agencies in the state have been allowed to join CalPERS.

Importance of Market Leverage Often Overstated

According to the conventional wisdom, large purchasers have a natural advantage in the health insurance marketplace. Health plans value their business not only for the number of covered lives but also for the prestige that is associated with having a well-known employer as a client. In turn, these two factors allow a health plan to attract more, higher-profile providers, which in turn attracts more business. Some of the private sector purchasers in our sample believe that their size or reputation has been instrumental in obtaining favorable rates from health plans. However, some employers also admit that (1) they do not have leverage in many markets in which they have employees and (2) acting alone, they may not even have a significant amount of leverage in markets where they have large concentrations of employees. Compared with the private sector, some state purchasers we interviewed are second only to the federal government in terms of the number of covered lives in a specific market area.

Several Factors Can Reduce the Leverage of Large Purchasers

Large private sector employers appear to be taking advantage of their size in purchasing health care coverage in some markets. However, given the size of their payrolls, they generally have less leverage than conventional wisdom would suggest. Factors such as the geographic distribution of employees, large numbers of part-time employees ineligible for benefits, and decentralization of the management of health benefits reduce employer leverage. PepsiCo has approximately 450,000 employees nationwide. Because a large number of them are part-time employees, only about 250,000 are eligible for health benefits. About 170,000 are hourly restaurant workers; they are eligible for a specialized health plan, but few elect to enroll despite the modest contribution required. As a result, PepsiCo only purchases standard health coverage for 85,000 workers. Moreover, benefit-eligible employees are located in all 50 states and distributed across 19,000 zip codes. The firm's largest concentration of employees in a single state is 5,000, and the next largest concentration is only 2,000, in Southern California. Some firms are organized along product lines or divisions, which purchase health care coverage independently. Different philosophies in the sales and manufacturing divisions of one firm in our sample result in decentralized health care purchasing. Another firm, with some demographic differences among its operating divisions, has decentralized health care administration along divisional lines. Employee demographics led another firm to divide its workforce into separate groups for the purpose of health care purchasing. While such arrangements may demonstrate flexibility, they come at the expense of purchasing power.

Little Consensus on Number of Employees Needed to Have Leverage

There was little consensus among benefit managers on the number of employees needed in a given market to wield significant buying power. Some firms were confident that they had leverage at least in the state where they were headquartered and often had their largest concentration of employees. One large regional firm in our sample told us that it has employees in every state but only has a significant concentration of employees in about 14 states. In several of these 14 states, the firm has between 7,000 and 17,000 workers and believes it has negotiating leverage. The firm's benefit manager noted, however, that whether a purchaser is one of the top employers at a location can sometimes be more important than its actual number of employees. Other benefit managers looked to purchasing coalitions to enhance their market power—even where their corporate headquarters were located. In areas where firms had small numbers of employees, the managers admitted that they had little leverage and frequently were price-takers.

State purchasers have considerable buying power, and some, like CalPERS, have used their leverage to obtain favorable rates. They are often the largest employer in a state, and their workforce is concentrated in a smaller area, that is, usually within the confines of state boundaries. As a result, they appear to have sufficient negotiating leverage on their own without joining coalitions.²¹ CalPERS represents about 425,000 employees and nearly 1 million covered lives generally concentrated in the state of California. As noted earlier, PepsiCo, the largest private employer in our sample, had 450,000 employees, but only 85,000 were enrolled in the company's health benefit program. Since 1994, CalPERS has used its buying power to demand rate reductions and improved data collection from HMOs. Moreover, several states are taking steps that could further enhance their buying power. Thus, Washington and Minnesota are attempting to coordinate the purchase of managed care benefits by different state agencies such as Medicaid.

Firms without a major presence in any particular market believe that large purchasers do have significant leverage—leverage that translates into better rates at the expense of smaller buyers. For example, two of California's largest purchasing groups—PBGH and CalPERS—have seen HMO rates decrease in recent years. The benefit manager from a California firm that had seen rate increases over the same time period suggested that health plans are shifting the cost of these discounts to smaller purchasers.

²¹CalPERS and HIPC are members of the Pacific Business Group on Health, but they only participate in the coalition's quality initiatives, not in its separate negotiating alliance.

Firms Use Variety of Techniques to Enhance Leverage

Faced with limited purchasing power resulting from the geographic distribution of employees and other factors, some firms in our sample have sought to enhance their leverage through a variety of techniques such as joining coalitions, relying on their national reputations, and limiting the number of health plans with which they contract.

Even in metropolitan areas, the large private sector firms in our sample often constituted only a small percentage of the potential business available to a health plan. As a result, about half of the firms in our sample have joined purchasing coalitions.²² While some BHCAG member firms have fewer than 4,000 employees in the Minneapolis area, the coalition consists of 24 major local employers, including firms with a national reputation such as 3M, Dayton Hudson, and General Mills; the firms represent about 400,000 covered lives—15 percent of the metropolitan area market. The PPO product offered to member firms through the end of 1996 attracted 100,000 enrollees, giving the coalition considerable market power. Similarly, the minimum number of employees required for a firm to join the PBGH negotiating group is only 2,000.²³ Altogether, however, this group represents 18 employers with about 400,000 active employees and dependents. All the members of the negotiating group we interviewed told us that they obtain lower HMO rates by jointly negotiating through the coalition.

While coalition administrators believe that there are still significant efficiencies to be gained in the health care market, it is not clear that mature coalitions will continue to achieve rate discounts. For example, after 2 years of rate decreases, 1997 rates for PBGH were flat. To further its purchasing goals, PBGH is looking for ways to strengthen its market power, such as recruiting new member firms or reducing the number of health plans with which it negotiates. This latter tactic could result in more aggressive plan bids because of the potential gain in new enrollees. Several firms in our sample that are not members of a purchasing coalition also cited the benefits of reducing the number of HMOs offered. This tactic not only rewards health plans that bid aggressively but also reduces the administrative cost of managing a benefit program. As with flexibility, maximizing buying power by reducing the number of available plans does not come without a cost. Thus, purchasers may find it difficult to eliminate

²²One coalition's executive director noted that even firms that have leverage on their own in a particular location may join a coalition because it provides access to a broader range of data on the local health care market.

²³Not all PBGH member firms are part of the negotiating group. For the 1997 benefit year, 18 of the coalition's 32 members participated in the coalition's joint purchasing initiative.

health plans because of the impact on employees. One purchaser noted that it would like to drop plans with high prices and poor quality, but the firm's corporate culture is to not disrupt employees. In some cases, agreement with unions may be needed to drop a plan.

In areas where no local coalition exists, firms use every means at their disposal to negotiate favorable rates. Like brand-name products, large firms frequently have a national reputation. Association with such an employer can be valuable to a health plan, even when the firm may only have a few hundred employees in the area. The value of such an association increases when it is a firm with a national reputation for innovation in health care purchasing. Benefit managers at PepsiCo, a large employer with a reputation for focusing on quality issues, told us that the firm has benefited from its reputation in markets where it only has a small number of employees. Other approaches used by firms in our sample that are trying to increase their market power include (1) establishing the National HMO Purchasing Coalition—an organization of large employers that have joined forces to buy coverage in markets where they each have too few employees to possess any leverage, (2) purchasing coverage from a limited number of insurance carriers that operate nationwide, and (3) using benefit consultants who also work with other large purchasers. Because of their relationship with and knowledge of premiums being quoted to other purchasers, benefit consultants may exert some market leverage over health plans on behalf of their clients.

Labor contracts or disagreement with what they referred to as the “cost focus” of some coalitions prevented a number of private sector firms from joining together with other employers to increase their purchasing leverage. Citing its labor agreements regarding benefit plan design as an impediment to joint purchasing, Southern California Edison only participates in PBGH quality initiatives. Other firms in our sample are more interested in driving changes in how the managed care industry operates than in obtaining discounts. For example, Xerox is philosophically opposed to negotiating discounts because of the potential for cost-shifting. Several firms told us that such discounts only represent a short-term phenomenon and that market power would be better used by insisting on improvements in the way health plans manage care, that is, data collection, analysis, and reporting. Firms with such views, however, may still join a purchasing coalition in order to participate in customer satisfaction surveys or other quality initiatives.

Purchasers Use Evaluation Criteria to Pursue Price, Quality, and Access Goals

Flexibility and market leverage are often considered to be natural attributes of the private sector—a foundation that some large purchasers have used effectively in their transformation from passive to active buyers of health benefits. However, flexibility and leverage alone are insufficient to achieve the accountability, increased efficiency, and quality improvements being sought by many large purchasers. For this reason, buyers have turned to a number of additional tools to help achieve their goals.

We have grouped these tools into three general categories: (1) health plan evaluation criteria, including techniques to assess premiums and foster competition among health plans; (2) incentives to sway employee behavior; and (3) overt marketing strategies to influence both the choice of delivery systems and of specific plans. This chapter focuses on health plan evaluation criteria; a subsequent chapter looks at how purchasers attempt to persuade an often reluctant workforce that a managed care strategy is also in their best interest.

Tension Between Need for and Adequacy of Evaluation Tools

The adoption of a strategy that encourages employees to join managed care plans contributed to, if not necessitated, the development of health plan evaluation criteria to help select HMOs. Price alone was no longer a sufficient criterion given employee reservations about choice and quality. The criteria, though imperfect and still evolving, serve several purposes. First, they help both employers and employees to compare health plans. Second, the criteria serve as improvement and development goals for the plans themselves. Third, employers use the criteria and the information collected from participating plans to justify their choices to employees. Finally, some employers use the criteria to select plans and/or to limit the number of HMOs offered in a given market.

Generally, the HMO evaluation tools developed by the purchasers we interviewed can be grouped into three broad categories: (1) price, (2) health plan quality, and (3) employee access to a choice of physicians. Many purchasers have not only articulated criteria that they expect health plans to meet, they have gone a step further and actually specified their requirements in a request for proposal (RFP) and/or in published “performance measures.” These criteria not only set forth a variety of performance thresholds but also require plans to demonstrate their level of performance by providing reliable data in specified formats. A few purchasers use the data to monitor the health plans with which they contract and impose sanctions if these goals are not met.

Some purchasers view their health plan evaluation criteria, especially those pertaining to price and quality, as works in progress, that is, rudimentary and imperfect. For example, one firm pointed out that the criteria are too process-oriented, too focused on what is measurable when the most important factors still cannot be quantified. This benefit manager characterized the firm's standards as "indemnity measures." Others even categorized some of their criteria as subjective. Furthermore, purchasers recognized that few plans could meet all of the criteria. As a result of these shortcomings, firms told us that they applied the criteria flexibly, using them more as goals than as absolute requirements. As research yields increasingly sophisticated measures of quality and efficiency, these purchasers expected to institute better and more rigorous requirements.

Price: Tools Used to Evaluate Premiums and Enhance Competition

In the past, widespread shadow pricing by HMOs had often resulted in premiums that bore little relation to actual health plan costs—a fact that, according to purchasers we interviewed, HMOs readily acknowledge. Rather than pursuing efficiency and passing the savings on to purchasers, HMOs competed at the employee level: they offered enrollees richer benefits with lower out-of-pocket costs and emphasized types of preventive care that appealed to younger and healthier individuals. In seeking to transform themselves from price-takers into active purchasers of health benefits, the large purchasers we interviewed have adopted a number of tools to encourage health plans to become more efficient and to ensure that savings accrue to the purchaser of health care.

Among the tools frequently cited as enhancing price competition at the purchaser level are (1) analyzing and negotiating premiums, (2) using a structured bidding process to solicit premiums, and (3) joining coalitions and eliminating plans to increase leverage. Purchasers told us that these tools have been successful in actually reducing premiums or in constraining premium growth. The variety of ways that large purchasers use and integrate these tools, however, makes it difficult to attribute their recent cost experience to any single tool or combination of tools. Moreover, some purchasers recognize that the context of fierce competition among HMOs for market share and the downturn in costs normally associated with the underwriting cycle clouds the entire issue of HMO pricing. As a result, other factors may be more important determinants of purchasers' recent cost experience than the specific tools used to enhance health plan competition.

Despite Difficulties, Purchasers Evaluate Premiums as a Prelude to Negotiations

Though cost is sometimes characterized as more transparent than quality, purchasers have had mixed experience in assessing the reasonableness of capitation payments requested by HMOs. As with quality indicators, some purchasers characterized current premium assessment techniques as rudimentary. Nonetheless, many view them as an essential prelude to subsequent negotiations. Some approaches are essentially analytical—a process one benefit manager characterized as akin to the delicate and difficult process of peeling back the layers of an onion. Others, however, rely on more subjective indicators, such as a “reading of market conditions” or evaluating the salaries of health plan executives. Often, purchasers seek assistance from consulting firms and actuaries. The purchasers in our sample said they used the following premium assessment techniques either alone or in combination: (1) adjusting for differences among the age and gender of employees (risk adjustment), (2) reviewing plan rate development methodologies, (3) comparing premiums with a standard or benchmark, (4) requesting utilization data from health plans, (5) examining health plan financial indicators, and (6) assessing market conditions.

Risk Adjustment

There can be significant differences in the cost of providing health insurance to different groups of individuals. Risk adjustment looks for demographic, geographic, health status, and other characteristics that can help predict the use of medical services.²⁴ Two common characteristics used by the purchasers in our sample were demographic, that is, age and gender. While the easiest to adjust for, they only partially account for differences in the health expenditures of different groups of employees. Several purchasers told us that they believed other factors might be more important predictors of the use of medical services, such as education level and nature of employment (sitting at a desk versus engaging in physical labor). Consequently, one health benefit manager asserted that it was “inappropriate” to base negotiations on an analysis of workforce demographics. Use of demographics is common, she maintained, not because of its predictive capability but because there are so few other widely accepted analytical tools. This same benefit manager also noted that health plans often do not have the capacity to prove otherwise when an employer asserts that the youth of its workforce justifies a rate reduction.

While demographic analysis may not be the most sophisticated means of assessing the risk of a population, when used in conjunction with other

²⁴Health Care Reform: Considerations for Risk Adjustment Under Community Rating (GAO/HEHS-94-173, Sept. 22, 1994).

tools, it can highlight apparent inconsistencies in a health plan's rate methodology. One firm told us that it has retained a consultant who has extensive data on the costs of delivering care by zip code. This consultant analyzes HMO premiums on the basis of age, gender, and geographic location. No HMO data on the actual utilization of services by enrollees is employed in this assessment. If analysis suggests that premiums are too high, the results are used during negotiations to obtain a reduction. Both PBGH and the Gateway Purchasing Association²⁵ analyzed members' premiums for differences in benefits and risk and found a lack of correlation with the rates actually charged. Thus, some firms with low-risk employees paid higher premiums than those with high-risk employees. Moreover, premiums did not appear to correspond to the volume of business. In short, some prices appeared arbitrary and too high across the board. At the same time, several members of the coalition we interviewed emphasized that PBGH is currently unable to determine the true cost of benefits delivered by contracting HMOs.

Review of Rate-Setting Methodologies

Several purchasers told us that they either engage consultants and actuaries to examine health plan rate-setting methodologies or perform the assessment themselves. The Minnesota state government's focus is on whether the plan's methodology is sound and accurate and whether any subjective elements are reasonable. For example, Minnesota found that one plan calculated its premium for family coverage by multiplying the single rate by 2.8—a significantly higher ratio than is commonly used. The plan, we were told, was trying to discourage more expensive families from joining. The state has since mandated use of a standard ratio of 2.5 by all plans. When Minnesota officials first began to ask plans to substantiate their rate-setting methodologies, some carriers were not well prepared to do so. This process uncovered significant errors that would have been costly to the state, but plans now do a better job and changes are less prevalent. Like Minnesota, Wisconsin and HIPC reported similar benefits from their reviews of health plan rate-setting methodologies.

Benchmarking

Evaluation of premiums often involves comparison with some standard or reference point. The types of benchmarks used by the purchasers in our sample include (1) indemnity or POS cost experience for which they often have considerable utilization data, (2) trends in health care premiums over several recent years, (3) premiums paid by employers with similar workforce demographics, and (4) rates charged by health plans that are judged as both efficient and of high quality.

²⁵Gateway represents 30 St. Louis area firms.

The Washington Health Care Authority estimates the per-member-per-month cost of enrolling all of its employees in the self-funded PPO plan. This analysis is facilitated by the similarity between PPO benefits and those that participating HMOs are required to offer. The Washington Health Care Authority told us that it then asks each HMO to bid using the assumption that all state employees would be enrolled in the bidder's plan. Minnesota, Wisconsin, and the Arizona Medicaid program also develop target premiums on the basis of the extensive data that managed care plans are required to submit. A Wisconsin official noted that this process alerts the state to underpricing by large plans trying to buy market share and prepares the state for subsequent negotiations if bids appear to be higher than they need to be. Since BHCAG members paid their self-funded PPO under a fee-for-service arrangement, they had several years of claims data to assess the reasonableness of the bids received from 15 so-called care systems. Purchasers also told us that HMO bids should be lower than their indemnity costs because such plans are known to attract healthier and therefore less expensive individuals than options that offer an unfettered choice of providers.

A different type of benchmark identified by purchasers we interviewed is reliance on trends in premiums over the past several years. Firms told us that they tend to challenge large premium increases. On the other hand, some purchasers are more inclined to go along with a proposed rate increase if it seems consistent with their recent experience. One firm said that it had seen some HMO rate increases in the neighborhood of 3 percent, which it views as reasonable and is willing to pay. On the other hand, many of the purchasers we interviewed told us that they have experienced actual HMO premium decreases in certain markets—a fact that may establish a different expectation.

Some firms told us that in markets where they are not a member of a coalition, they rely on consultants to tell them how well they are doing. For example, in return for sharing data on claims, premiums, and quality indicators, one consultant provides firms feedback on the average and best rates in a given market, adjusted for workforce demographics. A benefit manager said that prior to participating in this survey, the firm had no idea how well it was doing outside of California. Similarly, a coalition told us that its consultant has a large database on HMO rates that allows the coalition to compare its bids with the rest of the market. Since the levels of benefits provided by purchasers differ, such comparisons only provide a rough, but nonetheless useful, indicator.

In addition to comparing proposed premiums with indemnity costs, trends, and the experience of other firms, purchasers told us that they use the premiums of an HMO that they believe serves as a benchmark in terms of both cost and efficiency. Thus, PBGH told other plans that they had to meet Kaiser's rates. Similarly, another purchaser noted that many California HMOs see Kaiser as a market trendsetter. Thus, we were told, a rumor in April that Kaiser would drop its rates sent tremors throughout the market.

Health Plan Utilization Data

Many state governments, coalitions, and firms in our sample require HMOs to submit data on the utilization of services by their employees, information also referred to as encounter data. Reflecting a typical viewpoint, one health benefit manager told us that his firm wants to pay a fair rate that can be substantiated by documentation that employees have actually received medical services. Both firms and coalitions noted, however, that the quality of the data submitted by HMOs was often variable. CalPERS told us that staff-model HMOs or those that are claims-driven tend to have better data; on the other hand, larger, more loosely managed plans and those that are heavily capitated have poorer data. The vagueness or incompleteness of the data was attributed to plans simply lacking the information or not wanting to share it. California purchasers also cited the increased use of capitation within HMOs as having a negative impact on the availability of data. One firm said it was close to freezing enrollment in a plan whose move to capitate its hospitals had diminished the integrity of its data. Finally, a HIPC official told us that HIPC had to limit its risk-adjustment methodology to inpatient encounter data because many HMOs could not provide outpatient statistics. However, several plans admitted to HIPC that they even had trouble collecting the inpatient data. A California HMO noted that it is developing an outpatient database that is clinically, rather than claims-oriented. Thus, there may be a disconnect between the type of data systems plans are developing to effectively manage care and the type of data purchasers perceive they need.

Some private coalitions have put health plans at financial risk for poor results on performance measures, including the provision of data, customer service, and quality. For example, PBGH has negotiated individual HMO performance targets, and HMOs have agreed to put 2 percent of their premium at risk. Gateway Purchasing Association in St. Louis negotiated a similar arrangement. HIPC currently has the authority to fine a plan if data are turned in late and commented that it would also be helpful if it could penalize plans that submit poor-quality data.²⁶

²⁶Effective in July 1997, HIPC will no longer require HMOs to submit utilization data. Instead, HMOs will be asked to provide audited HEDIS data that in turn will be reported to enrollees beginning with the May 1998 open season.

Financial Indicators

Some purchasers told us that they look at financial indicators on plan profitability, loss ratios, administrative margins, and the salaries of top executives. In some cases, the purchaser’s RFP requires the submission of such data. CalPERS said that it would like to see administrative expenses, including profit, at about 10 to 12 percent. Similarly, its goal is for health plans to spend at least 86 percent of premium revenues on medical care—the so-called loss ratio. Digital also negotiates on the basis of a variety of financial indicators, including plan overhead. A company official told us that when premiums include a 15 to 20 percent charge for administrative costs, it establishes performance goals to reduce this component over time. Finally, purchasers expressed concern about the high salaries of health plan executives; such salaries, along with other financial indicators, suggested to them that more could be done to improve health plan efficiency without adversely affecting quality. An official at HIPC, however, sounded a note of caution about the reliability of plan financial data. He said that HIPC would like to use encounter data to calculate loss ratios but that it is not possible now because the data are simply too “hazy.”

Market Expectations

Assessments of the extent and nature of competition in a given market can also influence the stance that a purchaser takes during premium negotiations. One coalition that characterized competition in its market as “fierce” approached 1996 negotiations with the expectation that further rate concessions were still possible. Moreover, the coalition did not believe that it had reached the point where quality had been adversely affected by premium decreases. A coalition in a different market, however, cited the fact that plans were losing money as a factor that would make additional rate concessions difficult to obtain. Finally, officials at the Missouri Consolidated Health Care Plan, a coalition that represents state employees as well as other local government workers, benefited from what it characterized as a “market-share-buying” temperament among health plans in its 1996 bidding strategy.

Negotiations Seen as
Essential to Controlling
Growth in HMO Premiums

The extent to which purchasers in our sample—from both the private and public sectors—rely on negotiations to supplement structured bidding or a managed competition framework suggests that these approaches are either insufficient by themselves or that purchasers lack confidence in them as cost-containment tools. In fact, one state that added negotiation several years after it adopted a managed competition system now emphasizes that negotiation is a critical component of a competitive framework. Only one firm we interviewed characterized itself as a

“price-taker,” rejecting negotiation with health plans because the process simply extracts a discount while shifting costs to other purchasers.

During our interviews, we observed two basic strategies for negotiating with health plans. The primary emphasis of purchasers appears to be either market leverage or analysis of premiums. The two approaches, however, are not mutually exclusive. In markets where they believe they have sufficient size, purchasers may rely more on their leverage, while in others, they may see analysis as more appropriate. And, at times, the distinction between the two strategies is blurred as firms or coalitions adapt to market context or other circumstances. Regardless of the strategy used, purchasers (1) approach the negotiating table with a shared skepticism about health plan premiums and (2) often resort to similar tactics during their face-to-face meetings with health plans.

Skepticism: Foundation for Negotiations

Purchasers told us that they generally approach HMO premiums with skepticism—an attitude reinforced by past shadow pricing. One coalition told us that HMO pricing was still irrational. The benefit manager at another firm said that the pricing process appeared to be arbitrary—it looked as if plans decided what rates they wanted to charge and then backed in the costs to justify them. A few purchasers noted that the frequency with which errors are detected has not convinced them that HMO rate-setting methodologies are sound. Several years of premium decreases for some purchasers have probably reinforced skepticism about the actual basis for HMO rates, especially since these same purchasers do not believe that the quality of care has been adversely affected. The analysis conducted by both PBGH and the Gateway Purchasing Association noted earlier lends support to this general skepticism over the fairness of HMO rate-setting methodologies.

Negotiation: Continuum Ranging From Market Power to Analysis

Perhaps the most publicized advocate of the use of market power is CalPERS. CalPERS began to exert its market power when it sought a zero increase in premiums for the 1992 contract year. Citing the state’s worsening fiscal crisis, it asked HMOs to freeze rates and benefits at the 1991 levels. When Kaiser refused to accede to this strategy, CalPERS froze new enrollment for 8 months, sending a powerful message to California HMOs about the seriousness of its negotiating demands.

Starting with the 1994 contract year, CalPERS adopted an even bolder tactic: each year it has publicly announced, in advance of negotiations, that it was seeking a specific percentage reduction in premiums. And during three consecutive negotiating sessions with HMOs, CalPERS has achieved premium

reductions. An official at another coalition noted that CalPERS has a “huge hammer” when it negotiates with health plans—for many, CalPERS is their largest single customer. For example, about one-third of CalPERS enrollees are in Kaiser, and CalPERS’ members represent about 7 percent of Kaiser enrollment in California, a statistic few private purchasers can rival.

The PBGH Executive Director also characterized the coalition’s current approach to negotiations as one based on the use of market leverage—the size of the purchasing pool—to rein in prices. Like CalPERS, PBGH has threatened sanctions when plans appeared reluctant to offer rate concessions, a tactic one firm characterized as essential in shaping the outcome of negotiations. After 2 years of HMO premium decreases, however, the coalition was unable to gain further concessions in 1996, though that was clearly its intent. According to member firms, the coalition is now considering options to enhance its leverage—including expanding its membership and eliminating some health plans. The National HMO Purchasing Coalition has pursued an exclusionary policy from the outset. A coalition official attributed its success in obtaining several years of rate reductions not to analysis but to the policy of telling bidders up front that it only intends to contract with two to four HMOs in each market. Firms we interviewed criticized some purchasers as too focused on price. However, officials at PBGH, CalPERS, and Gateway Purchasing Association are convinced that continued pressure on HMOs to lower prices and to justify any increases will force plans to become more efficient, encouraging competition based on quality rather than on price. As one coalition director explained, “plans won’t focus on quality if employers are not tough on price. Nothing breeds innovation like necessity.”

For some large or influential purchasers, it is difficult to isolate the role of analysis from the context in which negotiations occur—a large purchaser whose business is important to a health plan asking informed questions about proposed premiums. As demonstrated by Gateway and PBGH, analysis of HMO premiums can be a powerful negotiating tool. Though PBGH, as it is currently configured, appears to have exhausted its market power, the coalition’s initial negotiating success may have relied more on its finding that differences in member premiums were not always correlated to firm size or risk pool.

Some purchasers we interviewed are motivated less by a concern over price concessions and more by a desire for fair and reasonable premiums that accurately reflect the utilization of their employees. And these same

purchasers are convinced that in the long run an emphasis on quality will do more to restrain cost increases than a short-range focus on prices. These purchasers generally rely on the analytical approaches outlined earlier in this chapter. For example, Minnesota uses the negotiating process to go over the results of its actuarial analysis of health plan bids. During these meetings, it may seek additional information and, where appropriate, ask for reasonable changes to the rates. Similarly, Wisconsin meets with plan representatives if its analysis suggests that proposed premiums are higher or lower than the target estimated by its actuary.²⁷ The target is developed on the basis of a review of plan-specific demographic, charge, and utilization data. The state asks all plans to submit a “best-and-final” offer. Finally, a number of purchasers appear to combine the use of market power—albeit on a different level compared with CalPERS—with reliance on analytical tools. For example, HIPC not only looks at health plan rate-setting methodologies and utilization data, it also asks health plans whether the proposed rate is commensurate with HIPC’s importance to their group of clients in the small-group market.

Feedback Provides Opportunity for Plans to Reconsider Bids

Regardless of the emphasis placed on market leverage versus analysis, many purchasers use a common set of tactics during negotiations. In general, negotiations are an opportunity to provide feedback to health plans on their respective bids. The objective is not to disclose the premiums of competitors but rather to give each plan an opportunity to reconsider its initial bid in the context of additional information.

Thus, Gateway Purchasing Association tells plans in general terms how they are positioned relative to the competition—high, low, or in the middle. Similarly, HIPC meets individually with health plans and gives them an overall evaluation of where their bids fall in relation to others in a specific market area. For example, during 1993 negotiations, HIPC informed one plan that its premiums were 40-percent higher than the lowest-priced competitor. Though it did not tell health plans that they were too expensive or that they had to reduce their prices, one-third of the plans lowered their premiums after these meetings. Providing feedback, however, does not guarantee that a plan will change its bid. For example, BHCAG told us about one Minneapolis plan that bid high in order to test community loyalty to its hospital. The plan believed this bid was worth the risk because it was already at capacity and BHCAG only represented about 5 percent of its business.

²⁷A premium lower than the actuary’s estimated target can alert the state to underpricing by a plan trying to buy market share. Unrealistically low premiums can give way to very large increases in subsequent years.

Purchasers commented that they also found it useful to provide feedback on the possible employee reaction to price increases. Thus, HIPC conducted an analysis of enrollees who changed plans during open season. During negotiations, it pointed out that 41 percent of enrollees changed health plans because of price and that one plan lost 16 percent of its enrollment after it raised prices 8 percent. Another coalition said it often sees price reductions after informing plans that their bids will result in employees having to pay more than they would for plans offered by competitors.

Some purchasers suggested that it is a mistake to accept the first price proposed by any health plan: asking for a second or even a third bid is just common sense. One benefit manager told us that had the firm not asked for best-and-final offers, it would have left about \$500,000 on the table. Another health benefit manager acknowledged that some, but not all, plans “game the system” by bidding high initially in expectation of lowering the bid during negotiations. The executive director of one purchasing coalition emphasized the importance of arranging a one-on-one meeting with a key decisionmaker at each plan in order to ensure that the plan understands its competitive position. Using this and other techniques, this director said that the coalition is able to move rates down from initial bids. We were told, however, that it is critical not to let a plan lower its bid once negotiations are completed. Plans should be forced to live with the consequences of their decision on premiums until the next round of bidding and negotiations. Finally, in accepting best-and-final offers, one purchaser told us that it will only accept new bids from the same plan that are lower than the initial offer.

Bidding Used to Structure Health Plan Competition

Many of the purchasers we interviewed are now using some form of bidding to select health plans and to help determine HMO capitation payments. Bidding is often used in conjunction with evaluation and negotiation. Plans are invited to submit sealed bids according to rules set forth in an RFP. The RFP also stipulates requirements for a plan to be considered qualified to bid. Generally, the purchasing coalitions and state governments in our sample re-solicit bids annually or on some other regular basis; individual firms, on the other hand, may use a bidding process to make their initial plan selections but not periodically rebid contracts unless a problem arises, such as employee complaints or dramatic price increases.²⁸

²⁸One firm that is playing an instrumental role in establishing a new purchasing coalition told us that no matter how good relations are with the contracting HMOs, soliciting bids every several years helps to restrain premium growth.

The underlying assumption of a bidding process is that competition among plans for market share will result in premiums that reflect costs plus a normal rate of profit. There is, however, no single, patented design for competitive bidding, and research does not indicate which attributes would clearly constitute the best system. In fact, competitive bidding is commonly associated with commodities whose costs and quality are easier to evaluate than the delivery of health care.

Consensus on Key Features

Although there is potential for considerable variation in the design of a bidding system, the purchasers in our sample cited the following general features as critical to eliciting more competitive bids: (1) standardized benefits, (2) employee incentives, (3) negotiation, and (4) flexibility.

Standardized Benefits. State governments and purchasing coalitions standardized benefits in the late 1980s and early 1990s, which contributed to their ability to undertake a rough comparison of premiums from competing HMOs.²⁹ In fact, benefits standardization may be a precondition to collective purchasing by private coalitions.³⁰ A second major advantage of standardization is that it constrains the ability of plans to compete or avoid risk on the basis of the benefits they offer. Some purchasers in our sample may lack the market power—that is, a sufficient number of employees in an area—to insist that all competing HMOs offer the same or roughly similar benefit packages. Another factor that may inhibit standardization for some firms is mandated state benefits that result in variations in covered services from state to state.

Employee Incentives. Purchasers understand that providing a financial incentive for employees to be cost-conscious in their selection of health plans can be a powerful inducement for greater competition among HMOs. As discussed in the next chapter, however, purchasers vary in the extent to which they have implemented effective incentives. Only a few purchasers have adopted what some consider to be the most effective employee incentive—tying the employer contribution to the lowest-cost plan offered. The losses in health plan enrollment that can result when a plan bid requires a greater out-of-pocket contribution from employees can

²⁹The degree of standardization ranges from identical benefits in Wisconsin to roughly comparable benefits in Minnesota. CalPERS allows health plans to offer several supplementary benefits. Washington Health Care Authority has a roughly comparable benefit design that applies to both its self-funded PPO and its HMO, albeit with different limits, copayments, and deductibles. Thus, both the PPO and HMOs cover preventive care. However, the state allows HMOs to waive inpatient hospital copayments of \$100 per admission. Gateway Purchasing Association has focused considerable energy on standardizing the benefit exclusion policies of contracting HMOs.

³⁰Private sector coalitions may accept bids on a standard benefit package but allow member firms to vary the mix of benefits that they actually offer to employees.

send a strong message to health plans. Although the structure of Medicaid prevents the use of financial incentives, since it is offered largely free of charge to beneficiaries, Arizona exercises the option of assigning the approximately 50 percent who fail to select a health plan to lower-cost bidders.

Negotiation. All but one of the bidding systems we examined assume that negotiation is an integral part of the process. Initially, however, one of the states in our sample did not negotiate with plans that submitted bids. Rather, this state's officials assumed that the competitive framework itself, coupled with heightened employee price sensitivity as a result of incentives, would help to control premium increases. A resumption of rapid price increases and concern about shadow pricing necessitated a modification of the original design. Wisconsin now sees evaluation of health plan bids and direct negotiation as integral to the design of its managed competition system. Unlike Wisconsin, CalPERS had previously discussed premium increases with health plans. However, pressure to contain costs became critical in 1991 when California froze the state contribution to premiums, magnifying the impact of rate increases on state employees. As a result, CalPERS began aggressive negotiations with health plans in 1992.

Flexibility. Purchasers in our sample believe that flexibility is key to maintaining and nurturing a successful bidding system.

- As noted earlier, Wisconsin's response to anticompetitive behavior was the introduction of negotiations. According to BHCAG, the 1996 care system bids resulted in a 9.5-percent reduction in per-member-per-month incurred claim costs—without negotiations. However, the coalition's Executive Director commented that he would not rule out negotiations in the future if the current approach showed signs of not working.
- Arizona Medicaid's competitive bidding process has continually evolved since its inception in 1982.³¹ Thus, the state's most recent RFP, issued in February 1997, contains a number of departures from past practice intended to increase competition and lower costs. First, bids will be solicited for a 5-year period rather than for 3 years. Second, the state has consolidated the 12 rural counties into 6 geographic areas and intends to maintain its policy of awarding a minimum of only two contracts for each

³¹Analysts familiar with the Arizona program have stressed the importance of allowing the bid process to change as the marketplace in a community changes. At some times, it may be important to stimulate entry by relaxing plan participation requirements. At other times, it may be important to ensure the stability of the program by requiring strict financial or other criteria for entry. See Lynn Paringer and Nelda McCall, "How Competitive Is Competitive Bidding," *Health Affairs* (1991), p. 229.

area. This consolidation could eliminate some health plans. Finally, in one urban county, the state's target is to contract with six rather than eight plans.

- As an incentive to bid competitively, Digital adopted a policy of allowing only its benchmark plan (in terms of quality and price) to offer a POS option to its employees. A company official added that this opportunity can be taken away from a plan if either its cost or quality performance slips. And, he noted, such slippages have caused Digital to change POS partners.
- In 1996, the Washington Health Care Authority switched from a 1-year to a 2-year contract period. An official told us that health plans realized that if they did not attract a large enrollment base with their bid, they would not be able to recover for 2 more years. A board member on the Missouri Consolidated Health Care Plan told us that the board believes its approach to multiple-year bids is unique. In 1994, it solicited bids that locked in rates for 5 years with a maximum yearly increase tied to the medical Consumer Price Index. However, because a buyer's market persisted and new entrants were willing to bid, it has tested the waters every year since then by calling for new bids. If an existing plan rebids, the board retains the right to accept the new bid if it beats the 5-year guaranteed rate or stick with the guaranteed rate through a renewal if the new bid is higher. In 1995, it did the former, while in 1996, the latter. Rebids also permitted the state to insert additional contract terms, which would not have been possible with a straight renewal.

Major Differences Observed Among Bidding Systems

Two major differences surfaced among the bidding systems we examined: (1) the number of winning bidders and (2) the criteria used to select them.

Number of Winning Bidders. Whether or not they belong to a purchasing coalition, the firms we interviewed are less likely than state governments to offer a large number of HMOS to their employees. They are concerned that fragmentation of their workforce among a large number of HMOS will reduce their leverage, not only in markets where they have a large presence but also in those where they have a small number of workers and there is no active purchasing group. In contrast, the state governments in our sample appear to have sufficient leverage on their own.³² They are often the largest employer in a state, and their risk pool is concentrated in a smaller area, that is, usually within the confines of state boundaries. Their large workforce allows them to negotiate with and

³²CalPERS and HIPC are PBGH members, but they only participate in the coalition's quality initiatives, not in its separate negotiating alliance. A HIPC official, however, told us that one motivation for joining PBGH was to observe the coalition's negotiating strategy and evaluate it for approaches applicable to HIPC.

actually offer more HMOs without fear of fragmenting their risk pool and diminishing their leverage. A CalPERS official told us that such a strategy might not be viable for smaller purchasers. For them, narrowing the competition might be a better approach.

Although there was no consensus on the optimal number of plans needed to maintain competition, a number of private firms suggested that, at a minimum, two plans should be required. Offering only one HMO, a benefit manager told us, opens up the possibility of becoming “a captive of that plan.” The number of plans typically offered is a “market-by-market” decision. Some markets have no competing HMOs, others are only beginning to experience competition, and some have undergone a consolidation that restricts competition. Thus, one coalition noted that the two to three dominant plans in a mature HMO market area refused to submit bids unless they were guaranteed that only one plan would be selected. The coalition refused to go along. A few firms did indicate that they only contract with a single HMO in certain market areas. According to one such firm, a consultant had advised it to add a second HMO in a particular market because offering only one plan had adversely affected its negotiating position. This firm now thinks competing plans is a better way to go. Another firm recounted that rates fell by 30 percent when it added a second HMO.

While firms may only contract with a handful of HMOs in a given market, some of the private coalitions in our sample appear to believe that competition and leverage are enhanced by accepting bids from a large number of plans. For the first round of negotiations in 1994, all HMOs in California were invited to submit bids. More recently, PBGH negotiated with and offered its members a choice of 15 HMOs for benefit year 1996. However, no member firm offers employees all of the plans and most contract with four or fewer. The inability of the coalition to obtain a third straight year of price reductions from participating HMOs has led PBGH to consider a number of options to enhance its market power, including expanding its California membership, moving into other nearby states, and excluding some HMOs from the negotiation process. We were told that the HMOs themselves suggested that further premium concessions might be possible if the market share of participating plans was increased.

Selection Criteria. In addition to price, many bidding systems incorporate quality and access criteria. The final section of this chapter describes how the purchasers in our sample integrate these three criteria to arrive at a decision.

Quality: Some Employers Hesitant About Using Quality Criteria

Ensuring the quality of health plans, particularly HMOs, poses a formidable challenge to purchasers—one for which past experience with indemnity coverage provides limited guidance. Nonetheless, the private sector has been on the cutting edge in exploring and mapping this new frontier. Capitation, a key characteristic of HMOs, underscores both the importance of purchaser-sponsored quality initiatives and the extent of the challenge. HMOs are usually prepaid a fixed per capita amount rather than reimbursed after the fact for each service rendered—an arrangement that some analysts believe creates an incentive to underserve.³³ Moreover, capitation negates what had previously served as a proxy for quality—the itemized invoice that gave indemnity insurance its fee-for-service nickname. Without claim forms, how are employers to assure themselves that employees are indeed gaining access to medical services? The overwhelming response to what is frequently referred to as the HMO “black box” can be summarized in one word—accountability.

Large Purchasers Developed Managed Care Accountability Tools

Large private sector purchasers have driven the development of two interrelated approaches to fostering accountability among managed care plans—accreditation and the Health Plan Employer Data and Information Set, commonly known as HEDIS. Accreditation involves a review of a health plan’s quality assurance system against 50 standards. The standards look for evidence that a health plan has the structures and processes in place to report on and continually improve effectiveness. HEDIS, on the other hand, actually measures performance in specific areas. The most well-known HEDIS measures focus on the ability to deliver a set of preventive services, including mammography, childhood immunizations, and cholesterol screening, to enrollees. While accreditation and HEDIS are closely related, accreditation is perhaps the easiest of the two criteria to interpret. An HMO is in one of three categories: (1) seeking or not seeking accreditation, (2) fully or provisionally accredited, or (3) denied accreditation. HEDIS data, on the other hand, demands more analysis and explication, particularly if an employer is attempting to compare a number of health plans across all 63 indicators.

Appendix II describes the origins of HEDIS and contains background information on the accreditation process. Appendix III summarizes the type of quality-related data that purchasers we interviewed typically expect from HMOs. The summary is based on performance goals published by Southern California Edison in 1995. Edison’s goals fall into four broad

³³On the other hand, reimbursement for each service, as in fee-for-service plans, may create an incentive to provide unnecessary medical treatment.

categories: (1) structure and philosophy, (2) service to enrollees, (3) clinical quality, and (4) finance and information. An Edison official told us that putting the goals in writing and using them during contract negotiations frequently strengthens the positions of individuals in health plans, such as medical directors, who have been stressing quality issues for a long time but have not received sufficient attention. In establishing its goals, Edison consulted with Digital Equipment Corporation, a founding member of the HEDIS initiative, and with NCQA. Though the specific measures parallel the 63 indicators found in HEDIS, Edison, like other employers, has customized the performance goals to reflect its own focus on patient-centered care in an organized, accountable delivery system.

How Purchasers Use Quality Indicators

Given the range of quality standards and measures available, which indicators do firms find the most useful? Two minimum requirements for contracting with managed care plans were frequently mentioned by the purchasers we interviewed—NCQA accreditation status and a willingness to collect and report HEDIS data.

Many purchasers told us that they give considerable weight to NCQA accreditation status.³⁴ Some view accreditation as an essential criterion for a plan to be offered, while others view it as a minimum proxy for quality. Thus, one purchaser added a particular HMO in order to send a message to other plans that it was serious about quality: This firm explained that the new plan's "strongest suit" was its NCQA accreditation. Though many of the private purchasers in our sample said they would refuse to contract with an HMO that has been denied accreditation, they continue to contract with HMOs seeking or making progress toward accreditation. In 1996, Xerox suspended new enrollment in 10 HMOs that it believed had not made sufficient progress. A Xerox official also told us that it threatened to freeze enrollment in a highly regarded HMO who argued that its reputation justified being exempted from the requirement. The plan in question is now well on the path to accreditation.

The second key indicator for the firms in our sample is a health plan's willingness to report HEDIS indicators or to provide other data. Some purchasers told us that health plans were initially reluctant to comply but that most now recognize it as a fundamental requirement for contracting with many large purchasers. Purchasers vary in the extent to which they

³⁴The Joint Commission on Accreditation of Health Care Organizations, a private, not-for-profit organization, also accredits HMOs.

actually use the data available from plans. It appears that, as with accreditation, some firms use the ability and willingness to report data as a proxy for quality. Thus, a benefit manager told us that although the firm lacked the resources to analyze health plan data, the plans themselves had to have HEDIS-type data to effectively manage care. Other firms, however, look beyond the mere ability to report data, and evaluate a plan's responsiveness to partnering with purchasers to continuously improve quality. For example, at a minimum, one firm conducts annual site visits to assess performance against its written goals and may schedule other visits to discuss ongoing projects directed at improving performance in the future. A coalition's executive director told us that it uses contract negotiations to provide plans comparative feedback on issues such as physician credentialing and compensation of doctors.

Some of the purchasers we interviewed are concerned about the integrity of the HEDIS data they receive from health plans. The Gateway Purchasing Association pointed to the discrepancies between plan-reported enrollee satisfaction and the results of an independent survey that it commissioned. While plans reported 90 percent or better satisfaction, Gateway's survey showed a range of satisfaction from 60 percent to 80 percent. Gateway also hired a consultant to audit four randomly selected preventive care measures. Gateway's Executive Director told us that data are more likely to be reliable if a plan believes that it might be audited. PBGH also uses independently verified data on preventive care measures in its quality reports and conducts its own annual satisfaction survey. Some purchasers, however, accept self-reported data and pass it on to their employees.

Recognizing that plan-level data may conceal performance differences among medical groups in large, broad network-model HMOs, several purchasers told us that they have recently been encouraging such plans to report data by medical group as well as for the plan as a whole. According to one firm, however, few plans are now willing to share such information. PBGH is also focusing on the differences between medical groups and is conducting its first survey that looks at enrollee satisfaction at the medical group level. Its sample is drawn from enrollees in 55 participating physician groups. PBGH hopes to use the data to gain a more complete understanding of the impact of health plan and medical group selection on satisfaction.

**Purchasers Emphasize
Need for Plans to Manage
Care**

Purchasers we interviewed are convinced of the potential for managed care to out-perform indemnity coverage in terms of quality. One firm told us that even in immature markets lacking well-developed HMOs, such plans

deliver higher-quality care than traditional indemnity coverage. The Executive Director of Gateway Purchasing Association told us, however, that purchasers want more clinical management, more integration, and more differentiation among the HMO products available. Though they see today's HMOs as a step in the right direction, this view does not connote satisfaction with the plans currently offered. Gateway requires health plans to sign an indemnification affirming that they are actually organized to manage the care delivered to enrollees. Although several large insurers had reservations about this contract provision, they eventually acquiesced.

Another coalition observed that the majority of HMOs do not currently have the integrated information systems necessary to manage care. Instead, HMOs manage cost—not care. Gatekeepers, we were told, too often limit access to more expensive services, rather than facilitating receipt of the care actually needed. The coalition's observations are based on medical reviews directed at identifying whether plans have the systems in place to (1) identify immediately the enrollees who are in need of care and (2) manage that care appropriately. The review itself consists of an examination of a random sample of high-cost cases to determine how the HMO responded. The coalition uses a staff of doctors and experts to review plan records. The focus is on the adequacy of the systems and procedures rather than on the outcomes themselves. The rationale for highlighting high-cost cases rather than more routine ones is statistical: a tiny percentage of individuals account for a disproportionate amount of health care costs. To become more efficient, we were told, purchasers and plans need to focus more attention on what actually generates costs rather than on easier-to-measure preventive services.

Benefit managers at another firm told us that they had come to a similar conclusion: sometimes an HMO tries to limit services at the front end—frustrating healthy people and delaying necessary treatment for people who are sick. Rather than continuing to hold premiums down by adding members, they suggested that HMOs need to make fundamental improvements in the way care is managed. Though this firm offers employees a choice of HMOs, where available, it is seeking to develop partnerships with plans that it identifies by a new acronym—OSC, or organized system of care.³⁵ The firm hoped that its OSC program will push health plans to reevaluate the way that they deliver care. An OSC, we were told, is what an HMO should aspire to be—that is, a plan that integrates the financing and delivery of a full continuum of care and is held clinically and

³⁵Company officials told us that they adopted the concept from the Washington Business Group on Health. Digital also now looks to the HMO to provide its services as an organized system of care.

fiscally accountable for the outcomes and health status of its enrolled population. Though such care systems do not actually exist today, the firm was attempting to identify plans that have the potential to evolve into OSCs because of their operating philosophies, information systems, and physician alignments. Eventually, the firm plans to drop its PPO and nonqualifying HMOs and contract exclusively with such care systems. The number of potential OSCs identified has grown from one in 1995 to nine in 1997. Benefit managers at this firm do not believe that some markets currently exhibit the innovation necessary to produce potential care system partners. Even a mature HMO market like Minneapolis, we were told, is not close to the point at which any plan would be considered a potential OSC.

Access: Employers Accommodate Employee Concerns About Choice

Employers and employees often use different criteria in evaluating access. Employers look at access in terms of the implications for health plan efficiency and the adequacy of an HMO's physician and hospital network, that is, its mix of physicians and their proximity to the population served.³⁶ Some purchasers we interviewed suggested that more tightly controlled HMOs with smaller networks are the most likely to yield efficiently delivered, high-quality health care. However, purchasers recognize that workers are still likely to judge access by their ability to maintain a relationship with a particular physician or by how easily they can obtain referrals to specialists of their choice.

Ensuring access to employees' physicians has become a major criterion in selecting HMOs. The firms we interviewed frequently stated that they like to offer HMOs with large networks, preferably ones that operate statewide. Such HMOs are often made up of numerous, independent medical groups or independent physicians operating throughout the state. One firm told us that its preference for statewide HMOs had led it to drop what it referred to as "mom and pop" plans that were only available in regional markets. In general, firms believe it is unnecessary to offer a large number of broad-based networks. Thus, most of the California purchasers in our sample offer only four HMOs to in-state workers, including at least one smaller, group-model HMO. One argument used to justify offering fewer HMOs is the overlapping networks of large plans. Because many physicians or physician groups contract with multiple HMOs, including additional plans with broad networks accomplishes little. One firm that wants to

³⁶For example, one of the purchasers we interviewed requires contracting plans to have at least two primary care physicians and two hospitals within 10 miles of 90 percent of its employees at a given location. Other purchasers have similar standards.

reduce the number of HMOs it contracts with told us that it will target such plans.

State purchasers, on the other hand, generally contract with a larger number of HMOs. For example HIPC, Washington, Wisconsin, and CalPERS each contract with between 9 and 24 HMOs.³⁷ Moreover, they are more likely to offer small, local plans or staff-model HMOs that operate in some but not all counties. A motivating factor is the desire to extend the HMO option to all enrollees, an option that is often considerably less expensive than the indemnity-type alternatives. In fact, an explicit criterion used by both CalPERS and HIPC for adding an HMO is the plan's ability to expand coverage to underserved areas.³⁸ Consequently, CalPERS has reduced to only one the number of counties without an HMO option. Similarly, Minnesota has cut in half the number of rural counties that have only one health plan option.

The states in our sample also offer employees a choice of broad network-model HMOs. Questioning whether such plans really compete against one another, Minnesota has a long-standing policy against expanding the number of broad network "look-a-likes." When state employees disenroll into another IPA-model HMO, they are often able to continue seeing the same physician—a factor that reduces plan control over provider behavior. However, when an employee leaves a staff-model HMO, the patient also leaves the provider. A HIPC official told us that it was hard to justify additional broad-network HMOs since 90 percent of physicians in California now participate in the plans it offers. In fact, HIPC has dropped one of its original access criteria: Does the plan bring in a new medical group not currently available through some other HMO? BHCAG is making a direct attack on broad-based networks. Starting in 1997, it will contract with 15 separate care systems. The RFP requires that primary care physicians contract with no more than one participating care system. Overall, however, the number of participating physicians will be larger than under the coalition's previous PPO product.

³⁷The number of HMOs offered by CalPERS varies considerably among California's 58 counties: 40 have between 4 and 11 HMOs; 5 have between 2 and 3; 12 have only one; and 1 county has no HMO option.

³⁸For the benefit year beginning August 1995, CalPERS began offering National HMO to state employees. National HMO is available in 13 counties, including three that had previously lacked an HMO option.

Application of Criteria Varies

We found that the purchasers we interviewed varied considerably in (1) the significance that they attach to a given criterion; (2) how they integrate access, quality, and cost criteria to arrive at a decision; and (3) their willingness to eliminate a plan on the basis of specific criteria. Purchasing coalitions and state governments, in particular, appear to be more reluctant than private purchasers to use quality indicators to select or eliminate HMOs. In general, the use of criteria by many purchasers we interviewed appeared to be subjective. One coalition that expressed confidence in the outcome of a quantification of bids acknowledged that the evaluation was subjective rather than scientific in some areas.

Few of the large purchasers we interviewed told us that price is their most important selection criterion. However, a recent study conducted jointly by a benefits consulting firm and the Washington Business Group on Health found that virtually all of the 368 large, medium, and small firms it sampled listed cost as their most important health plan selection and evaluation criterion.³⁹ Other highly-rated criteria were satisfaction with services, availability of utilization data, and access by employees. The survey noted that comparatively few used available quality assessment tools such as HEDIS, plan sponsorship of practice protocols, audited report cards, health outcomes, or accreditation status to evaluate health plans. These information tools were ranked at the bottom in terms of usefulness. The study concluded that while employers are interested in quality-based purchasing, they rate existing measures as less helpful than measures related to cost and service. The survey emphasized, however, that employers of various sizes use the available assessment tools differently. For example, large purchasers with more than 10,000 employees are far more likely than small employers to use HEDIS or report cards and to have adopted health plan accreditation criteria. Moreover, the study projected a significant increase in the use of these assessment tools over the next few years, especially by large employers.

Xerox, Digital, and Southern California Edison exemplify a large-employer approach that separates the consideration of quality from price. Both Digital and Edison have published the extensive performance measures that they use to evaluate plans and accept bids only from health plans that meet these quality standards. Digital told us that it only applies the performance measures to about one-half of the HMOs with which it contracts. It is difficult, an official explained, to impose standards on health plans in a market where the firm only has a small number of

³⁹Washington Business Group on Health and Watson Wyatt, Worldwide, *Is Cost Everything? Getting Value for Your Health Care Dollar* (Washington, D.C.: Feb. 1996).

employees.⁴⁰ Though it has no published performance standards, Xerox develops a quality ranking for each plan with which it contracts. The ranking includes a large number of variables, such as accreditation, and involves assigning a numerical score for each variable. A benefit manager told us that Xerox shares these quality rankings with HMOs to let them know where they stand. The firm is considering eliminating plans that fail to meet an acceptable threshold. As noted earlier, Xerox does not negotiate with health plans and considers itself a price-taker. Though Xerox will contract with plans that are considerably more expensive than its benchmark plan, employees must pay the difference.

Access is clearly an important criterion—one that appears to have had an unintended effect on the size and efficiency of health plans. Although some employers emphasized that they want plans to compete on the basis of the quality and efficiency of the medical groups in their networks, many acknowledged that they prefer plans with broad-based networks. The plans themselves, we were told, believe that they compete at the consumer level, where paramount importance is attached to maintaining ties to one's own doctor. As a result, some plans attempt to recruit as many medical groups as possible. One purchaser we interviewed conducted an access study to help it select HMOs. The rationale behind the study was that employees would be more inclined to join an HMO if they did not have to change doctors to do so. The firm's health benefit manager told us that two of the HMOs selected had higher costs, but the best access scores. Other purchasers, we were told, also based their selection of HMOs on access studies.

Finally, some purchasers took a quantitative approach to evaluating health plan bids. For example, the National HMO Purchasing Coalition and the Arizona Medicaid programs assign a weight of about 70 percent to quality and access criteria, and 30 percent to cost. The coalition's goal is to identify two to four HMOs in each market. In 1997, it will contract with 134 of the 380 HMOs that submitted bids. Arizona awarded contracts to 14 of the 21 health plans that submitted bids in 1994, selecting fewer contractors in rural areas than in urban centers. Florida Medicaid is also about to adopt a quantitative evaluation methodology. Although plans that do not achieve a minimum quality and access score will be eliminated, Florida plans to contract with all qualified bidders. Enrollment will be allocated among plans on the basis of their overall ranking. Plans with higher scores

⁴⁰Digital estimates that between 80 and 85 percent of employees are enrolled in plans subject to its performance standards.

will be rewarded with larger enrollment. Cost accounts for 20 percent of the total score.

Given the difficulty of distinguishing among HMOs using today's state-of-the-art techniques, some purchasers use criteria to establish a minimum threshold for health plan participation and to evaluate and monitor HMO performance. In some instances, a purchaser's market power allows it to dictate the minimum requirements for the plans it contracts with. Some of these purchasers tend to view any narrowing of the market as premature, given the preliminary nature of some of the criteria. The root of this caution is the difficulty of measuring an HMO's efficiency, true cost, and quality of services. Is one HMO less costly than another because it has healthier enrollees, rations care to save money, or puts effective systems in place to actually manage care?

The Executive Director of the Gateway Purchasing Association in St. Louis referred to this minimum threshold as the "ground-rules" for health plan participation. Plans that want to contract with Gateway must be licensed HMOs, be willing to provide data, agree to the coalition's benefits designs, and be willing to undergo performance measurement audits. State governments also have such minimum thresholds. Adopting minimum requirements, however, does not mean that such purchasers contract with every qualified health plan or that they forsake the use of specific criteria to eliminate health plans. Thus, as described earlier, HIPC, CalPERS, and Minnesota have specific criteria that they apply in deciding whether to expand employee health benefit options.

Plan Options, Incentives, and Marketing Used to Sway Employee Behavior

As of 1994, 19.5 percent of Americans were enrolled in HMOs; enrollment in HMOs by state ranged from over 35 percent in 5 states to less than 5 percent in 11 others. Measured against this standard, a representative group of purchasers in our sample has achieved significantly higher rates of HMO enrollment, even among unionized workers and retirees who are often exempt from requirements placed on active, nonunion employees. For example, only two purchasers have fewer than 50 percent of their active employees enrolled in HMOs, while 7 out of 11 purchasers have over 70 percent of such employees enrolled in HMOs. Table 4.1 summarizes, for a representative group of employers in our sample, changes in HMO enrollment that occurred after implementing major changes in their purchasing strategies. More recent statistics for some purchasers show how HMO enrollment has changed over time.

Table 4.1: HMO Enrollment for Purchasers in GAO Sample Before and After Changing Purchasing Strategy

Purchaser	HMO enrollment	
	Before changes in purchasing strategy	After changes in purchasing strategy
	Numbers in percent	
State purchasers		
CalPERS active employees	84 (1993)	84 (1996)
CalPERS retirees	50 (1993)	49 (1996)
Minnesota active employees	51 (1989)	48 (1993), 72 (1996)
Missouri active employees	32 (1994)	75 (1997)
Washington total employees	66 (1995)	77 (1996)
Washington active employees	70	83
Washington retirees	46	52
Wisconsin active employees	20 (1983)	55 (1984), 83 (1996)
Private sector purchasers		
American Express	29 (1993)	62 (1994), 74 (1995)
Digital	28 (1990)	60 (1992), 66 (1996)
NYNEX total employees	31 (1993)	46 (1996)
NYNEX union employees	34 (1993)	40 (1996)
NYNEX management	24 (1993)	64 (1996)
Safeway	21 (1992)	37 (1995), 63 (1996) ^a
U S WEST total employees	12 (1991)	42 (1996)
U S WEST union employees	Not available	45 (1996)
U S WEST nonunion employees	Not available	33 (1996)
Xerox	40 (1990)	80 (1997)

^aProjected.

To what factors do these purchasers attribute increased enrollment in HMOs or in other forms of managed care? The purchasers in our sample identified three basic tools that they believe had a major impact on employee health plan selections: (1) the type and mix of health plans offered, (2) financial incentives, and (3) the information provided on health plan options.

Evolution in Employee Benefit Options

The movement toward a managed care purchasing strategy is reflected in the type and mix of health plans offered by the purchasers in our sample. In some cases, however, purchasers told us that the current list of options is only an interim step in the direction of increased reliance on HMOs to serve the health care needs of their employees—albeit HMOs from which they expect improved management and accountability for the delivery of care. The range of plans offered reflects (1) a willingness to accommodate the high priority employees attach to selecting a physician and (2) the lack of alternatives to indemnity products in some markets. Few of these purchasers have abandoned plans that allow access to a wider choice of physicians, specialists, and hospitals. And still fewer offer only the most restrictive type of managed care—the staff-model HMO that employs its own doctors, operates its own hospitals, and uses a gatekeeper to regulate access to specialists.⁴¹ Instead, what has evolved often strikes a middle ground by restricting, but not eliminating, the right to select a physician and by addressing concerns about having too few physicians from which to choose.

Table 4.2 summarizes the health plan options for a representative group of purchasers in our sample.

⁴¹As noted earlier, the distinctions among managed care plans are becoming outmoded as plans rapidly evolve in response to marketplace demands. For example, Kaiser, a group-model HMO, now offers a point-of-service product in certain markets and sometimes contracts with non-Kaiser hospitals.

Table 4.2: Health Care Options Available

Purchaser	Type and mix of plans offered
State purchasers	
CalPERS	PPO and HMO
Minnesota	PPO and HMO
Missouri	PPO, POS, and HMO
Washington	PPO and HMO
Wisconsin	Indemnity, PPO, and HMO
Private sector purchasers	
American Express	Indemnity, PPO, and HMO
Digital	Indemnity, ^a POS, and HMO
NYNEX	Indemnity, POS, and HMO
Safeway	PPO, ^a POS, and HMO
U S WEST	POS and HMO
Xerox	Indemnity and HMO

^aEffective in 1997, Digital's indemnity option will be available only in areas with no POS plan. Safeway's PPO option is no longer available in 1997.

Indemnity

Although purchasers in our sample still offer an indemnity option, they have often introduced elements of managed care into their plan designs. Hybrid “managed indemnity” products now include features such as (1) utilization review; (2) mandatory case management of expensive services; (3) precertification for surgery, hospitalization, certain tests, and inpatient mental health treatment; and (4) centers of excellence renowned for treating certain diseases. Escalating costs have also persuaded some of the purchasers we interviewed to place special restrictions on some services—especially mental health. One company has even required precertification for substance abuse treatment. Some purchasers are worried about the continued viability of their indemnity option because of the tendency for higher utilizers of care to choose plans with fewer restrictions on selecting providers. In many markets, especially rural areas, there is no real alternative to an indemnity option.

Preferred Provider Organization

Some purchasers have substituted a PPO—a somewhat narrower network of doctors and hospitals—for their indemnity option. For example, the CalPERS PPO includes 83 percent of physicians in California, while the PPO offered to Washington State employees includes 85 out of 89 hospitals. Some PPO designs even incorporate an out-of-network option that provides

employees with a safety valve back to traditional indemnity coverage. As with indemnity coverage, purchasers have introduced similar management features to help control costs. The introduction of a management feature can be triggered by employee demographics or analysis that identifies a high-cost area. For example, analysis by one firm with a predominately young workforce suggested that maternity costs were its biggest expense. To help identify potential prenatal problems, this employer instituted a voluntary nurse advocate hotline. In Minnesota, state employees must now select a primary care physician gatekeeper, a feature often associated with HMOs, if they elect to enroll in the state's self-funded PPO. The use of gatekeepers is often associated with more restrictive HMOs. CalPERS developed a second, self-funded PPO product that was first offered in 1993. It was intended as a more affordable option for members who want fewer restrictions on their choice of providers. Its lower premiums are offset by higher out-of-pocket costs for enrollees. Minnesota also developed a second, more restrictive self-funded product in order to respond to an HMO with a self-referral option that was competing with the state's PPO product. A state official referred to this new option as an "HMO clone."⁴² It consists of a high-performance network of doctors and clinics that were handpicked because they were good at managing care. The only difference between the larger PPO network and this new option is that it eliminates the self-referral option still available through the larger network.

Point-of-Service

Some purchasers have replaced indemnity or PPO plans with a point-of-service (POS) option—a less contentious move, from the standpoint of employee relations, than adopting an HMO-only strategy. POS is a hybrid design that can have elements of an HMO, a PPO, and even a traditional indemnity product. Employees may decide which tier to utilize each time they seek medical services. Several purchasers told us that they view POS as a bridge from indemnity plans to HMOs. A few purchasers in our sample offer POS in conjunction with either traditional indemnity or a PPO option. In some instances, an indemnity-type option is only available if a POS plan is not offered in a particular market. Some purchasers, however, offer no middle ground between indemnity coverage and an HMO. HMO enrollees of one such firm have an out-of-network option for certain serious procedures, such as transplants.

Health Maintenance Organization

As discussed in chapter 3, most private sector purchasers emphasize broad-network HMOs that operate statewide and provide access to a wide

⁴²Although not licensed or regulated as an HMO, a state official told us that this option operates like an HMO with a closed panel of physicians.

choice of primary care physicians, specialists, and hospitals. State purchasers, on the other hand, are more likely to contract with smaller, local health plans in an attempt to provide an HMO option to as many employees as possible.

Developing Financial Incentives Poses Challenges for Purchasers

Purchasers we interviewed believe that financial incentives are an important tool in facilitating acceptance of HMOs by employees. They are often inherent in the design of a managed care or HMO option in the form of lower premiums, copayments, and deductibles coupled with a richer set of benefits. Such incentives, however, were generally viewed by the purchasers in our sample as less effective than ones that focus on the amount deducted from an employee's paycheck—that is, the employee share of the cost of health care coverage.

Before purchasers adopted a managed care strategy, employees were insulated from the true costs of their health care. To a greater extent than in the past, the purchasers we interviewed are exposing workers to the financial implications of their choices. The ability of purchasers to adopt stronger financial incentives, however, is often limited by a common set of constraints, including the extent to which workers are unionized or the corporate culture's perspective on employee cost-sharing.

The Theory Behind Contribution Formulas

Most employers pay a fixed percentage of an employee's health plan premium. Table 4.3 uses hypothetical monthly premiums for four health plan options to demonstrate the impact of different cost-sharing formulas on employee out-of-pocket expenses. For each option, the firm pays 90 percent of the premium according to the specified formula and the employee pays the remainder. For example, under the option 3 formula, the employer contribution is based on the cost of the benchmark plan⁴³—in this instance, HMO A—and totals \$108 (90 percent of \$120). An employee selecting HMO A pays the remaining 10 percent (\$12). On the other hand, an employee electing to enroll in the most expensive plan is responsible for 46 percent of the premium, and one choosing the least costly option pays nothing.

Moving across the table from left to right, each successive formula provides a stronger financial incentive for an employee to consider cost in choosing between indemnity and managed care options. So when an

⁴³The term "benchmark" is associated with Xerox and Digital, which screen the HMOs that they offer to employees on explicit quality criteria. Generally, the benchmark HMO is the lowest-priced plan in that market that year.

employer pays 90 percent of the cost of any plan (option 1), the employee only faces a \$10 differential between the low-cost HMO and the indemnity option. If, on the other hand, the employer's contribution is tied to 90 percent of the low-cost plan (option 4), an employee considering the indemnity option must contribute \$100 more each month compared with the least expensive HMO. In addition to widening the cost gap between indemnity and managed care options, each successive formula also forces an employee to take a closer look at the cost differential among managed care options. In our examples, HMO A is designated as a benchmark HMO because of outstanding quality. Under option 2, HMO A is free; however, under option 4, which uses a low-cost formula, the employee's share of the premium is \$30—\$20 more than HMO B, an acceptable, but less expensive, HMO.

Table 4.3: Hypothetical Firm-Employee Contribution Options (Single Coverage/Per Month)

	Formula: Firm pays 90% of (employee pays remainder)			
	Option 1: Cost for any plan selected	Option 2: Average cost of all plan options (\$124)	Option 3: Cost for benchmark plan (HMO A/\$108)	Option 4: Cost for low-cost plan (HMO B/\$90)
Indemnity: premium = \$200				
Firm pays	\$180	\$124	\$108	\$90
Employee pays	\$20	\$76	\$92	\$110
Point-of-service: premium = \$130				
Firm pays	\$117	\$124	\$108	\$90
Employee pays	\$13	\$6	\$22	\$40
Benchmark HMO A: premium = \$120				
Firm pays	\$108	\$120	\$108	\$90
Employee pays	\$12	\$0	\$12	\$30
Low-cost HMO B: premium = \$100				
Firm pays	\$90	\$100	\$100	\$90
Employee pays	\$10	\$0	\$0	\$10

The strength of any financial incentive is also influenced by a number of other factors, including (1) the magnitude of the difference among health plan premiums, (2) employer generosity, and (3) the characteristics of the workforce. The closer premiums are clustered together, the less incentive an employee has to discriminate among plans due to cost differences. Similarly, an employer electing to pay a higher percentage of the premium may reduce employee cost-sensitivity. Finally, a young, relatively healthy workforce will probably be more responsive to small changes in price than one that is older and sicker. Generally, however, a fairly significant price

differential may be required to convince employees to switch to a managed care plan with a more restrictive choice of physicians.

Employees Asked to Share More of Health Care Costs

We were told that in the past many employers targeted their contribution to higher-cost plans, reducing the incentive for an employee to choose a less expensive alternative. Although some purchasers in our sample continue to use higher-cost plans as a reference point in determining the level of employee cost-sharing, others have adopted contribution formulas that more explicitly encourage migration to what they consider efficient health plans. Only one firm told us that it did not believe in using financial incentives to influence employee choice. As noted earlier, the specific formula adopted, cost differentials between plan options, and employer generosity all influence the effectiveness of incentives. Whatever formula is used, however, purchasers we interviewed generally now ask employees to contribute more to the cost of coverage, particularly employees who choose an indemnity option. Table 4.4 describes the employee contribution formulas of a representative group of purchasers in our sample and provides a rough comparison of employee out-of-pocket costs if the employee elects to enroll in an indemnity-type product.

Table 4.4: Financial Incentives Adopted by Purchasers

Purchaser	Financial incentives (for active employees only)	Monthly employee share of family coverage under indemnity-type option
State governments		
CalPERS	Incentive for state employees based on California's freezing its contribution at the 1991 level.	Ranges from \$80 to \$256 for state employees, depending on the PPO option chosen.
Minnesota	Low-cost plan formula introduced in 1989. Low-cost plan is free for full-time employees.	\$84 in the Minneapolis area (PPO enrollment in 1996 was about 27%).
Missouri	Low-cost plan formula introduced for state employees in 1995. Low-cost plan is free for employees.	\$266 in the Jefferson City area for the PPO option. In contrast, the lowest-cost HMO is \$112.
Washington	First introduced cost-sharing in 1996. PPO is benchmark for cost-sharing.	\$36 (Enrollment in the state's self-funded PPO dropped 35% with the introduction of cost-sharing).
Wisconsin	Low-cost formula introduced in 1984. State pays the lesser of 90% of indemnity option or 105% of qualified lowest-cost plan.	Ranges from about \$75 (where there are no low-cost alternatives) up to \$333.

(continued)

Chapter 4
Plan Options, Incentives, and Marketing
Used to Sway Employee Behavior

Purchaser	Financial incentives (for active employees only)	Monthly employee share of family coverage under indemnity-type option
Private sector		
American Express	Gradually moving to benchmark plan formula by 2001. The benchmark is the local HMO with the highest value measured in terms of quality (70%) and cost (30%) and is usually, but not always, the lowest-cost plan. 1994 increase in HMO enrollment attributed to promoting HMOs in open season literature.	Unavailable.
Digital	Introduced a benchmark plan formula in 1991 in which firm pays 85% of plan that meets its cost and quality criteria. The benchmark plan is usually, but not always, the lowest-cost plan in an area.	\$623.92 in the Boston area (less than 6% are in the indemnity option in 1997); 16% are in POS in 1997.
NYNEX union	No incentive—free.	Indemnity option is free.
NYNEX management	Cash-back incentive increased significantly in benefit year 1994 for employees electing to join an HMO.	Ranges from \$214 to \$340, depending on the employee's location.
Safeway	First introduced cost-sharing in 1994. Starting in 1996, will pay 90% of average-cost plan.	Replacing PPO with POS in benefit year 1997. PPO enrollment dropped by 50% between 1994 and 1996.
U S WEST union	Limited incentive—POS and low-cost HMO are free; employee pays difference for higher-cost HMOs.	Indemnity no longer offered.
U S WEST management	Limited incentive—POS and low-cost HMO are free; employee pays difference for higher-cost HMOs.	Indemnity no longer offered.
Xerox union	No incentive—indemnity option is free to employee.	Unavailable.
Xerox management	Benchmark plan (low-cost) is free, and, in addition, employee gets cash back.	\$201.

Relatively few of the purchasers in our sample—only six—elected to target their contribution to the low-cost or benchmark plan. The two firms that use a benchmark formula screen plans using explicit quality criteria before offering them to employees. In adopting this approach, purchasers

need not penalize individuals living in markets with limited managed care alternatives. Thus, in rural areas with few HMOs, Wisconsin and Minnesota designate their indemnity and fee-for-service PPO plans as the low-cost option. In rural Wisconsin, a state employee pays only \$75 monthly for family coverage under the indemnity plan, while in areas with competing HMOs, the same plan costs as much as \$333.

The impact of a low-cost plan formula on employee choice can be dramatic. For example, Digital saw enrollment in HMOs double in one year from about 30 to 60 percent—a level where it appears to have stabilized. Xerox's enrollment in HMOs now stands at about 80 percent. Digital, unlike Xerox, offers a POS alternative that has attracted a steady 15 to 16 percent enrollment.⁴⁴ HMO enrollment by Wisconsin State employees went from 20 to 55 percent the year after it adopted a low-cost contribution formula that only offered a choice between HMOs and an indemnity plan.

On the other hand, Minnesota implemented a low-cost plan option in 1989. By 1993, HMO enrollment by Minnesota State employees had actually decreased slightly, from 51 percent to about 48 percent. During this period, the cost differential between the low-cost plan and the state's self-insured, fee-for-service PPO remained fairly constant. Officials attributed the recent growth in HMO enrollment, which now stands at 72 percent, to a widening of this cost differential. In 1995, an HMO with a self-referral option and a network that closely resembles the state's fee-for-service PPO product cut its rates by 25 percent. Since this HMO was now substantially cheaper, the state fee-for-service PPO lost 10 percent of its enrollment. The actual amount of an employee's share of the premium for alternative types of coverage also helps explain the impact of a low-cost formula on plan enrollment. For example, in 1996, a Minnesota State employee in the Minneapolis area who elects fee-for-service PPO coverage for his family paid about \$64 a month more than for the lowest-cost HMO. Minnesota still has about 27 percent of state employees in its PPO option. In contrast, a Digital worker in the Boston area who chose indemnity coverage for his family paid about \$560 per month more than for the lowest-cost HMO. Not surprisingly, only about 5 percent of Digital employees are still enrolled in the company's indemnity plan.

Over time, the already strong, low-cost incentive can become stronger: Those remaining in indemnity plans tend to be higher utilizers of health care services, increasing the cost per enrolled employee and the

⁴⁴As of January 1, 1997, Digital managed care enrollment stood at 82 percent: 66 percent of employees are enrolled in an HMO and 16 percent in a POS plan.

associated premium. But a firm may choose to subsidize its indemnity option to prevent this adverse selection “death spiral.” The incentive structure of such firms is based on the assumption that younger, single individuals use little health care and are thus cheaper to insure under an indemnity option.⁴⁵ Thus, single employees at two firms in our sample pay nothing for indemnity, while families are given a greater financial incentive to join an HMO. A different firm, on the other hand, has removed most of the subsidy for the indemnity option. Its goal is to eventually replace this option with a POS alternative.

The Missouri Consolidated Health Care Plan, which manages health benefits for public employees, adopted a low-cost formula for state workers in 1995. A board member suggested that purchasers who self-insure their indemnity plan often find it difficult to be neutral about the plan’s success or failure, including the extent to which employees share in ever-rising costs. Self-insurance, he argued, clouds a purchaser’s view of competing plans, a factor that contributed to the board’s decision to sell its indemnity product and offer a fee-for-service PPO option through an independent carrier. The logic behind the decision is that an insurance company is more likely to take the necessary steps to make such a plan competitive and to charge realistic premiums that ensure profitability. Another program for state employees, the Washington Health Care Authority, has been directed by the state legislature to study the advantages of selling off its fee-for-service PPO product.

One purchaser we interviewed adopted a more radical and costly approach to increasing HMO enrollment. Initially, a management-level employee paid nothing for the low-option indemnity plan and, in fact, got money back. To increase HMO enrollment, the firm required single employees to contribute toward the cost of this indemnity option and offered what the firm’s benefit manager characterized as a “huge” managed care incentive—\$2,000 to \$3,000 cash back. Its popularity has forced the company to gradually scale back the value of the incentive. Over a 3-year period, the firm’s nonunion HMO enrollment grew from 24 percent to 64 percent. Firms that pay 100 percent of coverage have also adopted a cash-back incentive model to increase participation in certain types of health plans. Another firm offers employees additional benefit options, such as dental and vision, rather than cash when they choose less expensive options.

⁴⁵This group also tends to be sensitive to smaller cost differentials.

The contribution formulas used by most of the purchasers we interviewed fall somewhere between a low-cost formula and one that pays a fixed percentage of any plan selected. Some of the approaches adopted include

- average cost of all plans, including the indemnity option,
- use of a PPO as a benchmark,
- grouping plans into low- and high-cost tiers, and
- freezing the employer contribution at the 1991 level.

BHCAG employers have agreed to group care system bids into three tiers and to base the contribution for each tier on the average premium. Employees choosing a plan in the first tier would pay the lowest cost for single coverage, but selecting a plan in the third tier would cost the employee the most. Moreover, some BHCAG members told us that they may eliminate some or all of the other plans currently offered to employees. Other purchasers we interviewed recently implemented or are in the process of phasing in stronger financial incentives. One firm is moving toward the low-cost plan approach over a period of 7 years. Other purchasers we interviewed also phased in stronger employee contribution formulas.

Purchaser failure to periodically review and update the contribution formula can water down its impact on employee behavior, especially when premiums are rising slowly or even declining in some markets. Such trends also lessen the urgency for a purchaser to strengthen incentives. For example, until 1991, the state of California based its contribution for active employees under the CalPERS program on the cost of the four most popular plans, which were also among the most expensive.⁴⁶ Since then, the monthly contribution level has been frozen at \$410 for family coverage. Although the goal was to establish a new contribution formula through collective bargaining, as of August 1996 no agreement had been reached for most of the bargaining units. The pressure to agree on a new formula may have been undercut by the fact that (1) many HMO premiums are now less than they were in 1993 and less than the state's "frozen" contribution level, (2) the most popular PPO has experienced a modest price increase of only 4.5 percent over 4 years, and (3) an alternative PPO option fell nearly 20 percent in cost since 1993. Chevron negotiates a fixed-dollar contribution with its employees every 3 years. With the decline in California HMO rates through its participation in PBGH, HMOs are now free to

⁴⁶Under the CalPERS program, California still uses the average weighted cost of the four most popular plans to calculate the premium contribution for state retirees. In 1996, the state's monthly contribution fell from \$410 to \$369. If this formula had still applied to active state employees, family coverage in the most popular HMO would have been about \$15 a month rather than free.

employees. Since the cost of the firm's POS alternative has also decreased, we were told that there is now little incentive for employees to join an HMO.

Purchasers also use financial incentives to steer employees toward specific health plans. Xerox announced that it would give employees a \$120 price break for joining HMOs that were fully accredited by NCQA. Members of the National HMO Purchasing Coalition meet annually by region with contracting HMOs and ask plans to set their own performance standards. Subsequently, one coalition member surveyed employees to measure health plan progress against these self-defined standards. Depending on the survey results, this firm will increase or decrease its contribution for the plan by up to 20 percent.

Constraints on Employee Cost-Sharing

Corporate culture, collective bargaining, and the low salaries of some workers limited the ability of firms in our sample to share the cost of health insurance coverage with their employees. The corporate culture of some firms in our sample is paternalistic toward employees, placing limits on the extent to which employees could be asked to contribute toward the cost of health care. One firm told us that it had a huge internal debate over employee cost-sharing and the adoption of a low-cost contribution formula. For years, the firm had told employees that it did not choose health plan partners on the basis of cost. Thus, switching to a low-cost contribution formula would have directly contradicted 10 years of emphasis on partnering with plans. The firm adopted a more modest cost-sharing formula, but the benefit manager was not sure that the differential between the plan options was significant enough to encourage migration into HMOs.

Other firms had a significant portion of their workforce covered under labor agreements that prohibit cost-sharing for traditional indemnity, PPO, and even POS plans. One company not only offers many of its plans free to union employees but also feels compelled to do the same for management-level staff to avoid making a union attractive to nonunion employees. The benefit manager of this firm commented that a larger percentage of union than management-level staff had enrolled in HMOs. All of the company's executives are in the POS plan, and there is not much encouragement from top management to develop stronger incentives for HMO enrollment. A few firms, however, have been able to persuade their unions to accept a POS plan in lieu of a PPO option. Benefit managers told us that a relatively small percentage of their POS costs were attributable to

enrollees who sought services outside the HMO tier, that is, the PPO or indemnity tiers.

Finally, some purchasers are limited in their ability to impose cost-sharing by the character of their workforce. A firm told us that even though it kept the premium contribution low, few of its hourly employees signed up for health benefits. One factor was low wages. This firm said that if it charged more than \$50 a month for single coverage, few, if any, employees would sign up. Another factor, we were told, was the youth of many employees, who would “rather spend the money on a car stereo instead.” Those who did enroll tended to be married and planning to have children.

Relative Importance of Incentives Sometimes Difficult to Discern

The relative importance of financial incentives versus other factors that influence an employee’s choice of health plans is difficult to distinguish. Clearly, workforce demographics, degree of HMO penetration, or dislike of the paperwork often associated with indemnity plans can also affect employee plan selection. Union employees are a case in point. Many of these workers have no explicit financial incentive to join an HMO other than copayments and deductibles, since indemnity coverage is often free. Yet purchasers told us that many union employees have chosen HMOs. Some firms attributed the high HMO enrollment of unionized workers, in part, to dislike for the indemnity claim forms and “red-tape.”⁴⁷

HMO penetration in a given market is another factor affecting the behavior of union workers. Thus, when Xerox began to implement its benchmark HMO strategy for management-level employees in 1990, the firm already had 40 percent HMO enrollment—largely among its union workers in Rochester, New York. According to Xerox, HMOs have long been accepted in Rochester and include almost every doctor in the area. In the early 1990s, HMOs provided insurance to more than half of the city’s residents.⁴⁸ In general, the purchasers in our sample have more employees enrolled in HMOs in areas with significant HMO penetration.

⁴⁷One employer, whose no-cost indemnity option for union employees had a \$250,000 lifetime limit, told us that many such employees chose an HMO not because of this low limit but to avoid the indemnity paperwork hassle.

⁴⁸Health Care: Rochester’s Community Approach Yields Better Access, Lower Costs (GAO/HRD-93-44, Jan. 29, 1993), p. 8.

Firms Try Marketing to Overcome Resistance to Managed Care

The most serious obstacle to the health benefit management strategies described in this report is often the negative employee perception of managed care. This general antipathy for restricted choice and apprehension about the quality of care have been heightened over the past several years by what purchasers characterize as a constant stream of negative publicity ranging from gag rules to maternity stays.⁴⁹ Employers have used three basic tools to help sway employee opinion and to assuage specific employee concerns about managed care. First, as discussed in chapter 3, they articulate and explain the criteria used to select managed care plans. Second, they now more prominently feature HMOs in their open enrollment literature. Finally, they provide employees specific comparative data about the quality of the available health plan options. The purchasers in our sample are not merely supplying relevant information; their role during the annual open season is sometimes one of advocate rather than neutral broker.

Open Enrollment Season Offers Opportunity to Promote HMOs

The purchasers in our sample give employees an opportunity to reassess their health plan selections annually during what is commonly referred to as an “open season.” American Express told us that after switching to an HMO strategy, it began to devote more space to the managed care options in its open season literature. Previously, this material had zeroed in on the company’s indemnity plan, leaving it up to the employee to take the initiative to learn more about participating HMOs. The open season brochure merely provided plan names and phone numbers. According to a benefit manager, the firm was more knowledgeable about and comfortable with how its own indemnity plan worked, and the open season literature simply reflected this fact. It was much harder to describe HMO benefits, since they differed from plan to plan.

Some purchasers we interviewed now routinely provide employees with basic information about the HMOs they offer. Although the specific data vary from employer to employer, the following categories of information usually were included:

- **General:** Description of how an HMO works, including an explanation of the difference between group/staff and IPA model plans, the role of the primary care physician, and how to obtain referrals to specialists.
- **Plan-specific data:** How long the plan has been operating, whether it is for-profit or not-for-profit, the number of enrollees it has, the growth or

⁴⁹The typical comments about HMOs from a focus group conducted by one purchaser were (1) “the care is inferior,” (2) “I don’t think my doctor participates,” and (3) “top-quality physicians aren’t available through an HMO.”

decline in enrollment over time, and the percentage of fellow employees who have selected each plan.

- Physician data: Physician turnover, the number of board-certified specialists and primary care physicians, and the percentage of primary care physicians accepting new patients.
- Hospital: Hospitals affiliated with the plan and those most frequently used.
- Accreditation: NCQA accreditation status.

Some purchasers in our sample give employees a context for interpreting the data provided, such as including a benchmark or goal for evaluating the physician turnover rate. Xerox informs employees how plan premiums have changed over the last few years and suggests a goal of less than 4 percent over a 3-year period.

As shown by the prominence of such data in this list, access may be the single most important issue for employees. One firm told us that it put together a special brochure to educate employees on the differences between Kaiser and several new IPA-model HMOs that were being offered for the first time. It wanted to be sure that employees understood that the new plans were different from Kaiser, which is a staff-model HMO with a much narrower choice of physicians and hospitals. This firm, as well as other purchasers, told us that employees are more willing to choose an HMO or other managed care product when they know that their doctors and local hospitals participate. While it is relatively simple to provide a list of affiliated hospitals, the names of network providers are generally only available from individual health plans. One purchaser, however, went a step further. HIPC now publishes a semiannual list of participating providers and the health plans with which they are affiliated. When a provider is available through several plans, as is often the case in California, it gives employees an opportunity to focus on other selection issues.

Some purchasers are also attempting to provide information on HMO benefits and exclusions in their open season material. This task was simplified for those purchasers who have adopted standardized HMO benefits. Standardized benefits, however, do not mean that the policies and procedures of each HMO are identical. For example, Wisconsin furnishes additional information on each plan regarding the policy on maternity stays, the operation of the drug formulary, procedures for dispensing drugs, covered outpatient mental health services, and how to obtain disposable diabetic supplies. For other purchasers we interviewed, however, explaining HMO benefits is complicated by the lack of

standardization. Despite the difficulty, some firms do provide comparative information on HMO copayments and limits for various services, while others still refer their employees to each health plan.

Quality Is Focus of Some Data, Especially Report Cards

Generally, purchasers recognize that they cannot advocate enrollment in managed care plans without addressing a fundamental employee concern—the suspicion that cost, not quality, is the motivating factor for adopting a managed care strategy. Some of the basic information just described touches indirectly on the issue of health plan quality—like the percentage of board-certified physicians and accreditation status. What are commonly referred to as “report cards” are an attempt to tackle the quality issue head on.⁵⁰

About half of the purchasers in our sample currently provide employees a report card on the HMOs that they offer, and others are planning to do so in the near future. These report cards focus on the results of employee satisfaction surveys and, to a lesser extent, health plan performance in delivering HEDIS preventive services such as immunizations or cancer screening. Purchasers offered a number of explanations for not putting greater emphasis on HEDIS measures. One firm that was involved in the development of HEDIS told us that it had doubts about sharing these data with employees because the attempts to measure quality are in their infancy. This firm is only issuing its first report card for the 1997 benefit year. Another purchaser noted that employees are not interested in HEDIS performance data; employees only wanted to know what the firm was doing to ensure that the “right” plans, that is, high-quality plans, were offered. Finally, research suggests that individuals have greater confidence in and attach more weight to the opinions of peers. A purchasing coalition that tested its report card on a focus group told us that individuals were unimpressed with the HEDIS data and were more likely to rely on the member satisfaction results.

As with other information on managed care plans, some purchasers try to help employees understand and use the report card data. Thus, rather than merely reporting a raw score, some report cards rank plans as either above or below average, making it easier for employees to compare plans and draw conclusions from the data. Xerox publishes a goal or standard for most satisfaction and performance measures. CalPERS actually includes a worksheet and encourages employees to use the report card data to

⁵⁰See Health Care Reform: “Report Cards” Are Useful but Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

compare plans and highlight areas of concern. Minnesota tells state employees how the satisfaction results for each plan have changed in targeted areas since the last survey. A few purchasers also include results on their own self-funded indemnity plan or the POS option, giving employees an opportunity to see how their peers rate satisfaction among the different types of plans available

Marketing Strategy: Using Information to Advocate Managed Care

The purchasers we interviewed believe that managed care offers the best “value”—the right combination of price and quality—for employees. Moreover, some are convinced that choosing a health plan is seldom a rational decision based on good information or even on the right information. Although they hesitate to recommend or endorse a particular plan, these purchasers are not bashful about advocating enrollment in particular types of managed care plans that they offer. And they use information both to support their position and to encourage employees to be more analytical about their health care options. According to one benefit manager, however, large purchasers are careful to make sure employees understand both the pros and the cons of managed care; they prefer not to deal with angry individuals who subsequently decide that this option is not for them.

Communications can be a powerful tool, because a purchaser has the latitude to either minimize or maximize the exposure it gives to a health plan in the plan’s interactions with employees. One firm told us that it was using compelling arguments and information to interest employees in a new class of managed care plans. When it first introduced these plans—without a lot of fanfare—only about 1 percent of those eligible signed up. It attributed a large enrollment increase the following year to an intensive marketing effort. Though written information played a role, the firm believes that meetings with employee groups was also a key factor in promoting these plans.⁵¹ A second firm implemented a sophisticated marketing strategy with similar results. This firm used employee focus groups to develop a video script; the video was produced with professional actors and a local physician, who responded to employee concerns and observations. The firm credited a significant jump in HMO enrollment to use of this video and to time spent talking with employees about HMO quality.

⁵¹A different firm told us that during open enrollment, it asks participating HMOs to bring in medical group representatives to talk to employees. Plans tend to bring in their best medical groups, which makes them more attractive to employees.

Observations

Our work suggests that some large purchasers and state governments have taken a more aggressive role in managing their employee health benefit costs. Double-digit premium increases common a few years ago have been controlled considerably in the last 2 years, a development attributable, at least in part, to more active management of health insurance costs. Some common elements distinguish these purchasers' benefit management strategies: (1) advocacy of managed care; (2) the application of competitive market principles to purchasing decisions; and (3) increased sharing of costs, responsibility, and information with employees. Despite common elements, a diversity of approaches is also evident—a diversity fostered by institutional flexibility and the willingness to pursue and wield purchasing leverage.

Advocacy of Managed Care

Advocacy of managed care, particularly HMOs, is the linchpin of the active purchasing strategies we examined. In response to employee skepticism, labor constraints, or the immaturity of HMOs in certain markets, some purchasers have introduced hybrid or less restrictive forms of managed care as a bridge to future HMO enrollment. The purchasers we interviewed have either incorporated elements of managed care in their indemnity products or replaced them with a fee-for-service PPO product. Their explicit promotion of HMOs contributed to, if not necessitated, other common elements of an active purchasing strategy: (1) the development of evaluation criteria based on price, access, and quality goals and (2) the adoption of financial incentives and information strategies to influence employee behavior. The criteria serve both employers and employees in comparing and contrasting plans and in justifying their selections.

Competitive Market Principles

Large purchasers have spurred the development of explicit criteria to help them evaluate and select competing health plans. Often, these criteria are spelled out in a request for proposal used to solicit bids. The criteria range from quality benchmarks such as National Committee on Quality Assurance accreditation or the ability to report HEDIS data, to standardized benefits that simplify a cost comparison among plans. Today, few of these purchasers would describe themselves as price-takers. Some closely analyze proposed premiums to help assure themselves that price quotations are based on the demographics and utilization experience of their workforce. Most actively negotiate with health plans and some use their market power to extract discounts.

Some employers do not hesitate to use their relative size to influence health plan behavior—a purchasing tool unavailable to a small firm or individual. Thus, size—either innate or attained by joining like-minded employers—allows some purchasers to demand that health plans negotiate or adopt a particular approach to quality assurance. However, market leverage stemming from a firm’s size or reputation is probably oversold as key to an effective health care purchasing strategy. Indeed, the firms we reviewed were more likely to adopt strategies that rely on competition among a number of health plans as opposed to strategies that would maximize a firm’s market power by demanding concessions from a single health care plan. To some extent, the development of employer coalitions, which combine the purchasing power of a number of large firms, appears to be an attempt to magnify a firm’s leverage. But even such coalitions appear to rely more heavily on setting up a competitive framework among rival plans. The public purchasers in our sample—often the largest single employer in a state—have also focused on developing a competitive framework.

By no means is there unanimity on the use of evaluation criteria. Many large purchasers we interviewed recognize the shortcomings of the cost, quality, and access criteria that have been developed so far. Thus, some told us that today’s quality criteria are too process oriented and incapable of distinguishing the plans that produce the highest-quality outcomes. Similarly, despite efforts to analyze proposed premiums, many purchasers acknowledged that they still have little idea of the true cost of providing coverage through HMOs. Though some are comfortable with using one or more criteria to eliminate health plans from contention, others see the criteria more as improvement and development goals for the plans themselves.

The purchasers in our sample generally believe that efficiency and quality are closely linked: in a situation in which care is, in fact, managed, lower cost is compatible with higher quality. Some are convinced that continued pressure on HMOs to lower prices and to justify any increases will force plans to become more efficient, encouraging competition based on quality rather than price. Others, however, are concerned that employers and coalitions are so focused on cost that they are doing little to ensure that health plans are taking the necessary steps to become more efficient. While the debate continues over the degree to which large employers’ contracting decisions are or should be influenced by cost, there is general agreement that enhancing competition is key in a health care system that looks increasingly to managed care to help moderate premium growth.

Influencing Employee Behavior

The negative public perception of managed care has played an important role in shaping purchasers' attempts to influence employee behavior. Employees, we were told, have been convinced by a barrage of unfavorable publicity that managed care achieves lower costs, not efficiency, by denying needed services and impinging on the doctor-patient relationship. In addition, employees are usually aware of the cost issues underlying employer decisions about health benefits. As a result, purchasers have used three basic tools to sway employee opinion and to assuage specific concerns about managed care. First, purchasers articulate and explain their criteria for selecting managed care plans; second, they now more prominently feature such plans in the open season material; finally, they attempt to provide employees specific comparative data about the quality of the available options.

Intuitively, financial incentives would appear to be a more powerful tool than communication in influencing an employee's health plan selection. For the purchasers in our sample, however, introducing effective and reasonable financial incentives was perhaps the most difficult aspect of implementing an active purchasing strategy. Few have adopted what is said to be the strongest financial incentive to select a managed care plan—targeting the employer contribution to the lowest-cost option. Most employers fall somewhere in between the adoption of a low-cost formula and one that provides no incentive to be cost-conscious. Whatever the formula, however, the purchasers we interviewed are generally now asking employees to contribute more to the cost of coverage, particularly for those who choose an indemnity option.

Common Elements, Yet Diversity of Approaches

Despite these common elements, a diversity of approaches more aptly characterizes the individual strategy and specific tools adopted by each of the purchasers in our sample. They have used the flexibility inherent in the private market to fashion strategies that are contingent on the unique characteristics of their workforce and the health markets where their employees reside. Their flexibility has temporal, locational, and structural dimensions. Thus, we observed firms that opted to make marginal changes and, in some cases, radically revised their strategies just a few years later. Firms can choose to employ a uniform strategy across all their plant locations or tailor their strategy to the characteristics of particular markets. Indeed, many firms choose to develop a benefit management strategy only in those markets where they have a reasonable expectation of gain.

These organizations face some important constraints in developing effective health benefit management strategies. Their approaches must be developed within the context of (1) labor-management negotiations and collective bargaining agreements; (2) the health care market structure in the firm's major locations; and (3) corporate cultures, which may require uniformity of benefits or cost-sharing by employees. These differing constraints are another factor that demands flexibility and contributes to the diversity of strategies by these large purchasers.

Characteristics of Purchasers in GAO Sample

Table I.1: Characteristics of Private Firms

Firm	Primary business	Number of active, U.S. employees eligible for health benefits	Headquarters location	Year current health benefit purchasing strategy was adopted	Purchases through coalition
American Express	Financial services	51,000	New York, NY	1993	Yes (National HMO Purchasing Coalition)
Bank of America	Banking	60,000	San Francisco, CA	1994	Yes (Pacific Business Group on Health)
Chevron	Oil and natural gas	30,000	San Francisco, CA	1993	Yes (Pacific Business Group on Health)
Dayton Hudson	Retail	110,000	Minneapolis, MN	1991	Yes (Buyers' Health Care Action Group)
Digital Equipment Corp.	Computers	27,000	Maynard, MA	1991	No
General Mills	Food processing	9,500	Minneapolis, MN	1992	Yes (Buyers' Health Care Action Group)
Mervyn's ^a	Retail	15,000	Hayward, CA	1994	Yes (Pacific Business Group on Health)
NYNEX	Telecommunications	62,000	New York, NY	1994	No
Pacific Bell	Telecommunications	48,000	San Ramon, CA	1988	Yes (Pacific Business Group on Health)
PepsiCo	Beverages, snack foods, and restaurants	250,000	Purchase, NY	1989	No
Safeway	Supermarkets	8,000 ^b	Pleasanton, CA	1994	Yes (Pacific Business Group on Health)
Southern California Edison	Utilities	14,000	Rosemead, CA	1995	No
Toyota Motor Sales	Automobiles	5,400	Torrance, CA	Not applicable	No
U S West	Telecommunications	60,000	Englewood, CO	1991	No ^c
Xerox	Office equipment	49,000	Stamford, CT	1991	No

^aMervyn's is a division of Dayton Hudson.

^bSafeway has about 85,000 employees. However, all but about 8,000 are union members whose health benefits are managed by a Taft-Hartley Trust.

^cIn 1997, U S WEST plans to purchase coverage for employees in Arizona through the Pacific Business Group on Health.

**Appendix I
Characteristics of Purchasers in GAO
Sample**

Table I.2: Characteristics of Private Purchasing Coalitions

	Headquarters location	Member firms	Covered lives ^a	Date activities initiated	
				Quality	Purchasing
Buyers' Health Care Action Group	Minneapolis	24	100,000	1992	1992
Gateway Purchasing Association	St. Louis	30	114,000	1995	1996
National HMO Purchasing Coalition	New York	9	Unavailable	1993	1993
Pacific Business Group on Health	San Francisco	18 ^b	280,000 ^b	1989 ^b	1994

^aRepresents employees and dependents insured through options negotiated by the coalition. Member firms frequently offer employees and their dependents health benefit options other than those jointly negotiated through the coalition. For example, Gateway firms employ 100,000 workers, for a total of 260,000 covered lives. However, only about 114,000 employees and dependents have enrolled in the HMOs with which Gateway negotiates.

^bThirteen additional firms plus CalPERS and the Health Insurance Plan of California also participate in the coalition's quality initiatives. Altogether, the 33 firms and state agencies involved in quality initiatives represent about 2.5 million covered lives.

Table I.3: Characteristics of State Government Programs

	Location	Covered lives	Year strategy implemented	Coalition membership
CalPERS	Sacramento, CA	1,000,000	1992	Pacific Business Group on Health ^a
Health Insurance Plan of California	Sacramento, CA	123,000	1993	Pacific Business Group on Health ^a
Minnesota Dept. of Employee Relations	St. Paul, MN	150,000	1989	Buyers' Health Care Action Group
Missouri Consolidated Health Care Plan	Jefferson City, MO	115,000	1994	None
Washington Health Care Authority	Olympia, WA	290,000	1996	None
Wisconsin	Madison, WI	209,000	1983	None

^aDoes not participate in the Pacific Business Group on Health subgroup that jointly negotiates premiums.

Background on HEDIS and NCQA Accreditation

The Health Plan Employer Data and Information Set (HEDIS) is the result of a 3-1/2-year cooperative endeavor between representatives of major employers and a combination of both large and small health plans. Employers had been searching for credible tools to help them identify, and demonstrate to others, the “value” resulting from premiums paid to HMOs. Their specific objective was to develop standardized performance measures that would help purchasers evaluate the quality of services across the managed care plans with which they contract. In 1991, a draft set of HEDIS performance measures known as version 1.0 was presented to several business coalitions and health care organizations for their use. When it became apparent that further revisions and refinements were necessary, HEDIS 1.0 was turned over to a committee of health plan representatives and corporate purchasers under the auspices of the National Committee for Quality Assurance (NCQA)—an independent, nonprofit institution that reviews and accredits managed care organizations.⁵² The result was HEDIS 2.0, which was released in October 1993. HEDIS 3.0, the latest iteration, has over 60 indicators that describe performance in five key areas.⁵³

NCQA only reviews health plans that are fully licensed and have been operational for at least 18 months. The typical review for a 50,000-member HMO is conducted by a team of three physicians and an administrative reviewer who spend 2 to 4 days meeting with key personnel and reviewing health plan records in six areas: (1) quality improvement, (2) provider credentialing, (3) utilization management,⁵⁴ (4) members’ rights and satisfaction, (5) preventive health services, and (6) medical records. Since NCQA began accrediting managed care plans in 1991, it has reviewed over 40 percent of the nation’s approximately 574 HMOs. Table II.1 summarizes the results of those reviews.

⁵²NCQA was founded in 1979 by two trade associations that represent the managed care industry. It became independent in 1990 and now represents the interests of purchasers and consumers, as well as health care organizations.

⁵³Compared with earlier versions, HEDIS 3.0 moves quality measurement closer to an outcomes perspective by including more standardized, relevant, useful measures than its predecessors.

⁵⁴Does the plan use a reasonable and consistent process when deciding what health care services are appropriate for individuals? When the plan denies payment for services, does it respond to member and physician appeals?

**Appendix II
Background on HEDIS and NCQA
Accreditation**

**Table II.1: Status of NCQA
Accreditation Reviews as of
December 1996**

Accreditation status	Number of plans	Percent
Full (3-year)	115	46.0
1-year	86	35.0
Provisional	21	8.5
Denied	26	10.5
Under review	21	
Scheduled for review	65	

Plans receiving a 1-year accreditation meet most standards and are reviewed again after a year to determine whether they should be granted full accreditation. Provisional accreditation means that a plan meets only some standards. According to NCQA, each of the plans denied accreditation was state-licensed and, in some instances, federally qualified as well.

Summary of Southern California Edison Performance Measures

Structure and philosophy	Service to enrollees	Clinical quality	Finance and information
Goals			
Assess plan commitment to principals of total quality management/continuous quality improvement.	Assess plan ability to meet enrollee needs.	Assess plan ability to meet goals for providing medical and behavioral services.	Assess plan ability to manage resources efficiently and monitor/improve data processes, integrity, and reporting.
Criteria			
Demonstrate and document results of quality improvement initiatives.	Provide choice of primary care physicians (PCP) that are a reasonable distance from Edison enrollees and maintain low PCP turnover rate.	Conduct systematic assessment of doctor/medical groups against accepted standards for referrals, clinical performance, utilization, use of protocols, and so on.	Use integrated information systems to provide high-quality care more cost-effectively.
Possess integrated information systems to track improvement initiatives, clinical outcomes, and enrollee satisfaction.	Provide reasonable appointment availability for nonurgent, urgent, and emergency care.	Credential and recredential physicians following NCQA standards.	Provide per-member-per-month trend data by category of service for administrative and medical costs/revenues for (1) all plan enrollees and (2) Edison enrollees.
Achieve full NCQA accreditation.	Ensure accurate/ timely communication with enrollees about how plan operates, for example, referrals, copayments, PCP selection, and grievances.	Develop clinical guidelines and disease-specific programs to reduce variation in practice patterns.	Pursue management goals that provide for efficient collection and reporting of all HEDIS data.
	Conduct annual satisfaction survey and/or focus groups.	Conduct health risk assessments that promote prevention, for example, cholesterol testing and prenatal care.	
		Ensure hospital affiliations result in coordinated care.	
		Provide care that integrates treatment of mental health/substance abuse under PCP.	

Note: Most criteria are backed up by specific standards. For example, PCP access criteria specify time and distance requirements, the availability of obstetricians/gynecologists and pediatric PCPs, and direct access to gerontologists.

Changes in HMO Enrollment, Plan Options, and Financial Incentives

Purchaser	Type/mix of plans	HMO enrollment for active employees (percent)		Monthly employee share of family coverage under indemnity option	Financial incentives (for active employees only)
		Before making changes in purchasing strategy	After changes		
Public purchasers					
CalPERS	PPO and HMO	84 (1993)	84 (1996)	Ranges from \$80 to \$256 for state employees depending on the PPO option chosen.	Incentive for state employees based on California's freezing its contribution at the 1991 level.
Minnesota	PPO and HMO	51 (1989)	48 (1993), 72 (1996)	\$84 in the Minneapolis area. 1996 PPO enrollment was about 27%.	Low-cost plan formula introduced in 1989. Low-cost plan is free for full-time employees.
Missouri	PPO, POS, and HMO	32 (1994)	75 (1997)	\$266 in the Jefferson City area for the PPO option. In contrast, the lowest-cost HMO is \$112.	Low-cost plan formula introduced for state employees in 1995. Low-cost plan is free for employees.
Washington	PPO and HMO	70 (1995)	83 (1996)	\$36. Enrollment in the state's self-funded PPO dropped 35% with the introduction of cost sharing.	First introduced cost-sharing in 1996. PPO is benchmark for cost-sharing.
Wisconsin	Indemnity, PPO, and HMO	20 (1983)	55 (1984), 83 (1996)	Ranges from about \$75 (where there are no low-cost alternatives) to \$333.	Low-cost formula introduced in 1984. State pays the lesser of 90% of indemnity option or 105% of qualified lowest-cost plan.

(continued)

**Appendix IV
Changes in HMO Enrollment, Plan Options,
and Financial Incentives**

Purchaser	Type/mix of plans	HMO enrollment for active employees (percent)		Monthly employee share of family coverage under indemnity option	Financial incentives (for active employees only)
		Before making changes in purchasing strategy	After changes		
Private sector purchasers					
American Express	Indemnity, PPO, and HMO	29 (1993)	62 (1994), 74 (1995)	Unavailable.	Gradually moving to benchmark plan formula by 2001. The benchmark is the local HMO with the highest value measured in terms of quality (70%) and cost (30%) and is usually, but not always, the lowest-cost plan. 1994 increase in HMO enrollment attributed to promoting HMOs in open season literature.
Digital Equipment Corp.	Indemnity, ^a POS, and HMO	28 (1990)	60 (1992), 66 (1996)	\$623.92 in the Boston area (less than 6% were in the indemnity option in 1997); 16% were in POS in 1997.	Introduced benchmark plan formula in 1991 in which firm pays 85% of plan that meets its cost and quality criteria. The benchmark is usually, but not always, the lowest-cost plan in an area.
NYNEX total		31 (1993)	46 (1996)		
NYNEX union	Indemnity, POS, and HMO	34 (1993)	40 (1996)	Indemnity option is free.	No incentive—free.
NYNEX nonunion	Indemnity, POS, and HMO	24 (1993)	64 (1996)	Ranges from \$214 to \$340 depending on the location of the employee.	Cash-back incentive increased significantly in benefit year 1994 for employees electing to join an HMO.
Safeway	PPO, ^b POS, and HMO	21 (1992)	37 (1995), 63 (1996, projected)	Replacing PPO with POS in benefit year 1997. PPO enrollment dropped by 50% between 1994 and 1996.	First introduced cost-sharing in 1994. Starting in 1996, will pay 90% of average-cost plan.

(continued)

**Appendix IV
Changes in HMO Enrollment, Plan Options,
and Financial Incentives**

Purchaser	Type/mix of plans	HMO enrollment for active employees (percent)		Monthly employee share of family coverage under indemnity option	Financial incentives (for active employees only)
		Before making changes in purchasing strategy	After changes		
U S WEST total		12 (1991)	42 (1996)		
U S WEST union	POS and HMO	Unavailable.	45 (1996)	Indemnity no longer offered.	Limited incentive—POS and lowest-cost HMO are free; employee pays difference for higher-cost HMOs.
U S WEST nonunion	POS and HMO	Unavailable.	33 (1996)	Indemnity no longer offered.	Limited incentive—POS and lowest-cost HMO are free; employee pays difference for higher-cost HMOs.
Xerox total		40 (1990)	80 (1997)		
Xerox union	Indemnity and HMO	Unavailable.	Unavailable.	Unavailable.	No incentive—indemnity option is free to employee.
Xerox nonunion	Indemnity and HMO	Unavailable.	Unavailable.	\$201	Benchmark plan (low-cost) is free and, in addition, employee gets cash back.

Note: If the state contribution exceeds the Medicare risk premium, the retiree can use the difference to pay the part B premium.

^aOnly if no POS option is available.

^bPPO option no longer available in 1997.

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