

NATIONAL
HEALTH CARE
PURCHASING
INSTITUTE

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*Corporate Health Care Purchasing Among The
Fortune 500*

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About the National Health Care Purchasing Institute

Mission: The National Health Care Purchasing Institute was founded to improve health care quality by advancing the purchasing practices of major corporations and government agencies, particularly Fortune 500 companies, Medicare, and public employers.

Objectives and Offerings: Our objectives are to help health care purchasers buy higher quality health care, save lives, and empower consumers to choose higher quality health plans and providers. We are also building the business case for effective, value-driven health care purchasing. Institute offerings include courses and workshops, technical assistance, convening of experts and working groups, research, and information on tools and best practices.

Sponsor: The Robert Wood Johnson Foundation (www.rwjf.org) sponsors the Institute through a \$7.7 million grant to the Academy for Health Services Research and Health Policy (www.academyhealth.org).

Institute Director: Kevin B. (Kip) Piper, MA, CHE, a vice president of the Academy, directs the National Health Care Purchasing Institute. His background includes Wisconsin state health administrator, CEO of the Wisconsin Medicaid program, managed care company executive, and senior health financing examiner with the White House budget office. Board certified in health care management, Mr. Piper holds a Master's degree in public administration from the University of Wisconsin. E-mail: piper@ahsrhp.org

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Peter Temin is the Elisha Gray II Professor of Economics at MIT, having been a full professor in the Economics Department at MIT since 1970. He received his Ph.D. in Economics from MIT in 1964. Professor Temin's fields of specialization are industry studies and economic history. His work has included studies of the economics and economic history of the health care and pharmaceutical industries in the United States.

Research for this project was conducted by **JSI Research and Training Institute** in Boston, Massachusetts. JSI is an organization committed to improving public health both in the United States and around the world. JSI conducts research on health policy as well as a variety of clinical topics. It carries out programs on AIDS, mental health, substance abuse, aging, access issues, managed care, and health care financing. JSI has offices in Boston, Washington D.C., Denver, and New Hampshire as well as in twenty-six countries ~~and~~.

EXECUTIVE SUMMARY

This report presents the results of the first academic study of health purchasing practices used by large companies to address the ongoing challenge of managed care. The study achieved a remarkable 84 percent response rate among the Fortune 500.

Five years ago, the transition to managed care was just underway for many corporations; at present, almost all large corporations are nearing completion of this dramatic migration. Contrary to early expectations, companies have not relied exclusively on HMOs. Fortune 500 firms reported a mix of plan models, with HMOs the most popular (36 percent mean enrollment), followed by preferred provider organizations (PPOs) (32 percent) and point of service plans (POS) (20 percent) in 1999.

Health benefits managers at large firms are becoming more active purchasers. Now wholly invested in managed care, firms are aggressively contracting with health carriers by using a request-for-proposal competitive bidding process. Sixty percent of firms re-bid all or almost all of their business in the past five years, and three-quarters of firms placed a portion of their administrative fees at risk for performance guarantees. Firms are also increasingly outsourcing components of health benefits to their carriers, and are often using consultants for carrier selection and administration.

To attract and retain a productive workforce amidst tight labor markets, firms have absorbed

the majority of premium inflation. Average employer contribution levels dropped just 2 percent since 1994 to a level of 82 percent in 1999. It is worth noting, however, that an increasing number of employers had moved below the 80 percent “benchmark” level by 1999 (up to one-third from one-quarter in 1994), and this trend towards lower contributions may continue.

Premium contribution-setting strategies vary across firms. Some companies (24 percent) reported using a flat-dollar strategy in which employer contributions are fixed at a single amount regardless of the plan. However, they more frequently reported using a complex range-of-percentages strategy (33 percent) or a flat-percentage approach (33 percent).

Health carrier choice is common among Fortune 500 companies. The vast majority of health-benefits-eligible employees of large companies are now offered a choice of at least two health carriers. For example, among the Fortune 100, three-quarters of employers offer a choice to at least 80 percent of their employees, and among other Fortune 500 firms, over half of employers do so. Nevertheless, the trend is towards limiting rather than expanding employee choice. Ninety-three percent of the Fortune 500 and 95 percent of the Fortune 100 report dropping more carriers than they added in the last five years.

Although virtually all companies reported collecting quality information about their health carriers, only a small number have been able to devote time and resources to health carrier quality management. Approximately one-half of companies require National Committee for Quality Assurance (NCQA) accreditation. One-third of companies require their health carriers to show annual improvements in clinical health care quality. Another one-third of employers disseminate some portion of quality information about carriers to employees. Employers reported a significant reliance on consultants as the most useful information source for health care quality management.

Consistent with other studies, the companies in our study experienced relatively modest premium increases over the past five years, with one half reporting 2-5 percent average annual increases since 1994. This was followed by much larger increases in premiums during the last year. More than two-thirds of firms reported increases exceeding 6 percent in 1999. Only a small minority of firms (5 percent) reported that their average annual premiums had declined over the five-year period.

We found three factors to be associated with lower premium inflation: firm size, a high percentage enrollment in the more aggressive forms of managed care (POS and HMO), and the presence of a regional purchasing strategy. Large numbers of employees give companies greater leverage in price negotiations with carriers, and reliance on gatekeeper managed care models has proven to be cost-effective. Lastly, companies implementing a regional purchasing strategy are able to select the lowest cost carriers in each market rather than locking into the aggregate premiums of a single national carrier.

Overall, health benefits managers frequently voiced concern that the financial gains from the managed care revolution have been exhausted. What does the future hold? Driven by the burgeoning costs of pharmaceuticals, premium rates are again rising at double-digit rates. Managed care backlash is widespread among consumers, and has become a favorite topic of the media and of many politicians. Finally, activities in the legislative arena at the federal and state levels are causing unease among many large employers.

The National Health Care Purchasing Institute helped to sponsor this report. The Institute is a multi-million dollar initiative of The Robert Wood Johnson Foundation and is committed to finding solutions that address the issues discussed in this report. The Institute promotes health care quality by influencing the purchasing practices of major corporations and government agencies, particularly Fortune 500 companies, Medicare, and public employees. The Institute is dedicated to helping public and private sector organizations improve health care delivery through results-driven purchasing. It educates purchasers by offering courses, workshops, and research briefings. Like the authors, the Institute believes America's largest companies will continue to shape health care purchasing practices among both the public and private sectors.

STUDY HIGHLIGHTS

Large companies have dramatically transformed their health care purchasing practices. Five years ago, Fortune 500 companies varied greatly in the distribution of employees in managed care health plans. By the end of 1999, the transition to managed care was nearly complete, with only a small percentage of employees remaining in traditional indemnity.

Most companies are now engaging in:

- Aggressive negotiations with health carriers and competitive bidding practices (60 percent of firms re-bid all or almost all of their business in the past five years);
- Modest reductions in their overall percentage contribution to premiums; and
- Greater use of outsourcing to both consultants and health plans.

Companies have achieved these changes while:

- Relying on a variety of managed care service models, including HMOs (36 percent), PPOs (32 percent) and POS plans (20 percent);
- Recruiting new managers into the health benefits function; and
- Implementing total-compensation strategies which include health benefits.

Employers are now concerned that gains from the migration to managed care have been exhausted. Managers among the Fortune 500 report these recent trends:

- A significant number of employee complaints;
- Concern over activity in the legislative arena; and
- Higher premium rates (two-thirds of firms had a 6 percent or greater increase in 1999).

This report found three factors associated with lower premiums:

- Larger numbers of employees;
- Greater HMO/POS enrollment; and
- Reliance on a regional purchasing strategy.

This report provides more detail on these key trends as well as on the practices and results of health care purchasing among the Fortune 500.

METHODS OVERVIEW

The data for this report were collected during the winter and spring of 1999-2000 from companies on the 1999 Fortune 500 list of the largest public U.S. firms by revenues.¹ These data were collected during a 30-minute phone interview directed toward the senior-most manager responsible for health benefits. We targeted every company on the Fortune 500 list, and our efforts resulted in a highly favorable 84 percent response rate overall (n = 408). Eleven firms had to be eliminated from the list because of recent merger and acquisition activity. The questionnaire responses were matched anonymously with financial and employment data from Compustat.²

For some analyses, we broke down the Fortune 500 by industry. The 12 industry categories are:

1. Petroleum
2. Finance and real estate
3. Durables
4. Basic industries
5. Food and tobacco
6. Construction
7. Capital goods
8. Transportation
9. Utilities
10. Textiles and trade
11. Service
12. Leisure

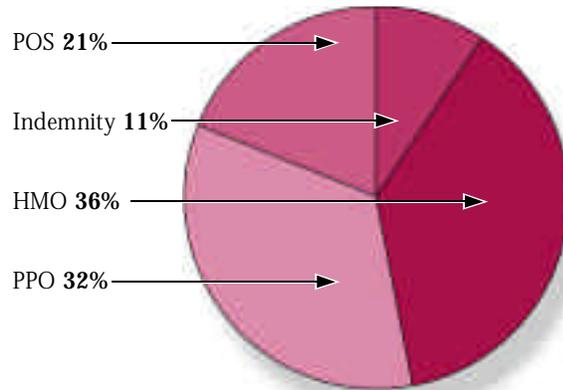
1 Fortune Magazine, Vol. 139, No. 8, April 26, 1999.

2 We asked companies to respond for a standard window of time, such as the 1999 calendar year. Since companies have different open enrollment periods and fiscal years, some of the reported 1999 figures may be for 12-month periods that extend forward into 2000 or back into 1998. We do not believe that this significantly influences the accuracy of the overall results.

HEALTH BENEFITS IN THE FORTUNE 500

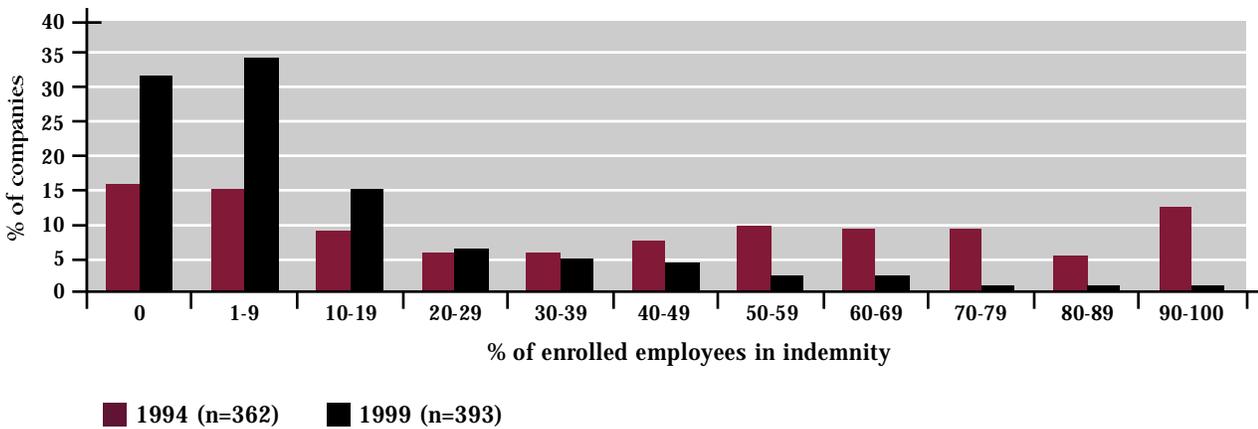
In 1999, Fortune 500 employees were enrolled in a diverse mix of service delivery models. Overall, firms had an average of 36 percent of employees in HMOs, 32 percent in PPOs, 21 percent in POS plans, and 11 percent in indemnity plans. Beneath these averages lies great variation among firms in the particular plan model combinations. Further, managers at Fortune 500 companies sometimes reported that health carriers offered “hybrid” models that blended characteristics of PPOs, POS plans, and/or HMOs.

1999 Enrollment



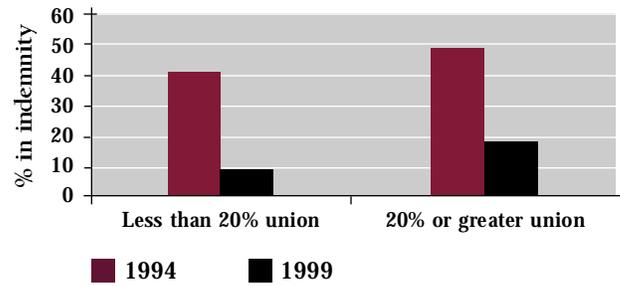
At the start of the study period (1994), there was a great deal of variation in companies' managed care enrollments, indicating a period of transition. By 1999, firms appeared to have largely completed the migration out of indemnity plans into managed care.

Indemnity enrollment for Fortune 500, 1994 and 1999



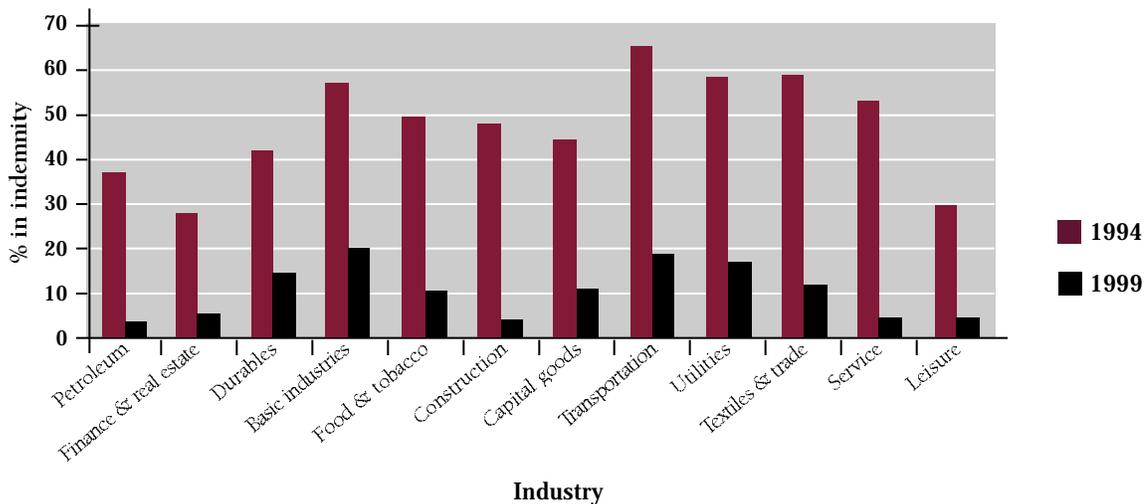
While all industries experienced dramatic declines in indemnity enrollment, figures varied widely across industries in both 1994 and 1999. For example, the basic and transportation industries were among those with the highest indemnity enrollment in 1994 and 1999. Finance, real estate, and leisure companies had the lowest indemnity enrollments on average throughout the period.

Employees in indemnity by unionization rate



Unionized firms typically had somewhat higher indemnity enrollment in 1994 than non-unionized firms. This difference was further accentuated in 1999 when unionized firms had approximately twice the indemnity enrollment as compared with non-unionized firms (18 percent vs. 9 percent, respectively). Health benefits managers at several unionized firms reported that they continued to face resistance to the implementation of managed care models in union negotiations.

Employees in indemnity by industry



New trends in coverage

The Fortune 500 reported that they were adding new components to their health benefits plans in response to the changing needs of a diverse workforce. Flexible benefits were offered at just over one half of companies, while almost all of the Fortune 500 reported having a pre-tax spending account. Domestic partner health benefits have already been adopted by 29 percent of companies, and many health benefits managers reported that the addition of these benefits is under consideration. Among the Fortune 100, 43 percent reported domestic partner eligibility for coverage.

New benefits among the Fortune 500

Benefit	Companies offering benefit
Flexible (cafeteria-style) benefits for health care	54%
Pre-tax spending account for health care	90%
Domestic partner health benefits	29%

“A key challenge for large companies like Lucent is offering an array of benefits that meet the diverse needs of all employees.”

– Pam Krol
Lucent Technologies

SOUTHWEST AIRLINES

Ralph Kimmich, benefits director at Southwest Airlines, observes that “a remarkable transition has occurred from indemnity coverage to managed care during the last decade.” Perhaps, even more remarkably, managed care has penetrated markets such as Southwest’s homebase of Dallas—a city where provider resistance has typically been strong. To ease the transition to managed care, large companies have offered soft alternatives to HMOs such as PPOs and POS plans. Southwest offers a range of plans to its employees. Kimmich believes in allowing employees to choose the type of coverage that best works for them. The company provides no incentive to choose one plan over another because, as Kimmich adds, “we aren’t even sure HMOs are more cost-effective in all cases.”

Looking ahead, Kimmich sees patient liability legislation as a crucial concern. Just the threat of liability legislation affects practices at the health carrier level. To avert future liability, carriers are relaxing their gatekeeper and certification benefits functions.

Kimmich asks, “How do you control costs while relaxing managed care restrictions?” In response to consumer demands, managed care is evolving away from HMO-type, gatekeeper-centered models. Employees are demanding more freedom to choose their own physicians and not rely on gatekeepers. Kimmich says, “Employees are asking for a hassle-free, paperless health plan. Employers want value for the health care dollars they spend.”

PREMIUM COSTS AND CONTRIBUTIONS TO EMPLOYMENT GOALS

The move from indemnity to managed care both fostered certain cost outcomes and influenced employee recruitment and retention. Overall, annual increases in Fortune 500 health insurance premiums clustered around 2-5 percent over the five-year period, with some companies reporting higher inflation and only a few reporting increases of less than 2 percent or declines in premiums. In the past year, premium rates were reported to have risen even more sharply. Almost a third of companies experienced greater than 8 percent inflation in the past year. This trend is true for the Fortune 100 as well as for other firms in the Fortune 500.

Average changes in premium costs, 1994-1999

Change	Fortune 500 1994-1999 average annual	Fortune 500 1999
Decline	5.4%	5.0%
Increase less than 2%	9.1%	6.8%
Increase 2-5%	49.9%	26.0%
Increase 6-8%	23.1%	31.5%
Increase more than 8%	12.5%	30.7%

Effective strategies for reducing costs

Three factors were found to be associated with the five-year premium cost increases.³ The first was the size of the firm, in terms of the number of health-benefits-eligible employees (full-time and part-time). Bigger firms reported lower premium increases, reflecting the reality that the larger the size of the

employee group, the more leverage the company has in negotiating with its health carriers.

Second, firms that purchased health insurance using a regional strategy rather than relying on national carriers tended to have lower premium increases. By purchasing from carriers on a regional basis, a company can select the lower-cost carriers in each market. It may be difficult for national carriers to stay competitive with the combined performance of these “best” regional carriers.

Finally, companies with a greater percentage of employees enrolled in HMO and/or POS plans had lower premium increases. The strategy of moving to managed care has paid off for large employers over the last five years. Enrollment in aggressive forms of managed care with gatekeepers (HMO and POS as opposed to PPO) has been the most successful strategy. However, it is not clear whether enrollment in managed care on its own will be an adequate antidote to future cost increases.

Value of health benefits for employment goals

Large companies have a competitive need to attract and retain skilled employees, especially in today's tight labor markets. Health benefits remain an important tool in attracting and retaining a productive workforce. In addition, a well formulated health benefits strategy is increasingly viewed by senior human resource managers as necessary to promote health and productivity in the workplace. Healthy workers are expected to have greater productivity and commitment to their companies.

3. All three of these findings were highly statistically significant (p<.01) and remained significant after controlling for differences across industries, firm assets, and other firm characteristics.

On average, respondents clearly believed that their companies valued health benefits in achieving overall employment goals. Specifically, respondents were asked to rate on a scale of 1 to 7 (7 being strongest) the contributions of health benefits toward attracting, retaining, and increasing productivity of employees.

Contributions of health benefits toward employment goals

Employment goal	Average score
Attracting employees	5.3
Retaining employees	5.1
Increasing employee productivity	4.3

Health benefits were viewed as contributing most to employee attraction, followed by employee retention and increasing employee productivity. However, respondents varied greatly in the extent to which health benefits contributed to these goals. In the retail sector, for example, some firms are attempting to distinguish themselves in recruitment by offering more extensive health coverage than their competitors.

Total compensation strategy

Companies that adopt a total compensation approach view wages and benefits as equal parts of the employment package. Rather than making decisions about health benefits separately, companies that adopt a total compensation approach address health benefits and compensation issues in an integrated fashion. The majority of respondents, and particularly those in the Fortune 100, reported that their company has implemented a formal strategy

“This is an important and challenging idea, since it obviously implies that firms ought to think about their wage and benefits policies as part of an integrated whole, with common costs and common benefits, rather than viewing them as separate components to be looked at or determined separately.”⁴

– Mark V. Pauly

for total compensation. Of these, many have been implemented since 1994. Health benefits were very likely to be integrated into these total compensation strategies. Eighty-six percent of firms with total compensation strategies reported that health benefits were included. Some firms, for example, have established quantifiable goals for recruitment and employee health improvement as part of these strategies.

Total compensation strategy	Fortune 100	Fortune 500
Formal strategy in place for total compensation	79%	67%
Of those firms with a formal strategy:		
New since 1994?	38%	42%
Includes health benefits?	80%	86%

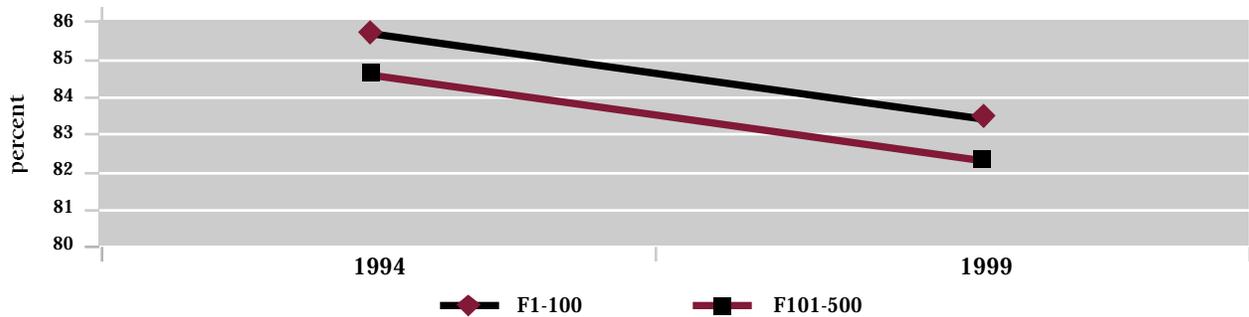
4. Health Benefits at Work: and Economic and Political Analysis of Employment-Based Health Insurance, Mark V. Pauly, Michigan: University of Michigan Press 1997, p. 121.

EMPLOYER PREMIUM CONTRIBUTION LEVELS AND STRATEGIES

The expansion in managed care enrollment was accompanied by only modest reductions in companies' percentage contributions to health insurance premiums. On average, contributions for single employee coverage declined about 2.5 percent from 1994 to 1999.

While these average values mask a great deal of variation and movement among individual firms, the period witnessed a dramatic shift away from 100 percent contribution. In 1994, about one-quarter of firms still paid their employees' full premiums; by 1999, less than 10 percent did so. Another trend was an increase in companies moving below the 80 percent level of employer contribution. While in 1994 about 20 percent

Percent average employer contribution for single coverage

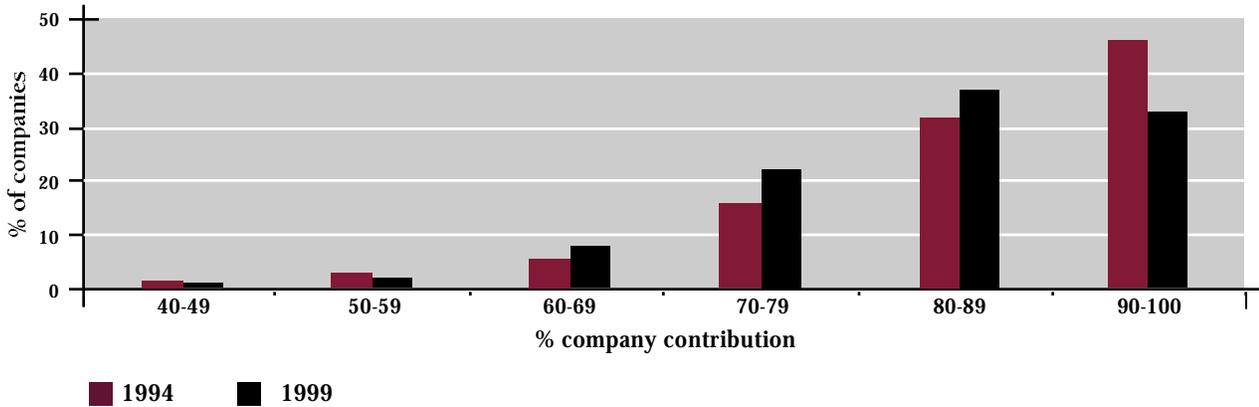


Premium contributions dropped at approximately the same rate for the Fortune 100 as among other large companies. However, the Fortune 100 continued to have slightly higher contribution levels in 1999 (84 percent versus 82 percent), on average, as compared with the Fortune 101-500.⁵

of firms set premium contribution levels below this mark, by 1999 almost a third of the sample were doing so. However, there was no noticeable increase in the fraction of firms moving below the 60 percent mark throughout the five-year period.

5. It should be noted that, for each company, these contribution levels represent an estimated average across their entire eligible single population enrolled in all of their health plans and geographic regions.

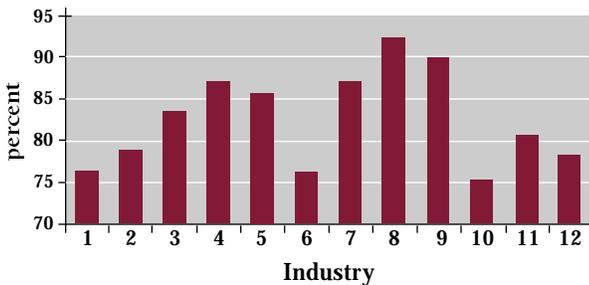
Company contributions, 1994 and 1999



Industries varied greatly in their contribution levels and in changes to contributions over the five-year period. Those sectors with the highest contribution levels in 1999 included transportation and utilities. Among the lowest average contributions were the construction, leisure, and petroleum industries. The transportation and capital goods sectors made the largest reductions in company contributions over the five-year period.

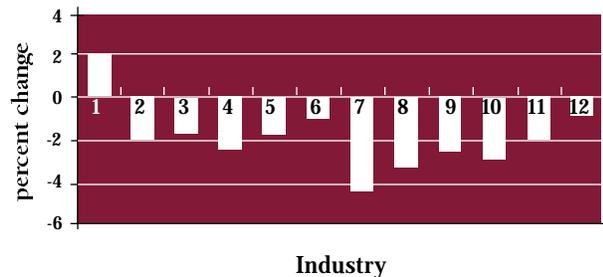
Unionized firms have kept significantly higher contribution levels, with an average of 88 percent versus 80 percent for non-unionized firms in 1999. Many unions in the manufacturing sector have maintained a preference for the “first-dollar” coverage that was typically offered by Blue Cross plans. This preference has kept contribution levels high among unionized firms.

Company contributions by industry, 1999

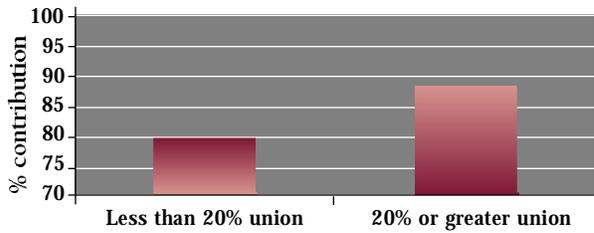


- | | | | |
|----------------------------|---------------------|-------------------|------------------------|
| 1. Petroleum | 4. Basic industries | 7. Capital goods | 10. Textiles and trade |
| 2. Finance and real estate | 5. Food and tobacco | 8. Transportation | 11. Service |
| 3. Durables | 6. Construction | 9. Utilities | 12. Leisure |

Change in contributions by industry, 1994-1999



Company contributions by unionization, 1999



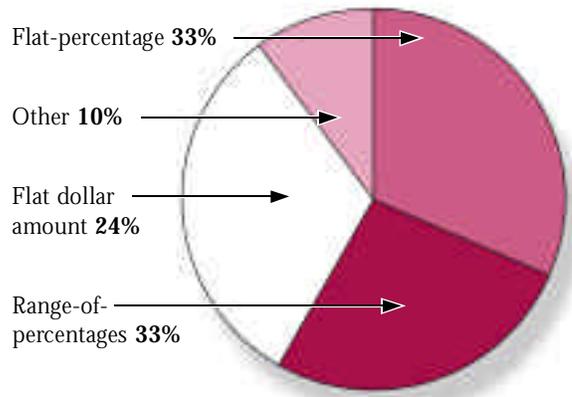
Employer premium contribution strategy

We asked companies to characterize what basic strategy best described the way they set their premium contributions.

The first option was a flat-percentage strategy, in which employee premium contributions are set at the same percentage (for example, 80 percent of the total premium cost of any plan). A second option was a flat-dollar strategy, in which employer premium contributions are set at a fixed dollar amount (usually tied to the lowest cost plan). In this scenario, employees wanting to purchase a health plan with more comprehensive coverage must pay the full cost of the added insurance. The third option was a range of percentages for different types of plans, with a final option possibly involving a combination of the first three options.

Companies most often used a flat-percentage strategy (33 percent) or range-of-percentages strategy (33 percent), while one-fifth of the sample (24 percent) used a flat-dollar approach.

Employer premium contribution strategy



Forty-two percent of companies altered their basic contribution strategy based on the union status of employees, while only about one-sixth of companies reported varying policies by geographic regions, business unit, and/or other employment conditions.

Conditions affecting contribution strategy

Contribution policy varied by	Fortune 500
Union status	42%
Geographic region	18%
Business unit	17%
Other condition	16%

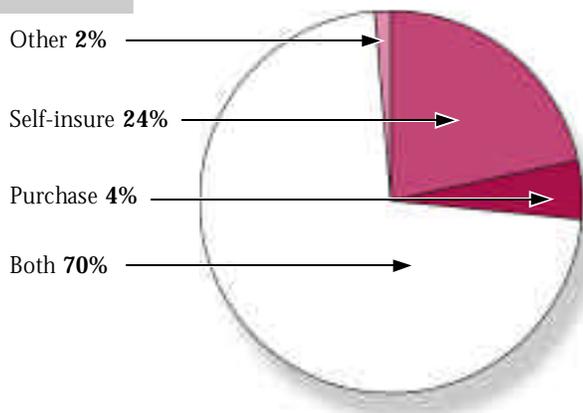
“We need a positive behavioral impact to justify shifting costs onto employees through plan design. If shifting costs will result in more prudent purchasing behavior, then it is a positive reason.”

– Gary Krueger
Circuit City

PURCHASING APPROACH AND SUPPLIER RELATIONS

The great majority of companies (70 percent) reported a mix of self-insuring and purchasing health plans. One quarter of companies exclusively self-insured their health care, while less than 5 percent only purchased health insurance.

Self insurance vs. purchasing



Fee at risk

Most companies set aside a portion of their health carriers' administrative fees to be contingent on performance. Among the Fortune 100, 81 percent pursued this type of contracting guarantee, while among the Fortune 500, 71 percent did so.

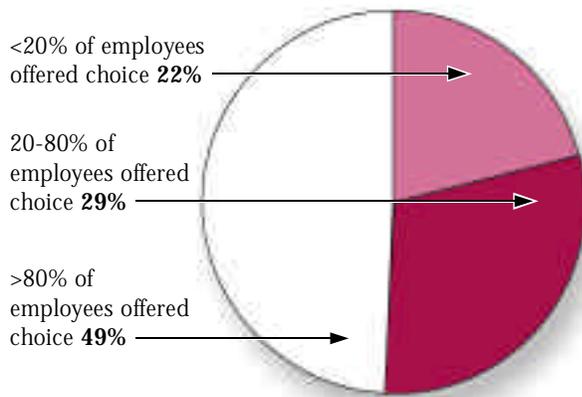
Carriers

A majority of companies purchased from a mix of national and regional health insurance carriers. However, many reported contracting only with carriers that operated on a national basis. Overall, 13 percent purchased only regionally, 29 percent purchased only nationally, and 58 percent used some combination of regional and national carrier purchasing.

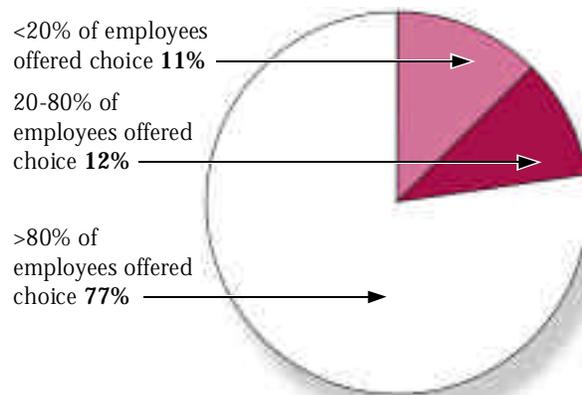
Choice of health carriers

Most companies offered a choice of at least two health carriers to their employees. In 1999, about half of the firms offered the great majority (80 percent or more) of their employees a choice, while less than a quarter had multiple carrier options available to only a small minority of their employees.

Fortune 500 firms offering employees choice



Fortune 100 firms offering employees choice



More than 75 percent of companies in the Fortune 100 offered choice to the great majority of employees. Our interviews suggested however, that far fewer companies offer more than two or three carrier choices to employees.

Net change in health carriers over last five years

	Fortune 100	Fortune 500
More carriers	0%	0%
Fewer carriers	95%	93%
Equal carriers	5%	7%

The table above shows a negative net change in health carriers over the last five years. In other words, over 90 percent of companies dropped more carriers than they added in that time period. Contracting with fewer carriers allows companies to obtain leverage in their price negotiations.

Supplier relations

To explore how companies managed their relations with health carriers, we asked several questions about companies' approaches to health care purchasing, as well as how their actual purchasing practices were executed. We focused on two contrasting modes of buyer-supplier relationships: competitive bidding and long-term partnering. These modes are often used to define practices in general business procurement.

To collect information about these practices, our central measure was the use of request-for-proposals (RFPs) as a way of administering competitive bidding among vendors. Bidding involves explicit

comparison of different suppliers on their products and prices, and sends a signal to current vendors that their relationship may not be guaranteed over the long term. On the other hand, long-term partnering implies a more collaborative relationship, in which neither party sacrifices its own interests for the sake of the other, but each communicates and coordinates its actions for the purpose of furthering its own interests.

Supplier relations approach

When we asked managers to describe whether their supplier relations were best described by competitive bidding or long-term partnering, just 27 percent of the Fortune 500 responded that bidding was their current approach. In contrast, 64 percent responded that long-term partnering was their current approach. (Nine percent reported "other," often insisting that they did both).

Supplier relationship	Fortune 100	Fortune 500
Competitive bidding	29%	27%
Long-term partnering	59%	64%
Other	12%	9%

"At Digital we sought to build meaningful partnerships with our plans. We knew that unless we shared our vision, and they understood our purchasing objectives, we were unlikely to succeed."

- Michael Bailit
Bailit Health Purchasing

Supplier relations practices

Ninety percent of Fortune 500 employers reported using bidding for some aspect of their health purchasing in the last five years. Sixty-five percent used it to select health carriers for employees in new regions of their business, while 66 percent used an RFP process to add new managed care products (such as an HMO) to existing regions. Only 41 percent of companies used bidding to add a specific component such as mental health to their benefits program. Sixty-two percent of companies simultaneously rebid all of their health care business in a major region or nationally over the past five years.

Use of RFP bidding since 1994

RFP bidding approach	Reported practice
Any RFP bidding	90%
RFP for new regions	65%
RFP for new managed care products	66%
RFP for new components (e.g. mental health)	41%
RFP for all business in a major region or nationally	62%

The majority of firms rely on one-year contracts, though a significant minority (32 percent) have contracts of three years or more.

Average length of contract

Contract length	Reported practice
Less than 1 year	1%
1 year (annual)	53%
2 years	14%
3 years or more	32%

GENERAL MOTORS' PURCHASING STRATEGY DRIVES SUPPLIER QUALITY

With 1.25 million covered lives and an annual budget of \$3.9 billion, General Motors (GM) is the largest private purchaser of health care in the United States. GM has used its purchasing leverage to improve quality in several ways, including benchmarking its carriers and using incentives for employees to select the highest quality plans.

GM aggressively uses benchmarking to rate its carriers on their quality performance. Each year, GM asks 134 HMOs nationwide to provide HEDIS and other quality measures required by its RFI. This information includes clinical and preventive measures (number of Caesarian sections, routine diabetic exams, etc.), provider access, and other guides to performance. GM rates carriers based on these measurements and then disseminates "report cards" to participating carriers, other purchasers, and employees. Through the report cards, GM holds carriers accountable for their performance. Moreover, because many purchasers and enrollees see the results, carriers with low scores feel pressure to improve. The data are also used to identify specific clinical processes for which carriers should target continuous quality improvements. "Essentially," says Bruce Bradley, director for managed care plans at GM, "this information is aimed at three types of customers. GM uses benchmarking in its purchasing decisions, our employees and retirees use the report cards to help choose a carrier, and finally, report cards help providers directly improve the quality of health care."

Bradley maintains, however, that companies cannot just supply employees with quality data and expect responsible decision-making. GM also uses "flex pricing" to encourage migration into higher quality carriers. To price plans, GM begins with the assumption that the very best managed care plans offer a greater level of benefits and are considerably more efficient than the indemnity option. As a result, a GM employee choosing a higher-rated benchmark carrier will pay less than they would pay for indemnity coverage.

Carve-outs and direct contracting

Many firms made use of carve-outs and direct contracting for specific aspects of their health benefits programs. Overall, a great deal of carve-out pharmaceutical programs were being used (81 percent among the Fortune 100, 69 percent among Fortune 500). In addition, about one-half of firms reported having separately administered mental health care programs (51 percent among the Fortune 100, 43 percent among the Fortune 500). Only 10 percent of firms directly contracted with provider organizations for some other component of care. Many companies reported that direct contracting with providers would require administrative resources and medical expertise that was only available to pharmaceutical and/or health care companies.

Presence of carve-out and direct contracting arrangements

	Fortune 100	Fortune 500
Mental health/ substance abuse carve-out	51%	43%
Prescription drug benefit carve-out	81%	69%
Hospital direct contracting with provider	6%	10%

Outsourcing

Relative to 1994, most firms have increased their reliance on external organizations for their health benefits programs. Among the Fortune 100, 53 percent have increased their use of outsourcing, while 62 percent of firms in the Fortune 101-500 have done so. On the other hand, 69 percent of Fortune 100 firms reported shifting administrative activities to health carriers since 1994, compared to only 56 percent of other firms having done so.

Health benefits managers

Health benefits managers reported a wide range of professional training and background. Respondents were able to choose multiple categories among five main options (benefits, finance, human resources, medicine, and other). About half included benefits in their response, one-third indicated human resources, one-fifth said finance, and a slight fraction chose medicine. In addition, all respondents were asked about their supervisors' backgrounds. More supervisors were reported to have training in human resources, perhaps reflecting their broader responsibilities outside of benefits.

Background of benefits managers and their supervisors

Background and training	Respondent	Supervisor
Benefits	57%	31%
Finance	21%	17%
HR	33%	44%
Medicine	3%	2%

QUALITY ACTIVITIES AND OUTCOMES

Quality in health carrier selection and contracting

Many companies were working on various quality activities in health care contracting. The great majority of firms reported incorporating quality as a formal criterion during health carrier selection. Approximately one-half of firms actually required National Committee for Quality Assurance (NCQA) accreditation of their health carriers. (The NCQA is the most widely used managed-care benchmarking organization.) Sixty-one percent of firms stipulated provider access requirements in contracts. Fewer companies required annual improvements in health carrier clinical quality (32 percent). Many companies set standards in contracts for customer service (86 percent).

Quality concerns in contracting

Requirements	Companies using requirement
Quality criteria in carrier selection	83%
Require NCQA accreditation	55%
Requirements for network composition	61%
Customer service standards in contract	86%
Annual improvements in clinical quality	32%

“Quality management has come a long way this past decade. It is striking that 53 percent of the Fortune 500 report HEDIS data while more than 50 percent require NCQA accreditation.”

- Jeffrey Harris
Centers for Disease Control

Quality data collected

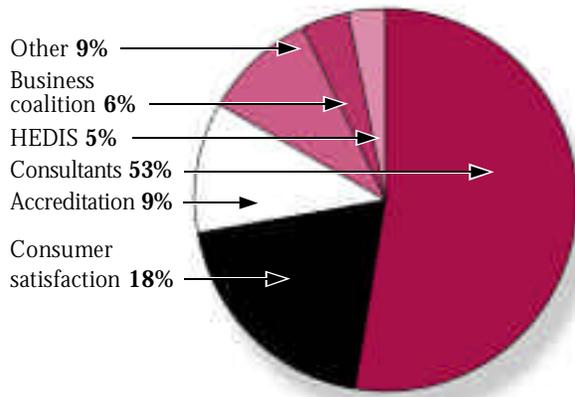
The great majority of companies collected some information about health carrier quality. More than half the firms collected accreditation status, and the majority also collected consumer satisfaction data. Fewer companies (approximately one-third) distributed this quality information to their employees.

Quality information collection and dissemination

Quality information activities	Companies reporting activity
Collect any quality information	93%
Accreditation by NCQA or other	55%
Consumer satisfaction survey	58%
HEDIS	53%
Consultants	79%
Disseminate any quality information	35%

When asked, health benefits managers reported that the quality data provided by their various consultants was most useful to them (53 percent). However, the importance of consumer satisfaction data was also reported by almost one-fifth of those in the Fortune 500 who collect any quality information.

Most useful source of quality information



Quality management

Many companies actually use the information they collect to improve clinical quality. Looking beyond cost containment, they use their purchasing leverage to demand carrier quality. Extensive quality management requires commitment and resources within companies as well as frequent interaction between companies and carriers.

Meetings with carriers to discuss quality management

Frequent meetings with carriers represent an integral part of quality management. A majority of companies (64 percent) reported scheduling regular meetings with health plans to discuss quality. Of those companies, the most common frequency (47 percent of firms) was more than three times per year. Nineteen percent of firms scheduled meetings twice per year, and 20 percent scheduled them once per year.

Frequency	Fortune 100	Fortune 500
1/ year	22%	20%
2/ year	20%	19%
3/ year	5%	6%
More than 3/ year	48%	47%
Other	6%	8%

With the market's emphasis on price competition, some prominent purchasers believe that there are inadequate incentives to pursue quality in health care purchasing. By adjusting premium contributions, companies encourage quality management by allowing people to pay less for such carriers. However, very few companies—only 7 percent of the Fortune 500—adjust employee premium contributions based on health carriers' quality ratings. Significantly, 20 percent of the Fortune 100 provide positive financial incentives to employees based on carriers' quality ratings.

“The employer community is sending a message that quality really matters. The market is saying, we want the best health care available for our employees. We would like to see more employers take the next step by giving quality information to their employees.”

- Margaret O’Kane

National Committee for Quality Assurance

Positive financial incentives for quality

Employee incentives	Fortune 100	Fortune 500
Adjust employee premium contributions based on quality ratings of health carriers	20%	7%

Companies also use disincentives, or penalties, to regulate health carrier quality. The next table presents a range of actions Fortune 500 companies have taken. Fifty-five percent of Fortune 500 companies increase monitoring of offending carriers; only 17 percent freeze enrollment. 47 percent of Fortune 500 companies pursue a more drastic course and drop offending carriers. Of course, these numbers may also reflect the prevailing trend among companies to drop carriers.

SIX SIGMA QUALITY AT GENERAL ELECTRIC

General Electric (GE) transferred industrial purchasing practices from its manufacturing operations to health care by adopting a Six Sigma approach. “Six Sigma Quality” refers to an initiative, launched by large employers including GE, that calls for no more than 3.4 mistakes per million opportunities. An important lesson of Six Sigma, says Chuck Buck, former head of Health Care Quality & Strategy Initiatives at GE, “is that while there is underuse in health care, very often the development of mistake-free, customer-oriented processes also reduces overall costs.” Buck hopes that “by establishing a stretch goal of Six Sigma performance, we ‘raise the bar,’ both in terms of the speed of progress and the level of quality we are seeking to achieve.”

Managers at GE realized the limits to working primarily with carrier performance. To succeed, Six Sigma must also focus at the provider level. Buck claims that employees “understand that true medical quality happens one layer down with the physicians and the hospitals.” Large employers must use their purchasing clout to promote quality and patient safety at both the carrier and provider levels.

This is one of the reasons GE is a founding member of the Leapfrog Group, a coalition of companies committed to reducing the number of medical errors (leapfroggroup.org). Comprised of Fortune 500 companies and large public purchasers, Leapfrog aims at ensuring and rewarding ‘leaps’ in patient safety. By educating employees, and rewarding providers with higher quality standards and performance, large employers send an important message to health carriers, providers, as well as other purchasers.

Buck thinks that “Leapfrog is an important step in creating a transparent consumer-centric health care market—one where patients and their families select providers based on information about the providers’ performance on important quality measures as well as on price.”

Plan penalties for quality over the last five years

Type of plan penalty	Fortune 100	Fortune 500
Increased monitoring of that carrier's quality	57%	55%
Froze enrollment	30%	17%
Dropped carrier	51%	47%

Fortune 500 companies are collecting large amounts of quality information, and significant numbers are also setting quality standards in their contracting. A few companies are moving beyond monitoring customer service. These innovators are managing clinical quality by cooperating with carriers, joining coalitions, and rewarding carriers for quality improvement.

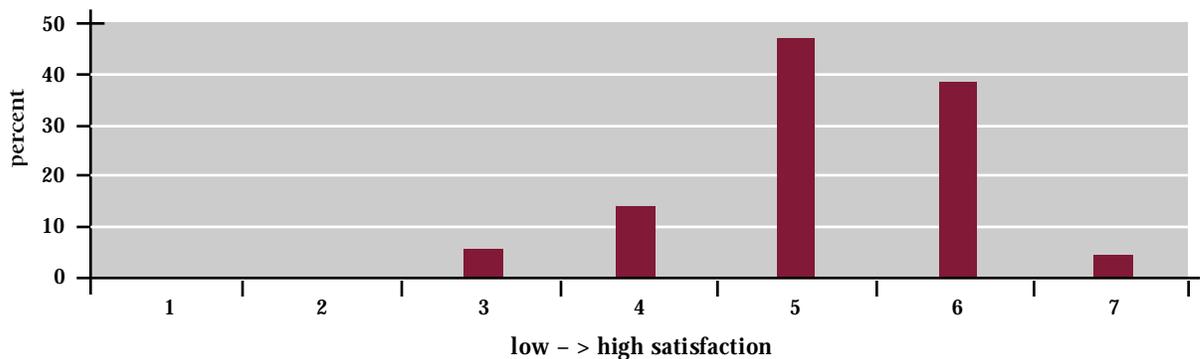
“To be good corporate citizens, companies must promote health and disease management, even in industries where they may not see a direct return because of turnover.”

– Gary Krueger
Circuit City

Employee complaints and satisfaction

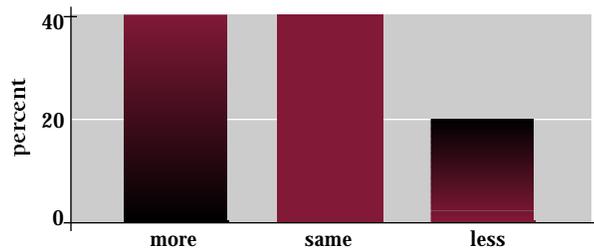
An important outcome related to quality is employee satisfaction with carriers. Many large corporations monitor quality by conducting employee satisfaction surveys and focus groups, and by tracking the numbers and types of employee complaints. We asked respondents what they perceived as the five-year trend in employee complaints (more, fewer, the same), as well as overall employee satisfaction with the health care provided by current carriers. Forty percent of companies reported that they now receive more complaints about health care coverage than in 1994, 40 percent estimated a stable number, and only 20 percent reported fewer complaints. The larger volume of complaints may be due to the transition to managed care models, which have been widely perceived as more restrictive in care delivery. Also, increased dissemination of quality information by companies may be empowering consumers to voice dissatisfaction.

Managers' perception of employee satisfaction with health care



Despite the trend toward increasing complaints, Fortune 500 respondents believed that their overall employee satisfaction was relatively high. On a scale of 1 to 7 (7 being most satisfied), the majority of companies estimated their workforces to be at 5 or 6 in satisfaction.

Managers' perception of employee complaints since 1994



“Because consumers are their main leverage point, Lucent and other large employers are educating them to become better purchasers.”

– Pam Krol
Lucent Technologies

CDC AND PBGH PARTNER FOR HEALTH PROMOTION

The Centers for Disease Control and Prevention (CDC) is the lead federal agency responsible for promoting health and quality of life through the prevention and control of disease, injury, and disability. The CDC has partnered with large corporations and business coalitions in the areas of health promotion and disease prevention.

The CDC has worked successfully with the Pacific Business Group on Health (PBGH) Negotiating Alliance to include prevention guidelines for benefits in their purchasing. The PBGH Negotiating Alliance purchases health insurance on behalf of large employers in California and the western United States. In 1999, the alliance purchased health insurance for 410,000 employees covered by nine HMOs.

The CDC-PBGH partnership targeted smoking cessation treatments not typically covered by employers. Before the initiative, PBGH covered prescription anti-smoking treatments but not over-the-counter drugs and behavioral therapy to aid smoking cessation. Even before its new benefits design, PBGH's coverage exceeded the norm. According to Harris, less than half of California employers covered smoking cessation treatments in 1999.

Newly covered services at PBGH include nicotine patches, behavioral therapy, and drugs. Jeffrey Harris, M.D., M.P.H., of the CDC believes that “the business case needs to be made before employers will offer or expand coverage.” The business case for expanding coverage of smoking cessation treatment is strong given the costs of smoking, the effectiveness of available treatments, and rapid rate of return for smoking cessation programs. Harris reports that a smoking cessation program pays for itself about three years after inception. Besides cutting health care costs, PBGH's new benefits are expected to lead to lower absenteeism and higher productivity. According to Harris, “the inclusion of these benefits presents an ideal investment for employers to increase productivity and maintain a long-term relationship with their workforce.”

CONCLUSION

As demonstrated by our data, the first managed care revolution is nearly over. The vast majority of Fortune 500 employees are now enrolled in managed care models rather than in traditional indemnity. There is a widespread perception among large employers that the major cost savings from this migration were a one-time phenomenon based upon discounted fees paid to health care providers. This discounting began with health carriers and has evolved in the recent trends toward carve-outs for pharmaceuticals and mental health. Health care costs however, have risen substantially within the past couple years for most employers.

Not only are the financial gains from managed care largely exhausted, but employees have also voiced numerous complaints about the existing generation of managed care programs. Although the media have highlighted and perhaps amplified these complaints, managers are increasingly concerned about being responsive to employees. A tight labor market in most industries has led companies to reemphasize employee satisfaction to meet attraction and retention needs.

Unlike in the early 1990s, there is currently no clear and widely applicable solution to the current gridlock between large employers and their health carriers. One option for large employers is to shift the rising premium costs on to employees. This cost shifting however, has not been a feasible option for many companies; in particular, employees in low-wage industries cannot afford rising premium costs, and are increasingly declining coverage.

A number of employers are experimenting with new programs that are designed to reduce the costs of health care and to make managed care more acceptable to employees and their families. These experiments range from designing more consumer-friendly forms of managed care, to the unbundling of managed care services from carriers, to working with new non-traditional vendors, and even adopting new information technologies for disease management and health promotion. Whatever direction the nation's largest employers take, their new purchasing practices will continue to exert a powerful influence over other private and public purchasers as well as the health care delivery system.

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