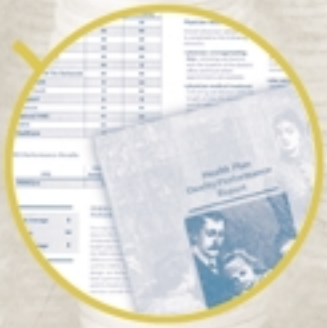
Purchasing PATHFINDERS

On Their Way, But Still Wrestling with the Realities of Containing Costs and Promoting Quality



Produced for The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Program

Written and Published by Alpha Center

Credits

This report was prepared by the Alpha Center under The Robert Wood Johnson Foundation's *Changes in Health Care Financing and Organization* (HCFO) program. The HCFO program supports the research, demonstration, and evaluation projects that examine major changes in health care financing and organization issues with implications for current public policy. The Alpha Center serves as the Foundation's national program office for this initiative.

Special Thanks to Meeting Presenters:
Brian E. Dowd, Robert Ihrie, Clark E. Kerr, James H. Maxwell, and Jack A. Meyer

Written by:
Carole C. Lee
Deborah L. Rogal
Kerry B. Kemp

Program Director:
Anne K. Gauthier

Designed by:
Bremmer & Goris Communications, Inc.

On the Cover:
Health Plan Quality Report used by permission of the California Public Employees Retirement System.

Foreword

Over the last decade, as the health care system has become an increasingly competitive marketplace, many public and private purchasers of health care have begun to recognize that they hold significant market power, which they can use to drive down costs and promote quality in health care. Although public purchasers were involved in some of the earliest efforts to contain costs by changing their purchasing methods, large private employers now lead the way in determining how to convert their potential market influence into true negotiating advantage. Purchasing innovations have generally taken the shape of purchasers using financial incentives to change employee behavior and to foster competition among health plans. As might be expected, cost-containment efforts have gained greater headway than have quality initiatives, but overall, significant progress has been made in all directions.

Under its *Changes in Health Care Financing and Organization* initiative (HCFO), The Robert Wood Johnson Foundation has supported several projects that have examined the activities of public and private purchasing innovators and sought to assess their impact and potential. In addition, the Foundation has sought to encourage substantive exchanges among researchers, purchasers, providers, and policymakers in order to deepen understanding of several issues, including identifying the essential components of successful purchasing innovations, recognizing the obstacles to designing and implementing new approaches, and anticipating the challenges that must be overcome for additional purchasers to try the new strategies. One such exchange took place at a HCFO meeting held in July 1997, where a purchaser, a consumer representative, and researchers were among the presenters, and many public and private policymakers were among the participants. The resulting discussion proved valuable for helping researchers understand how their work was being used in a practical and policy sense and for helping policy leaders understand better what is happening in the "real world" of purchasing. The meeting also provided an opportunity to assure purchasers that they have a hearing among those who study and regulate them. This report seeks to promote further interaction among all the players by providing an overview and synthesis of the initiatives implemented thus far by a significant number of the innovators in the purchasing arena.

While not an exhaustive review, the efforts outlined here represent an extensive collection of the new approaches that have been applied so far. The goal of this report is to broaden knowledge of the new activities that have taken place in order to allow other interested public and private purchasers to consider the extent to which they might be able to apply some of the innovations described here. The report also seeks to aid health policy researchers as they pursue further studies on the potential value and impact of new approaches in health care purchasing, and to equip policymakers to determine where and how they may need to step into the purchasing process as regulators.

Clearly, concerns of cost and quality remain vital in our health care system, and all current momentum suggests that market forces will continue to define the nature of health care financing well into the future. Therefore, the behavior of both public and private purchasers will only gain importance as a factor that influences how health care is paid for and delivered. It is our intention that this report will help ensure that further innovations and policy actions take place in a well-informed environment.

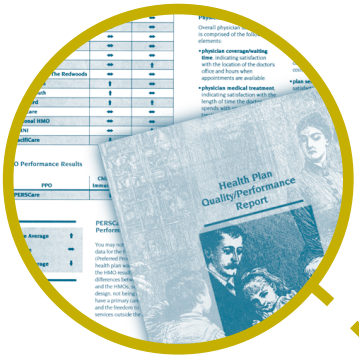
Anne K. Gauthier,
Program Director

Deborah L. Rogal,
Deputy Director

Executive Summary

The experience of innovative public and private purchasers of health care coverage thus far indicates that aligning incentives to contain costs is simpler than determining how to motivate competition based on quality. Nonetheless, the awareness that cost and quality are intertwined remains vital among many purchasing innovators. The early evidence is encouraging regarding health care purchasers' ability both to control costs and assure quality through new purchasing practices.

However, critical questions about the potential of purchasers' leverage to influence the market remain and will only be answered if purchasing innovations are adopted on a broader scale. Broader adoption of new purchasing practices will depend in part on broader dissemination of the experiences to date, so that purchasers can see for themselves the potential value from and barriers to implementing new approaches to purchasing health care coverage.



Further progress in improving the cost efficiency and quality of health care will require drawing together the lessons learned by all types of purchasers. Public and private sector purchasers bring different strengths and weaknesses to the table, even though private purchasers are considered the innovation leaders at this point.[1] For example, public sector purchasers bring tremendous market clout, and the private sector brings an ability to rapidly adapt to changing market conditions. The challenge ahead, it seems, is leveraging all those strengths in the health care market to reduce health care costs while also improving access and quality.

To the extent that purchasers' influence continues to grow, critical questions also remain for policymakers regarding the role government should play in influencing health care purchasing decisions, particularly with respect to assuring quality. Questions state, federal, and local governments need to resolve include the following:

- Should government develop measures and criteria for evaluating purchasing decisions?
- Should government support data commissions to develop coordinated data collection efforts to further quality initiatives?
- How can public purchasers adapt and implement successful private sector practices for public employees, Medicaid, and Medicare, keeping in mind the constraints that are unique to the public sector?

[1] **Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Quality First: Better Health Care for All Americans, Washington, DC, March 13, 1998 [http://www.hcqualitycommission.gov].**

Purchasing Pathfinders:

On Their Way, But Still Wrestling with the Realities of Containing Costs and Promoting Quality

In recent years dramatic increases in health care costs have prompted some public and private purchasers to pursue innovative strategies in the way they buy health care coverage. The success the early innovators have reported in achieving lower premiums has motivated some additional purchasers to try the new approaches, but the number of purchasing innovators across the country still remains low, as do the number of evaluations of their experience. As a result, the overall impact innovative purchasing efforts could have if applied more broadly remains unclear, but the research that has been conducted has confirmed the innovators' claims of cost savings and has shown, in some cases, improved quality as measured through greater employee satisfaction.

Because of the generally positive experience innovators have had thus far, other purchasers are likely to follow their lead. In the interest of helping those future innovators benefit from the experience of their predecessors, this special report provides a synthesis of what is known to date about the approaches tried and lessons learned by the purchasing pathfinders who have taken chances and tested the potential of new ideas. This report also considers what might or should be the ongoing role of employers and government in shaping the future of the employer-based health insurance system.

The evolution that has brought the health care market to its current state began in the 1980s when both medical inflation and the increased availability and use of medical technologies resulted in dramatically higher health care costs for employers. Initially, cost concerns voiced by large corporate purchasers motivated insurers — who had served largely as bill payers to that point — to begin to try to control costs through such approaches as limiting coverage and negotiating contracts.

In more recent years, large private employers — who represent approximately 26 percent of the nation's health care expenditures — have recognized that the numbers of people for whom they buy coverage gives them significant market influence, and they have taken the lead in both pushing traditional insurers to find savings and stimulating new types of health plans to respond to their specifications. These employers, seeking to rein in costs and to preserve the current voluntary-based health insurance system, have instituted a variety of purchasing innovations, and health insurance purchasing decisions have become a significant area of focus at executive management levels.

Public purchasers, particularly those responsible for state Medicaid and employee group health insurance, have also realized the weight they have in the market and have responded by beginning to apply innovative practices to their health care purchasing. Beyond the efforts taking place separately in the public and private sectors, there has also been some exploration of public-private health care purchasing partnerships in the hopes of combining leverage and expertise in order to improve access to useful information on the performance of health plans, encourage the development of a community health information system, and reduce cost shifting among purchasers.

One more area of innovation has resulted from purchasing innovators realizing that if they work in concert with other purchasers as they all change their own behaviors, they could gain even more bargaining power with plans and providers. Therefore, some business coalitions have formed and explored how they might work together on activities ranging from developing common sets of guiding incentives and shared needs to actually joining together in contracting for coverage. In addition, these experiments in cooperation have provided a means to explore community-wide solutions to rating or risk selection problems in the health care market rather than developing solutions that simply shift costs from one population or purchaser to another.

Overall, innovators acknowledge the value and potential for managing both costs and quality through health care purchasing, but largely due to clearer incentives and more straightforward and less expensive implementation, cost-containment efforts have gained greater headway than have quality initiatives. The more limited, though impressive, work that has been invested in making quality a priority in the purchasing process will be discussed in greater detail later in this report. First, however, the report will review the progress made by private employers and by public purchasers in their cost-containment initiatives.

Medicare Took Early Steps in Attempting to Contain Costs

Although private purchasers now occupy the role of leaders in purchasing innovation, Medicare — with its 37 million enrollees — was one of the first purchasers to attempt to address the problem of spiraling health care costs.[1] In 1982, Congress sought to cut federal outlays for the program by mandating that Medicare payments for inpatient hospital care be changed to per case payments based on diagnosis-related groups (DRGs). In the years that followed, Medicare adopted other far-reaching payment reforms, including restricting doctors' charges to preset amounts — usually much less than private insurers paid-for particular physician services.[2]

As a result of the payment reforms, Medicare's costs per beneficiary began to grow more slowly than the private sector's. Unfortunately, however, for the long-term viability of this approach, Medicare's savings came somewhat at the expense of other purchasers as some doctors and hospitals shifted costs where possible to compensate for the reduced income from Medicare. Essentially, individuals, private employers, local governments, and other purchasers with less market power ended up paying for part or all of Medicare's savings.[3]

Large Private Corporations Took Over the Leadership Role

Because Medicare's changes came about at approximately the same time that some large corporations that had been examining their growing health care expenditures began actively seeking ways to reduce costs, the absorption of Medicare's savings by the rest of the system did not last long. Rather, the private employers took over the momentum in purchasing innovation, trying a broader range of new approaches, which have over the years significantly changed the nature of the health care system. Some companies took the rather bald actions of cutting back benefits, shifting costs to employees, or completely eliminating health insurance for their employees. Others, however, began to look for creative ways to save money and still provide the health care benefits employees had come to expect from their employers since the end of World War II.

In this context, Paul Ellwood and Alain Enthoven introduced the principles of managed competition, which surfaced prominently in discussions of the Clinton health reform proposals in the 1990s.[4] Managed competition essentially involves creating a more traditional market for the purchase of health care. This requires gathering information on the cost and quality of products and then fostering competition among suppliers.

Enthoven's principles of managed competition include a several step process for the purchase of managed care — implementing a competitive request for proposal (RFP) bidding process to encourage competition among managed care plans, the use of financial incentives to encourage individuals to enroll in the lowest cost plan, incorporating quality components into the health plan evaluation process, and consolidating purchasing power.[5]

Despite the failure of national reform, managed competition has exerted extensive influence on the American health care system. Although no public or private purchaser has adopted or implemented managed competition principles uniformly, many purchasers have combined various mixes of those principles with other business tactics to become savvy health care purchasers.[6,7] They have essentially used managed competition as a starting place for developing purchasing innovations that fit their organizations and take into account such factors as size, short- and long-term business objectives, financial health, existing purchasing capabilities, and human resource needs. The result is a collection of approaches with enough variety to suggest that interest and motivation — rather than size and type of business — would be the key indicators as to which purchasers might find value in exploring the purchasing innovations that have now entered the market.

The Experience of Private Employers Shows the Range of Options

Among large, private employers, “We have found as many corporate health care purchasing strategies as corporations,” says James Maxwell, director of Health Care Policy and Management at John Snow, Inc. (JSI), who with his colleagues examined corporate approaches to managed competition among 15 large purchasers located in four relatively mature managed care markets (Boston, San Francisco, Minneapolis, and Orlando) and known for their health care purchasing innovations.[8] “Most of the 15 corporations — which include GTE, Digital Equipment (bought by Compaq in 1997), American Express, Xerox, Lockheed Martin, the Minnesota Employee Group Insurance Program, General

Mills, Disney, 3M, and others — have mixed and matched different combinations of financial and quality elements in their purchasing strategies."

Requiring Enrollment in Managed Care

Among the 15 companies studied, most have either encouraged or required employees to enroll in managed care as more types of managed care plans became available,[9] and the transition to managed care has typically led to at least one-time savings for those purchasers, Maxwell says. GTE, Digital Equipment, American Express, Xerox, Lockheed Martin, General Mills, Disney, and 3M are among the employers that have sought to take advantage of the curbs on unnecessary services and rising costs that theoretically come with providing care in a more coordinated manner and financing it through prepaid capitation.[10] To motivate employees to move into managed care plans, employers have typically applied financial incentives, such as level-dollar contribution policies to make employees more sensitive to costs in their selection of health plans. For example, Digital Equipment of Boston decided in 1989 that "well-organized, well-managed, efficient HMOs offered more value to the company — that is, a combination of low price and acceptable quality — than indemnity plans and began setting its contribution to all employee health plans based on the least-cost HMO," explains Maxwell. "The aerospace firm Lockheed Martin has also changed its contribution to employee health premiums." Prior to 1994, the company's contribution was based on an average of indemnity and managed care health plan premiums for a family. In 1994, the company began changing its contribution, in a step-wise fashion, to encourage its employees to enroll in managed care plans. In 1997, Lockheed reduced its premium contribution to 85 percent of the lowest cost plan.

The private employers took over the momentum in purchasing innovation, trying a broader range of new approaches.

Competitive Bidding and Aggressive Negotiation

An approach that most of the 15 corporations in Maxwell's study have examined, but not yet pursued because of potential employee disruption, is the use of competitive bidding and aggressive negotiation with health plans. The corporations recognize that through this approach they could expand their leverage in premium negotiations, but they also recognize the possibility of having to freeze enrollment with, or even cut, certain plans if negotiations fail. In such tactics the corporations see significant potential for negative impact on their work force.

A few that have taken on the challenge of aggressive negotiation are Lockheed Martin, General Electric, and the Raytheon Corporation.[11] In 1993, Lockheed-Martin used a standardized benefit package and a competitive bidding process to select managed care plans, along with aggressive negotiations. "This approach resulted in a 10.7 percent drop in per capita costs for the subsequent year, and Lockheed had per capita costs in 1996 that were comparable to those in 1989," says Maxwell.

Direct Contracting with Providers

Finally, an even less common strategy for holding down costs among large purchasers has been direct contracting with providers, which means employers bypass plans to give more control and responsibility to consumers and their physicians.[12] One example of a company that uses such an approach to hold down costs and tailor a benefit package and provider network to its needs is Parket Hannefin in Cleveland, which University of Minnesota professor Jon Christianson has reported on as part of a study by the Center for Studying Health System Change on the activity of health care systems in 12 communities. Parket Hannefin has a partnership with the Cleveland Clinic to offer illness prevention activities for its employees. It has also created its own preferred provider organization (PPO) with the intent of benefitting directly from control of its health care costs.[13]

Private Purchasing Coalitions Have Shown Some Potential for Cooperative Contracting

In reverse of the trend among individual large corporations, private purchasing coalitions have typically been more active in promoting quality initiatives than in cost containment because cost-related efforts involve drawing businesses together for shared negotiating and contracting. Nonetheless, in a few parts of the country, large companies have pursued cost-containment initiatives through employer coalitions that increase the size of their purchasing pools.

Pacific Business Group on Health

For example, the Pacific Business Group on Health (PBGH), an association of large corporations based in the San Francisco Bay Area, is dedicated to reducing health care costs and improving quality. Founded in 1989, PBGH currently consists of more than 30 firms representing

3 million employees, dependents, and retirees.[14,15] Member firms spend $3.5 billion annually on health care. In the 1990s, after discovering that the premiums they paid individually to HMOs varied widely for no good reason, PBGH members decided to leverage the large numbers of employees covered by the coalition's members and joined together to negotiate a single rate with each HMO for a standard benefit package.[16] In 1994, PBGH formed the Negotiating Alliance and initiated joint negotiations, which resulted in premium reductions for all its members.

Although the Alliance did not achieve premium reductions in each individual year, from 1995 to 1998, members have realized a 13 percent reduction in HMO rates.[17,18]

Buyers Health Care Action Group

Established just about a year before PBGH, the Buyers Health Care Action Group (BHCAG) in Minnesota — a health care purchasing coalition that includes American Express-Minnesota and about 10 other prominent self-insured employers with headquarters in Minneapolis/St. Paul — has aggressively sought in recent years to contain costs and maintain quality through purchasing innovations.[19,20] In 1991, BHCAG initiated joint purchasing of health insurance for its members' Minnesota employees, seeking bids from HMOs and provider networks for a contract to establish a health plan to be offered to these employees. Called Choice Plus, the plan was made available to employees in 1993 and grew within four years to include 125,000 employees.

Recently, however, BHCAG has become concerned that over-consolidation among Twin Cities HMOs — caused in part by the presence of BHCAG and its emphasis on having managed care plans offer wide provider networks — has reduced competition below optimal levels. In 1997, therefore, BHCAG stopped contracting with HMOs and began contracting on behalf of its corporate members with groups of hospitals and physicians known as care systems. Primary care physicians are restricted to membership in only one care system.[21] The hope is that the new BHCAG system will generate more competition.

For the Twin Cities, BHCAG accepted the bids of 15 care systems.[22] BHCAG divided the bids of care systems into low-, middle-, and high-cost categories. The monthly rates ranged from $80 to $105 per member per month and averaged about $100, well below the premiums that non-BHCAG employers were paying. According to BHCAG, premiums in 1997 were 8.5 percent below what they would have been had BHCAG continued to contract through HMOs.

"If the new BHCAG system is a success," says Christianson, "it might be transferred to other health care markets where over-consolidation of health plans has not yet occurred. In essence, motivating competition closer to the provider level might prevent the consolidation problems caused by requiring managed care organizations to provide broad access to primary care physicians and specialists."[23] All BHCAG employers — which include American Express, 3M, Hudson Department Stores, Honeywell, and Pillsbury — offer Choice Plus, but most also offer HMO and PPO plans.[24]

Coalition Initiated by American Express and Merrill Lynch

Another coalition in which several major corporations are seeking to join forces to buy coverage began in 1993 when the national offices of American Express and Merrill Lynch, which have a combined employee pool of almost 250,000 workers in 26 locations, agreed to participate in joint purchasing of health benefits for their employees. To manage much of the purchasing process, they hired William H. Mercer, Inc.[25] Leonard Reesman, a cardiologist and consultant with Mercer, chose 50 case files from each health plan and reviewed the care choices that were made, particularly concerning allocation of care to sick patients. Then he developed overall plan ratings based on quality (weighted at 70 percent of the rating) and premium price (30 percent). American Express and Merrill Lynch chose two to four plans in each market according to how well the plans were rated. Other plans were dropped or had enrollment frozen. In addition to the selected HMOs, an indemnity plan was offered in each location. The final premium rates and employee contribution strategy were determined and administered by each employer, apart from the joint purchasing negotiations.

Building on its initial experience the coalition has grown and by the middle of 1995, the start of the purchasing year for 1996 coverage, the following six corporations had agreed to join American Express and Merrill Lynch as members of the final coalition: Marriott, Pfizer, Sears, ITT Hartford, Nabisco, and Mobil. In each market in which coalition members operate, the health care

State governments have implemented a variety of approaches in their attempts to create incentives to contain costs and make health care markets more competitive.

plans used by participating companies were again rated by Mercer and subjected to the scorecarding process used previously by American Express and Merrill Lynch. All members of the coalition that wished to participate in purchasing in a given region met to go over the results of the scorecard system. The coalition then selected from two to four HMOs in a given region. Some incumbent plans did not rank among the top four in a region, but had previously served a large number of coalition employees. The flexible nature of the coalition's selection process made it possible to bypass the scoring system, permitting the retention of the plans despite poor scorecard rankings. American Express and the other coalition members also kept independent control over the price structure presented to employees, as long as only those managed care plans chosen by the coalition were offered. In addition, American Express continued to offer an indemnity plan to all corporate employees.

The first selection by the expanded coalition was in early 1996 covering 27 markets and 600,000 lives. Significant rate decreases have been cited as a result of this initial round, and employee satisfaction appears to have remained high. The 1997 selection included 38 markets and 83 HMOs, and covered over 1 million lives.

The Prominence of Purchasing Innovation Has Varied Among Public Purchasers

Where public purchasers have adopted purchasing innovations, they have picked and chosen among the same approaches used by private purchasers, but because public and private purchasers operate in different market contexts with different priorities, there is some variation in which approaches have gained prominence in the two sectors. In addition, the choice of purchasing innovations has varied within the public sector, depending on whether the purchasers are responsible for public employees or for public coverage programs.

Public Employers Have Sought to Contain Costs and Make Markets More Competitive

"States, as employers, are intrinsically important due to the number of people they employ," explains Brian Dowd, professor in the Institute for Health Services Research at the University of Minnesota. "In many states, the state government is one of the largest employers. Nationwide, state employees represent a sizable population — 4.56 million in 1994 — 90 percent of whom have health insurance."[26] In addition, because they purchase across a large geographical area, the markets each state government faces can range from highly competitive in one part of the state to a virtual monopoly in another. Like all employers, state governments have implemented a variety of approaches in their attempts to create incentives to contain costs and make health care markets more competitive. Most states offer employees a choice of plan, hold open enrollment periods, and give employees comparative information on benefits and premiums charged by health plans.[27]

Encouraging Public Employees to Enroll in Managed Care Plans

Encouraging or requiring public employees to enroll in managed care plans is an approach commonly used by public employers who have pursued innovative approaches. For example, the Minnesota Employee Group Insurance Program, which is the largest employer-based health insurance group in Minnesota, with 140,000 employees, dependents, and retirees, began moving all state employees into managed care in 1989 under a policy of paying for the lowest-cost health plan in each county.[28]

"By moving all state employees into fully managed care or a preferred provider option and setting rules regarding which health plans can compete to offer state employees health care, Minnesota has reined in escalating costs and increased its influence over the health care delivery system," says Christianson.

Likewise in Missouri, the Missouri Consolidated Health Care Plan (MCHCP) places heavy emphasis on moving increased numbers of employees into managed care plans, according to Jack Meyer at the Washington, D.C.-based Economic and Social Research Institute (ESRI). Created by the Missouri legislature to act as a purchasing cooperative for state and local government workers, MCHCP began operation in 1994 and purchases coverage for about 140,000 state and local government employees and their dependents.[29]

Gaining Authority to Negotiate Premiums with Participating Plans

Beyond pushing enrollment in managed care, some governing boards and agencies that purchase health care for state and local employees have gained from their legislatures both wide latitude in designing and managing their benefit programs and authority to negotiate premiums with participating plans.[30] The purchasers that have taken advantage of their ability to negotiate more aggressively have achieved lower premiums. For example, in 1995 the MCHCP governing board was given some authority to negotiate with health plans, allowing it to obtain significant reductions in HMO premiums.

Even earlier, in 1992, the California Public Employee Retirement System (CalPERS), which negotiates health

care coverage for 1 million public employees, representing about 8 percent of the state's privately insured population, achieved an unprecedented 0.4 percent rollback in health insurance rates for 1993.[31] This rollback was followed by a 0.7 percent reduction in rates in 1994 and a 5 percent reduction in 1995. According to Maxwell, "The CalPERS experience demonstrated that substantial price breaks were possible for employers willing to challenge managed care organizations on price." In addition, even when negotiations have not yielded the desired results, CalPERS has still managed to take advantage of its market power in California. For example, when Kaiser refused to freeze rates and benefits at the 1991 level for the 1992 contract year, CalPERS froze new enrollment for eight months.[32]

Level-dollar Premium Contributions

Turning their focus back to influencing employee behavior, half of the states (22 out of 44) that offer multiple health plans with periodic open enrollment opportunities are experimenting with defined or level-dollar premium contributions for family coverage to make consumers sensitive to costs in the selection of health plans. Slightly less than half (17) of the states that offer multiple plans use defined contributions for single coverage. For both family and single coverage about half the states using this approach set their contribution either equal to the premium of the lowest cost plan (5 states do for family; 5 for single) or equal to a percentage of the lowest cost plan (6 states do for family; 5 for single). Other methods vary from state to state, including in one state, the use of an enrollment-weighted average premium, like the one used by the Federal Employees Health Benefits Plan (FEHBP), for single coverage only.[33,34]

As noted above, the Minnesota Employee Group Insurance Program pays for the lowest-cost health plan in each county.[35] Employees who want more expensive plans have to pay the difference in cost as their premium. According to Maxwell, this premium-setting approach saved the state more than $124 million from 1992 to 1995.

Missouri's MCHCP has geared its premium contributions since 1994 to the lowest-cost HMO in an employee's county of residence. In rural areas, where provider networks and physician access are limited, MCHCP is more flexible with regard to its premium contribution policy.[36]

Medicaid Purchasers Have Sought to Control Costs and Improve Quality

With as many as 34 million enrollees in Medicaid programs across the country, many states have begun to seek ways to reduce costs and improve the quality of care in these programs as well.[37] The vast majority of states have made managed care the centerpiece of initiatives to restructure their Medicaid systems, requiring at least some Medicaid beneficiaries to enroll in private managed care programs. A few states — including Oregon and Tennessee — have initiated ambitious managed care programs designed to expand coverage for low-income adults and children under Medicaid waivers from the Health Care Financing Administration (HCFA). The Balanced Budget Act of 1997 allows states to implement mandatory managed care for Medicaid beneficiaries, so the percentage of Medicaid beneficiaries enrolled in managed care can be expected to grow. A survey of 12 studies that examined the impact of managed care on costs to state Medicaid agencies found mixed results.[38]

An increasing number of state Medicaid programs are also entering into competitive bidding processes or other negotiating strategies with health plans or other providers. Even before purchasing innovations entered the market, federal law defined a formula that specified a ceiling limiting the amounts that state Medicaid programs could pay to health plans. Contracts to purchase managed care for the Medicaid program must be structured to comply with that federal ceiling as well as with other federal and state requirements. As noted in a report produced by the Alpha Center and the Center for Health Care Strategies, state purchasers are standardizing purchasing specifications and describing them with more specific contract language.[39] In addition, like only a few private corporations, some state Medicaid programs are contracting directly with community providers that can serve vulnerable populations.

Recent Medicare Innovation Has Been Limited

Medicare's movement to managed care and other cost-driven purchasing innovations has been slow relative to the rest of the health care market — in large measure because Medicare beneficiaries have been at best wary and at worst highly resistant to the prospect of changing their traditional fee-for-service coverage arrangements. There has, however, been some movement since the Omnibus Budget Reconciliation Act of 1995 established the MedicarePlus program, giving Medicare beneficiaries the option of enrolling in managed care plans. An increasing number of Medicare beneficiaries are now choosing managed care plans, and as of January 1, 1997, approximately 4.9 million Medicare beneficiaries had enrolled in a total of 336 managed care plans, accounting for 13 percent of the total Medicare population.[40] To encourage more Medicare beneficiaries to enroll in managed care, Congress established Medicare + Choice in the Balanced Budget Act of 1997. Medicare + Choice seeks to expand the options available to Medicare beneficiaries by expanding the types of managed

care plans that can contract for Medicare business. Medicare + Choice also provides information intended to equip beneficiaries to make good decisions about which coverage options best suit them.[41,42]

Since its efforts in the early 1980s to slow cost growth, Medicare has not been a leader in purchasing innovations; however, the program has considerable market clout, and any changes it does make in terms of payment or other policies will have ripple effects throughout the U.S. health care system.

Quality Initiatives More Complex to Implement

Although from its original conceptualization managed competition has always included the incorporation of quality components into the health plan evaluation process, purchaser-driven quality initiatives are less well developed than are purchaser-driven efforts to contain costs. Ideally, innovations in purchasing would combine the pursuit of cost containment and quality improvement. In reality, however, "the use of managed competition strategies intended to drive down costs tends to outweigh [the implementation of] strategies intended to maintain and improve the quality of care," Maxwell explains.

One reason quality initiatives lag behind those targeting cost containment, Maxwell suggests, is that competitive bidding and financial incentives to get employees to choose the lowest-cost health care plans are fairly easy to implement and promise large savings to purchasers.

In contrast, he says, corporate quality and education initiatives — for example, performance-based contracting — are not well developed, are more complicated to implement, and can require a multi-year, million-dollar commitment. Many firms simply lack the necessary resources while others lack the desire to make such an investment because the potential gains from implementing health care quality initiatives — for example, improved worker productivity or labor relations — are outweighed by the additional cost and effort required to implement such initiatives.[43] Despite the contrast between the straightforward challenges and clear rewards of cost containment and the complex challenges and less tangible rewards of quality improvement, Maxwell argues that "what distinguishes the best corporate health programs is the linkage between the financial and quality control elements of their programs. The best corporate purchasing programs reward plans financially for high quality."

One Challenge in Promoting Quality Lies in Measuring It

Even where firms want to pursue quality through purchasing, an additional obstacle that must be considered is the lack of a consensus on how best to evaluate the quality of health care. The science of evaluating the quality of health care is still evolving. A few pioneering Fortune 500 companies — including GTE, Digital Equipment, and Xerox — have been in the forefront of efforts to develop standardized, valid, and reliable information about the quality of care for several years. Their efforts led to the creation a few years ago of the National Committee on Quality Assurance (NCQA) in Washington, D.C.

NCQA's Health Employer Data and Information Set, commonly known as HEDIS, is a set of standardized measures of performance in specific areas (e.g., cholesterol screening) that is being used by large private purchasers — and more recently by state Medicaid programs — to evaluate the quality of managed care plans.[44] Surveys suggest that a majority of large employers are now requesting HEDIS data from all of their health plans.

A few pioneering Fortune 500 companies have been in the forefront of efforts to develop standardized, valid, and reliable information about the quality of care.

GTE has also taken the further step of creating its own HEDIS database on the plans it offers employees.[45] According to Maxwell, one of the reasons GTE decided to create its own HEDIS database was that the company could not depend on either the regional or national HEDIS coalitions to meet internal deadlines for its annual cycle of quality benchmarking, regional contract negotiations, and the dissemination of information to employees prior to annual health care plan enrollment.

Several other important quality initiatives are also underway. For example, the Foundation for Accountability (FACCT) — a nonprofit organization in Portland, Oregon — is working to develop consumer-oriented quality measures that people can use to choose health care on the basis of quality.[46,47] Several prominent consumer groups and large health care purchasers in both the public and private sectors are supporting FACCT's efforts — among them are General Motors (GM), AT&T, American Express, the AFL-CIO, the American Association of Retired Persons, HCFA, the Department of Defense, and the FEHBP.

In Spite of Difficulties, Some Purchasers Have Proceeded With Quality Efforts

Even as quality mechanisms continue to evolve, there are

corporations, private employer coalitions, and state-level purchasers that have already taken steps that reflect an understanding of quality and cost issues as intertwined. Following is a review of those purchasers that have been willing to press ahead in using quality measures even though they are not perfect and in implementing quality incentives even though the pay-offs may be less tangible than for cost-cutting measures. Typically, the purchasers who have taken on this more demanding approach have done so because they are convinced that progress toward cost containment that neglects quality could actually undermine quality and consumer trust in the system.

Because, as in cost-containment initiatives, private employers have led the way in innovation, their activities will be reviewed first in this section, to be followed by private coalitions and then public purchasers. While all three types of purchasers share a great deal in terms of the types of innovations pursued, the emphasis they place on a given approach varies according to their priorities, and the order followed in each of the sections below varies to reflect the purchasers' differing priorities.

Choice has gained considerable importance as a component that weaves together the elements of cost containment and quality improvement.

Choice and Information Are Basic Features in New Purchasing Approaches

As might be expected in a system driven increasingly by competition, choice has gained considerable importance as a component that weaves together the elements of cost containment and quality improvement. As discussed above, on the cost side purchasers are increasingly combining multiple options with financial incentives to encourage enrollees to choose the most cost efficient plans. On the quality side many innovators rely on informed choice by consumers as the centerpiece of their efforts to motivate plans to offer high quality products cost effectively. The idea is that if consumers can choose they will choose the highest quality, lowest-cost plan, and the result will be a market in which the plans and providers who thrive will be those that offer the best value in terms of cost and care. Therefore, although a number of employers have been moving to consolidate their plan offerings to enhance their leverage in negotiations with health plans, many large employers in the JSI study typically still offer their employees a choice of between two and eight insurance plans.[48,49]

For example, one of the 10 largest companies on the Fortune 500 list, the telecommunications company GTE, has 265,000 employees, dependents, and retirees, has operations in 40 states, and offers 300 health plans across the country.[50] Believing that health care is a local business and that its health care strategy could best be implemented by regional managers with an in-depth understanding of the local markets and their delivery systems, GTE has hired five regional health care managers (for the Northeast, South, Central, West, and Midwest regions) who are responsible for evaluating and selecting health plans offered to GTE employees. According to Maxwell, GTE's Chief Executive Officer Charles Lee has said, "Competition empowers consumers, and it is they who should be allowed to choose the winners and losers in the telecommunications industry." Lee believes that the same principles apply in health care.

Another example, Digital Equipment, which employs 60,000 people worldwide and spent about $250 million on health care in 1995, offers its employees more than 100 different plans across the country and describes that approach as an "employee-friendly posture."[51] "Choice remains a cornerstone of Digital's health care management strategy," says Maxwell. "Digital retains its commitment to offering employees a choice of plans even though the company could perhaps obtain purchasing leverage by consolidating the number of health plans with which it contracts." In each region of the country, Digital offers its employees a choice of managed care plans that meet its service criteria plus the company's two standard indemnity plans; it also offers a point-of-service (POS) managed care plan that allows employees to obtain care outside the provider network, but at a higher cost. GM, which has about 173,000 active and retired employees scattered across Michigan, Ohio, Indiana, western New York, and Wisconsin, provides a choice of plans for those it covers by contracting with about 100 managed care organizations that offer various HMO products.[52]

Effective Choice Depends on Sufficient Information

As noted above, it is *informed* choice by consumers that purchasers see as a means of promoting quality; therefore, developing and distributing performance information on available plans plays an essential role. As a result, according to a recent ESRI study, a number of large employers — national companies such as GTE and Digital Equipment, as well as regional employers such as Edison International, Federated Department Stores, and

US WEST — are providing employees with information about their health plan options in an effort to help them make decisions during the open enrollment period.[53] "The companies' report cards vary in both content and format," says co-author Elliot Wicks, "but all reflect a concerted corporate strategy to shift responsibility for health care-related decisions to consumers and to create pressure on plans to respond to enrollees' concerns about quality of care in managed care environments."

Some Corporations Are Developing Standards and Benchmarking Plans

While report cards are becoming increasingly common, some employers are taking steps beyond simply producing and distributing the information to enrollees. In fact, a growing number of Fortune 500 companies have initiated efforts to develop and implement quality standards for health plans and providers.[54] These fairly aggressive innovators, which include GTE, Digital Equipment, Allied Signal, Ameritech, Bristol Myers-Squibb, Chrysler, Ford, GE, IBM, Marriott, Mobil, NationsBank, PepsiCo, Procter & Gamble, UPS, USAir, and Xerox, have started requiring or requesting NCQA accreditation of the health plans they do business with.[55] NCQA accreditation involves a review of a health plan's quality assurance system against 50 standards. Some companies also require the HMOs with which they contract to submit data from HEDIS.

In addition to developing standards and making sure employees know what plans have to offer, some corporations have moved into the arena of benchmarking, or designating clearly how well plans measure up to selected standards. In the material it provides to employees, GTE uses its HEDIS database to provide both national and regional benchmark rankings, Maxwell says. To determine a plan's national ranking GTE rates each plan using standard HEDIS measures in five separate quality domains (surgical quality, medical quality, satisfaction/access, physician quality, and preventive care). Health plans scoring in the top 15 of all plans are given an exceptional quality designation.

Benchmarking of health plans in five regions of the country (the Northeast, South, Central, West, and Midwest regions) similarly involves the use of HEDIS measures but also includes perceived cost-effectiveness as compared to other plans in the region. Following the quality benchmarking at the national and regional levels, GTE establishes a final ranking of each managed care plan and each indemnity plan using a comprehensive measure of value that includes both cost and quality. GTE also provides feedback annually to the plans based on the national and regional benchmarks. After the plans have reviewed their performance reports, GTE disseminates its national ranking of health plan performance. In addition, as discussed further below, GTE was among the first purchasers to use quality benchmarking to reward health plans financially.

Digital Equipment has developed customized report cards that indicate the performance of only those plans available to a given employee.[56] The report cards present each HMO's results, as well as the performance standards established by the company for that measure. In some cases, national averages are also provided. The information is also available to employees through Digital's Intranet.[57] According to Maxwell, quality improvement and employee choice are central features of Digital's managed care strategy introduced in 1991.[58] HMOs that meet preferred standards for quality, access, and costs are designated benchmark low-cost HMOs. Digital offers financial incentives to employees to use these plans.

GM gives its employees report cards that reflect the performance of HMOs relative to national standards and local norms.[59] HMOs that GM believes offer the best combina-

A Few Companies Are Applying TQM to Health Purchasing

One strategy that is somewhat rare is the application of total quality management or TQM principles to the purchase and delivery of health care. For example, Digital Equipment makes a commitment to work with select managed care plans on a long-term basis. According to Maxwell, "Digital Equipment executives believe that TQM principles—which include working with health plans in an iterative and interactive process driven by the philosophy of continuous improvement—will simultaneously drive down costs and improve quality." Digital managers hope that they can strategically use the company's partnership with managed care plans and its TQM-based feedback process to drive the development of products and services that previously did not exist or did not meet the needs of Digital employees. As part of its TQM strategy, Digital requires managed care plans to develop standards for their own suppliers. Thus, Digital encourages improvements throughout the supply chain.

tion of cost effectiveness and quality performance are designated benchmark HMOs. According to the ESRI report, GM's report card initiative introduced in the fall of 1996 indicated plan performance in eight areas: NCQA accreditation, benchmark HMO (yes or no); operational performance, preventive care, medical/surgical care; women's health, access to care (e.g., appointment waiting times), and patient satisfaction. Since the distribution of the report cards, the company has been evaluating their usefulness to consumers. One finding was that employees wanted report cards that allow them to compare HMOs and indemnity plans, so GM has been developing those.

The telecommunications firm US WEST provides member satisfaction scores and the results of seven HEDIS measurements through *Health Pages* magazine, which goes out to employees in Colorado, and *Health Pages* Online, which allows employees to search for information of interest to them.

Edison International (formerly Southern California Edison) tries to help its enrollees choose among six plans by providing the results for six HEDIS measures, various member satisfaction scores for specific administrative and clinical issues, and the plans' NCQA accreditation status.[60]

Financial Incentives for Consumers to Choose Quality Are New and Rare

Rewarding health plans for quality by giving financial incentives to health care consumers to select high quality plans or providers is a new approach that only a tiny minority of health care purchasers have adopted. "The crux of this approach," says Meyer, "is using the flow of patients and premiums to health plans with better performance results to motivate health plans to alter their behavior."

According to Maxwell, GTE, Digital Equipment, and GM adjust their health care premium contributions to encourage employees to enroll in benchmark plans.[61] "The experience of these companies suggests that differences in employer contributions can lead to major shifts in enrollment among managed plans," says Maxwell. "In markets dominated by overlapping provider networks," he notes, "employers can change insurers or health plans without disrupting existing relationships with physicians."

Among the first corporations to adjust its premium contributions to encourage employees to enroll in benchmark plans, GTE relies on its five regional managers to determine premium contributions using a combination of health plan benchmark outcomes and professional judgment.

In each market a benchmark-priced plan is designated, but this plan carries neither price incentives nor disincentives to the employee. In some markets, if it is warranted, GTE designates a super benchmark plan, which is offered to employees at a 5 percent discount. In addition, plans that receive GTE's exceptional quality designation are offered to employees at premiums discounted an additional 5 percent.

Digital Equipment, with more than 100 different kinds of health plans across the country, designates low-cost HMOs — with cost calculated on the basis of total costs to Digital and its employees, not just costs for the company alone — that meet preferred standards for quality and access as benchmark low-cost HMOs. Digital offers financial incentives to employees to use these plans.

GM combines the information it provides in report cards with a premium contribution policy that creates financial incentives for employees to choose benchmark plans (HMOs and PPOs). For all three of these companies, this combination of strategies has led to a modest

There Are Rare Examples of Coalitions Expanding Choice

In addition to providing information for employees, some coalitions also help their member employers provide a greater choice of plans. One example is The Alliance in Denver, which offers two products to its 1,100 employer members. The members range in size from one employee to 400 employees. For large, self-insured Alliance members such as US WEST, The Alliance offers a PPO across the state of Colorado that offers discounted services. For small employers, The Alliance offers through its CHIP (Cooperative for Health Insurance Purchasing) a choice of three different benefit packages—basic HMO, standard HMO, and standard HMO with an out-of-network option (a POS plan)—at four HMOs. The employer chooses the benefit package it wants to offer and establishes its contribution level; then employees and their families choose among the HMOs. Employers in the CHIP may not use financial incentives to steer employees to any particular plan or to limit their plan options in the cooperative in any other way.

migration of employees toward benchmark plans.[62]

Finally, a small number of innovative purchasers have begun giving health plans and providers added financial incentives — beyond marketshare — to improve quality. One such method is to put a percentage of health plan payments at risk to encourage quality.[63]

For example, to encourage quality improvement, Digital Equipment and its health benefits manager John Hancock often hold a portion of their administrative fees at risk. Lockheed Martin has placed 2 percent of the administrative premium at risk based on performance, and the PBGH has pursued a similar strategy. GM is currently considering how it might link plan performance to the reimbursement of the plan and is considering the pros and cons of rewards vs. sanctions.[64]

Private Coalitions Focus More on Information Than on Expanding Choice

Although a few coalitions have gotten into both helping to increase the choice of plans companies can offer and seeking to implement financial incentives for quality improvement, most coalitions — because they are voluntary cooperatives among independent businesses and organizations — have so far been most successful at producing and distributing information about health care and health care quality to employees. First among the multiple examples is PBGH, which has also been active in cost-containment efforts. Describing PBGH as "spearheading much of the performance assessment activity in California,"[65] Meyer explains that in the early 1990s, PBGH negotiated an agreement among public and private health care purchasers, health plans, and providers to form the California Cooperative Healthcare Reporting Initiative (CCHRI). The initiative has proven an effective mechanism for setting standards for collecting and reporting data about quality of care and service.

Pacific Business Group on Health's current projects include a health plan satisfaction survey, consumer web site and brochure, and a first-of-its-kind physician group survey that rates performance at the provider level.

In addition to its success with CCHRI, PBGH has pursued several other quality initiatives. Some of PBGH's current projects include an annual health plan satisfaction survey, a consumer website (http://www.healthscope.org/core.htm) and brochure, and a first-of-its-kind physician group survey that rates performance at the provider level.

Another coalition that has also successfully pursued cost-containment efforts, BHCAG has supported its commitment to promoting competition at the provider level through care systems by distributing detailed booklets of descriptive information also organized at the care-system level.[66] The booklets provide information on location, hours of operation, clinical and patient-reported measures of quality, service, and satisfaction. In the 1996 enrollment period, some employers also offered computer terminals, called kiosks, to provide online data about the care systems, including profiles of each physician.

In addition, The Alliance, an employer purchasing cooperative in Denver, worked with NCQA to develop a report card with information about the four HMOs it offers small employers under the Cooperative for Health Insurance Purchasing (CHIP), which The Alliance created in 1995 to open up the benefits of group purchasing to small employers that cannot afford to self-insure. According to ESRI's report, the report card covered three areas: health plan performance, customer satisfaction, and NCQA accreditation status. As of 1997, The Alliance was working with NCQA to evaluate the report card's usefulness to consumers. Employers in the cooperative are prohibited by Colorado law from using financial incentives to steer employees to any particular plan or to limit their plan options.[67]

Five of Cincinnati's largest companies — Federated Department Stores, Cincinnati Bell Telephone, BE Aircraft Engines, Kroger, and Procter & Gamble — collaborated to produce the first annual comparative assessment of the performance of 17 managed care networks in Cincinnati under The Cincinnati Health Care Plan Value Project.[68] The goals were to measure the value of managed care plans relative to each other and national standards, to obtain performance data from the plans and provide them with targets for improvement, and to stimulate competition and continuous quality improvement.

Although many report cards provide information on the performance of health plans, relatively few provide information about doctors or hospitals. The Health Action Council of Northeastern Ohio, representing 140 employers in and around Cleveland, has one of the first organized, private sector efforts to generate comparative quality data on hospitals — Cleveland Health Quality Choice Initiative (CHQC).[69] "CHQC was

designed to benefit both the purchaser of health care and the high quality provider," says Meyer. The information that is generated is geared primarily toward employers, providers, and health plans rather than toward consumers.

A Few Coalitions Have Implemented Financial Incentives to Promote Quality

In only a few cases, purchasing coalitions have implemented financial incentives to encourage plans to improve quality. To contract with the PBGH, several San Francisco-area HMOs agreed to put 2 percent of their premiums at risk — in other words, PBGH pays the HMO the 2 percent only if the HMO meets performance standards in the areas of customer service, quality, and precision of data.[70]

Likewise in Colorado, The Alliance uses financial incentives to reward the best performing and penalize the worst performing of the four HMOs with which it contracts under the CHIP for small employers. Each year, The Alliance works with the four HMOs to develop mutually agreed upon performance objectives for a set of performance indicators, including HEDIS, customer service, and customer satisfaction measures.[71] Each of the HMOs puts 2 percent of its premium at risk, which is then prorated across the performance standards.[72] If an HMO doesn't meet one or more of the mutually agreed upon objectives, it forfeits the pro-rated portion of its premium. At the end of each reporting year, 50 percent of the money that has been collected for each indicator due to penalties over the past year is awarded to the HMO with the best performance in that standard.

Although shared financial negotiations and incentives are rare so far among private coalitions, Maxwell is convinced that eventually "business coalitions can be involved in some of the same kinds of quality initiatives as individual corporations. By acting in concert, corporations can leverage their resources and provide consistent measures to managed care plans. Otherwise, managed care plans must often grapple with inconsistent quality-related demands from multiple employers,"[73] he explains.

One more example is the Health Action Council of Northeastern Ohio. It has used the comparative quality data on hospitals generated by its Cleveland Health Quality Choice Initiative to designate specific regional hospitals as centers of excellence to be used for the purchase of high-cost, high-volume procedures such as heart surgery and transplants.[74]

Public Purchasers' Quality Initiatives Vary by Geography and Type of Purchaser

As with cost containment, quality-initiative experience among public purchasers has varied depending on whether they are buying for public employees or for public programs. Predictably, due to the mandates and politics involved in changing either Medicaid or Medicare, public employees have tended to implement more varied innovations than have the purchasers for public programs, but public purchasers have pursued new approaches in the interest of improving quality.

As Purchasers for Their Employees, States Maintain Their Individuality

For public employers as for private, choice is an essential feature, and many state and local employee health insurance programs offer multiple health plans with periodic open enrollment opportunities. In 1993, the Minnesota Employee Group Insurance Program began offering employees a choice of six plans. And as of 1997, CalPERS was offering 10 HMOs, four preferred providers associated with particular employee unions, and two self-funded PPOs with different benefit levels. "It also was assessing the costs and benefits of offering a POS plan to make freedom of provider choice more affordable than it is under the very expensive PPO," Meyer says.[75] The MCHCP also offers a wide range of options — including HMOs, PPOs, POS plans, and indemnity plans with PPO regions — giving workers in St. Louis and other densely

Questions for Policymakers Regarding Government Role in Purchasing

- Should government develop measures and criteria for evaluating purchasing decisions?
- Should data commissions to develop coordinated data collection efforts to further quality initiatives be supported?
- How might public purchasers adapt and implement successful private sector practices for public employees, Medicaid, and Medicare, keeping in mind that public sector purchasers are often constrained by unions and administrative rules in ways that private sector employers are not?

populated regions as many as a dozen plans while workers in rural areas may have only one or two.[76]

Meanwhile, the Washington State Health Care Authority — which buys health care on behalf of 500,000 state employees and for the Washington Basic Health Plan and is subsidized for low-income people without insurance — offers 22 health plans.[77]

Federal government employees are also offered a choice of multiple health care delivery plans and products under the FEHBP and can change plans during open enrollment periods.

Federal government employees are also offered a choice of health care delivery plans and products under the Federal Employees Health Benefits Plan and can change plans during open enrollment periods.

Providing Performance Information on Plan Options

In terms of providing enrollees with performance information on plan options, CalPERS is among the most advanced state-level purchasers. It has produced three rounds of useful report cards and uses feedback from consumers to improve them each year.[78]

In addition, federal government employees and retirees can obtain information about the costs and benefits of every health plan available through the FEHBP, as well as plan-by-plan results of a customer satisfaction survey for both fee-for-service and HMO plans offered from *Washington Consumers' Checkbook Guide to Health Insurance Plans.* The guide is published by the Center for the Study of Services, an independent, nonprofit consumer organization founded in 1974 with the help of funding from the U.S. Office of Consumer Affairs and Consumers Union (publisher of *Consumer Reports* magazine).

Developing and Implementing Quality Standards and Financial Incentives

In the area of developing and implementing quality standards, the State of Ohio and unions representing its employees are among the leaders, having required since 1997 that HMOs providing health care benefits to the 40,000 state employees have NCQA accreditation. Also, in 1996, Ohio began requiring the HMOs with which it contracts to submit data from HEDIS.[79]

State health care purchasers in Massachusetts also work with managed care organizations to continuously improve health care quality. Through the contracting process, health plans set specific annual improvement goals with state purchasers. Twice a year, purchasers review each plan's progress toward the goals.[80]

Attempting to provide financial incentives for plans to improve quality, CalPERS ties a portion of premium m revenue to plans' ability to meet performance targets.

Medicaid Has Implemented Some Choice and Selective Contracting

Recognizing the importance of choice in ensuring quality, federal law requires states that mandate managed care for Medicaid beneficiaries to obtain a waiver if enrollees are not going to be given a choice of plans. Absent a waiver that demonstrates that enrollees have sufficient access to care through a single plan, states mandating Medicaid managed care must offer enrollees a choice of managed care plans or a fee-for-service option if only one managed care plan is available.[81]

Because Medicaid contracts are part of a larger set of existing state and federal laws that define relationships between federal and state governments, beneficiaries, and health care providers, building quality incentives into the contracts is not an option, and some state agencies simply contract with all health plans that meet certain structural standards for quality and agree to a payment rate below the specified ceiling.[82] But a few, more innovative states selectively contract with the best performing health plans using weighted criteria for assessing price and quality features.[83]

For example, in Arizona, the state's Medicaid program assigns a weight of about 70 percent to quality and access criteria and 30 percent to cost in evaluating potential health plan contractor proposals. Based on this strategy, in 1994 Arizona Medicaid awarded contracts to only fourteen of twenty-one plans that submitted bids to become Medicaid contractors.

Medicare Has Begun to Introduce Choice

As in Medicaid, Medicare beneficiaries are guaranteed a choice of health care plans/systems under federal law. They can enroll in any fee-for-service Medicare or other Medicare-contracting health plan serving their geographic area. Medicare beneficiaries choosing traditional fee-for-service coverage have a much wider range of doctors than individuals who elect to join HMOs, but those who join HMOs receive coverage for some services (e.g., regular checkups) that Medicare normally excludes.

In January 1997, the first six health plans under HCFA's Medicare Choices demonstration became operational. Medicare Choices was a demonstration designed to expand the types of managed care plans available to

Medicare beneficiaries (e.g., PPOs, HMOs, and integrated delivery systems and test new ways to pay for managed care.)[84] Medicare payments for each of these plans will be adjusted according to the health status of beneficiaries rather than just according to demographic factors. Also, as noted above, in order to encourage more managed care enrollment, the Balanced Budget Act of 1997 established Medicare+Choice, which extended HCFA's authority to contract with HMOs, PPOs, and provider-sponsored organizations, as well as fee-for-service plans.[85]

In the interest of Medicaid and Medicare beneficiaries and of private health plan enrollees, HCFA is beginning an initiative to communicate health plan information to consumers. In 1995, HCFA sponsored a study by the Research Triangle Institute, Benova, and Health Economics Research to learn more about the information needs of Medicare and Medicaid beneficiaries and privately insured adults under age 55 in selecting plans.[86] HCFA is also supporting quality initiatives related to beneficiary-centered purchasing, such as the FACCT effort to develop consumer-oriented quality information.[87]

Finally, unlike some states that choose to do so for their Medicaid program, HCFA does not competitively select health plans based on evidence of higher quality care, but is required to contract with all health plans that meet specified standards on quality, access, financial stability, and other features.

In recent years many observers expected Medicare to be a source of much purchasing change and innovation, but political realities have limited Medicare's role in that process. Nonetheless, Medicare maintains a marketshare that will always make its purchasing approaches important to the entire market. Eventually Medicare will likely make moves that will drive meaningful shifts throughout the health care system.[88]

Where Might Future Innovations Come From?

In the immediate future, additional changes in the way health care is purchased can be expected to continue to come from the private sector, from individual states, and from the delivery system itself as health plans are responding to the increasing influence of managed competition by trying to anticipate the demands of purchasers, rather than resisting them. Further progress in improving the cost efficiency and quality of health care will also likely depend on drawing together the lessons learned by all types of purchasers as public and private sector purchasers bring different strengths and weaknesses to the table in improving the efficiency and quality of health care.[89] For example, public sector purchasers bring tremendous market clout, and the private sector brings an ability to adapt rapidly to changing market conditions. The challenge ahead, it seems, is leveraging those strengths in the health care market to reduce health care costs while also improving access and quality.

While federal, state, and local purchasers all have tremendous potential to transform their marketplaces, the realities of their bureaucracies and politics could make it difficult for governments to take on the leadership in integrating quality initiatives into purchasing norms; therefore, private pathfinders may have to continue to handle that responsibility. As Meyer explains, spreading quality innovations more broadly will "require visionary leaders who are willing to build good staffs, take risks to develop their bargaining clout, and make changes that reach beyond a single company or coalition." The leaders who are willing to take on the challenge may be able to "change patterns in their communities," he says.

Meyer also acknowledges that if private efforts are not enough, regulation for the sake of quality comes easily to mind. But he offers an interim option, suggesting that public-private partnerships may be what is needed. In theory, public and private health care purchasers working together have the opportunity to begin to strive for both greater economic value and quality in community health care markets. In addition, public-private partnerships offer the possibility of exploring community, regional, or state solutions to rating or risk selection problems in the health care market instead of solutions that simply shift costs from one population or purchaser to another. As noted earlier, HCFA has indicated an interest in supporting such partnerships.[90]

"We think there is much that private and public purchasers could learn from each other," says Meyer. Although many of the innovations Meyer has studied have been developed by Fortune 500 companies such as GTE and Digital Equipment, he points out that a few states are actually moving ahead of their private counterparts in incorporating value-based purchasing strategies into benefit designs for state employees. By considering linking forces with public sector employers, coalitions of private employers could increase their bargaining clout.

Next Steps

Before any purchasers, public or private, can be expected to move toward applying purchasing innovations more broadly, the practices currently in place need to be refined, and their sustainability needs to be confirmed, observes Maxwell. The impact of special issues, such as mental health and retiree benefits must be examined, and the future role of federal, state, and local governments all also need to be clarified.

Notes

1 Health Care Financing Administration Medicare web site: www.hcfa.gov/Medicare/Medicare.htm

2 The Twentieth Century Fund, *Medicare Reform, A Guide From The Twentieth Century Fund.* (New York: Twentieth Century Fund Press, 1995 [http://epn.org/tcf/tcmedi.html]).

3 Lewin-VHI, Inc., "Potential Cost Shifting Under Proposed Funding Reductions for Medicare And Medicaid: The Budget Reconciliation Act Of 1995," prepared by John F. Sheils and Gary J. Claxton for the National Leadership Coalition on Health Care, Washington, DC, Dec. 6, 1995 [http://www.nchc.org/lewinstudy.html].

4 James Maxwell, Forest Briscoe, Stephen Davidson, Lisa Eisen, Mark Robbins, Peter Temin, and Cheryl Young, *Corporate Approaches to Managed Competition*, prepared for the Alpha Center under The Robert Wood Johnson's *Changes in Health Care Financing and Organization* (HCFO) program (Boston, MA: 1997).

5 Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (Supplement): 24-48, 1993.

6 James Maxwell, Forest Briscoe, Stephen Davidson, Lisa Eisen, Mark Robbins, Peter Temin, and Cheryl Young, "Managed Competition in Practice: Value Purchasing by Fourteen Employers," *Health Affairs*, Volume 17, Number 3, 216-227, 1998.

7 G. Jenson, M. Morrisey, S. Gaffney, and D. Liston, "The New Dominance of Managed Care Trends in the 1990s," *Health Affairs*, pp. 125-136, January/February 1997.

8 Maxwell, *Corporate Approaches to Managed Competition*.

9 Ibid.

10 Maxwell, "Managed Competition in Practice: Valve Purchaseing by Fourteen Employers."

11 Maxwell, *Corporate Approaches.*

12 Maxwell, "Managed Competition in Practice: Valve Purchaseing by Fourteen Employers."

13 Jon B. Christianson, "The Role of Employers in Community Health Care Systems," *Health Affairs*, pp. 158-164, July/August 1998.

14 Maxwell, *Corporate Approaches.*

15 Pacific Business Group on Health web site: www.pbgh.com.

16 Thomas Bodenheimer and Kip Sullivan, "How Large Employers Are Shaping the Health Care Marketplace," *New England Journal of Medicine* 338(14):1003-1007, 1998.

17 Pacific Business Group on Health web site: www.pbgh.org.

18 U.S. General Accounting Office, *Health Insurance Management Strategies Used By Large Employers to Control Costs*, GAO/HEHS-97-71 (Washington, DC: May 1997).

19 Bodenheimer and Sullivan.

20 Christianson.

21 Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, "Drilling Down in Search of Value: A Closer Look at the Buyers Health Care Action Group (BHCAG) Purchasing Initiative," Meeting sponsored by the User Liaison Program, Rockville, MD, September 1997.

22 Bodenheimer and Sullivan.

23 Agency for Health Care Policy and Research.

24 Bodenheimer and Sullivan.

25 Maxwell, *Corporate Approaches.*

26 Bureau of Labor Statistics. *Monthly Labor Review*, Table 19, Volume 118 (12), December 1995, p. 81.

27 Matthew L. Maciejewski, Bryan Dowd, and Roger Feldman, "How Do States Buy Health Insurance for Their Own Employees?" prepared under a Robert Wood Johnson Foundation grant. Institute for Health Services Research, School of Public Health, University of Minnesota, December 31, 1996.

28 Maxwell, *Corporate Approaches.*

29 Jack A. Meyer, Elliot K. Wicks, Lise S. Rybowski, and Michael J. Perry, *Report on Report Cards: Initiatives of Health Coalitions and State Government Employers to Report on Health Plan Performance and Use Financial Incentives*, prepared for the Alpha Center with funding under The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) program. (Washington, DC: 1997).

30 U.S. General Accounting Office, *Health Insurance Management Strategies Used by Large Employers to Control Costs*, GAO/HEHS-97-71 (Washington, DC: May 1997).

31 Bodenheimer and Sullivan.

32 U.S. General Accounting Office, *Health Insurance Management Strategies Used by Large Employers to Control Costs*, GAO/HEHS-97-71 (Washington, DC: May 1997).

33 U.S. General Accounting Office.

34 Maciejewski, p. 15.

35 Maxwell, *Corporate Approaches.*

36 Meyer, Wicks, Rybowski, and Perry.

37 The Twentieth Century Fund, Medicaid Reform, A Guide From The Twentieth Century Fund. (New York, Twentieth Century Fund Press, 1995) [http://epn.org/tcf/tcmedi.html]).

38 Ibid.

39 Caren Ginsburg, *In Pursuit of Value: Innovative State/Medicaid Purchasing Strategies*, summary of a conference conducted by the Alpha Center and the Center for Health Care Strategies and cosponsored by The Robert Wood Johnson Foundation, the Health Care Financing Administration, and the U.S. Department of Health and Human Services (Washington, DC: March 1997).

40 Health Care Financing Administration, U.S. Department of Health and Human Services, "HCFA: The Medicare and Medicaid Agency" [http://www.hcfa.gov].

41 "Regulating Provider Sponsored Organizations: 1997 Federal Budget Provisions May Change Dynamics," *State Initiatives in Health Care Reform* newsletter, Alpha Center, November 1997.

42 "Refinements Made to Medicare+Choice Program: Patient Protections, Access to Information and Reductions in Administrative Burdens Included in New Rules," HCFA Press Release. (Washington, DC: February 11, 1999).

43 Jack Meyer, Sharon Silow-Carroll, Ingrid A. Tillmann, Lise S. Rybowski, *Employer Coalition Initiatives In Health Care Purchasing*, Volume 2, Economic and Social Research Institute. (Washington, DC: 1996).

44 National Committee for Quality Assurance, HEDIS (Health Plan Employer Data and Information Set) 3.0 [http://www.ncqa.org].

45 Maxwell, *Corporate Approaches.*

46 Lisa Belkin, "But What About Quality?" *New York Times Magazine,* p. 68-71, 101, 106, Dec. 6, 1996.

47 Medical Outcomes Trust Source Pages: Foundation for Accountability (FACCT) [http://www.outcomes-trust.org/srcpages/pm5.htm].

48 Mary Clark Jordan Hewitt Associates, "Fortune 200 Companies Use of Employer-Issued Report Cards to Help Employees Choose Health Plans," presentation at *Value and Choice: Providing Consumers With Information on the Quality of Care,* conducted by Health Systems Research, Inc., for the U.S. Public Health Service's Agency for Health Care Policy and Research and the Henry J. Kaiser Family Foundation, Washington, DC, Oct. 29-30, 1996.

49 Maxwell, *Corporate Approaches.*

50 Ibid.

51 Ibid.

52 Meyer, Wicks, Rybowski, and Perry.

53 Ibid.

54 Maxwell, *Corporate Approaches.*

55 National Committee for Quality Assurance, Home Page: Employers and Purchasers [http://www.ncqa.org].

56 Meyer, Wicks, Rybowski, and Perry.

57 Maxwell, *Corporate Approaches.*

58 Ibid.

59 Meyer, Wicks, Rybowski, and Perry.

60 Ibid.

61 Maxwell, *Corporate Approaches.*

62 Meyer, Wicks, Rybowski, and Perry.

63 Maxwell, *Corporate Approaches.*

64 Meyer, Wicks, Rybowski, and Perry.

65 Ibid.

66 Bodenheimer and Sullivan.

67 Meyer, Silow-Carroll, Tillmann, Rybowski.

68 National Committee for Quality Assurance, NCQA Case Studies: Federated Department Stores: Managing Quality Within a Budget [http://www.ncqa.org].

69 Meyer, Wicks, Rybowski, and Perry.

70 Maxwell, *Corporate Approaches.*

71 National Committee for Quality Assurance, NCQA Case Studies: The Alliance [http://www.ncqa.org].

72 National Committee for Quality Assurance, NCQA Case Studies: The Alliance [http://www.ncqa.org]

73 Maxwell, *Corporate Approaches.*

74 Meyer, Wicks, Rybowski, and Perry.

75 Ibid.

76 Ibid.

77 Ginsburg.

78 Meyer, Wicks, Rybowski, and Perry.

79 National Committee for Quality Assurance, NCQA Case Studies: State of Ohio: Labor and Management's Quality Commitment [http://www.ncqa.org].

80 Ginsburg.

81 Under section 1932 (a) of the federal Social Security Act, a state Medicaid program may restrict choice by offering a choice between at least two health plans or a health plan and a primary care case manager. In rural areas, a Medicaid beneficiary who is offered no alternative to a single health plan or case manager must be given a choice between at least two physicians. Special needs children, dual Medicare-Medicaid beneficiaries, and members of federally-recognized American Indian tribes are exempt from mandatory enrollment in Medicaid managed care programs.

82 Ginsburg.

83 Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Promoting, Protecting, and Improving Health Care Quality," background paper prepared by the Subcommittee on Roles and Responsibilities of Public/Private Purchasers and Quality Oversight Organizations," June 18, 1997 [http://www.hcquality-commission.gov].

84 Carole Lee and Deborah Rogal, *Risk Adjustment: A Key to Changing Incentives in the Health Insurance Market—A Special Report,* produced for The Robert Wood Johnson Foundation's *Changes in Health Care Financing and Organization* (HCFO) program (Washington, DC: March 1997).

85 Health Care Financing Administration, U.S. Department of Health and Human Services, "HCFA: The Medicare and Medicaid Agency" [http://www.hcfa.gov].

86 Lauren A. McCormack, "Lessons From a HCFA-Funded Study of Consumer Information Needs in Choosing Health Plans," presentation at *Value and Choice: Providing Consumers With Information on the Quality of Care,* conducted by Health Systems Research, Inc., for the U.S. Public Health Service's Agency for Health Care Policy and Research and The Henry J. Kaiser Family Foundation, Washington, DC, Oct. 29-30, 1996.

87 Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Promoting, Protecting, and Improving Health Care Quality," background paper.

88 Ibid.

89 Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Quality First: Better Health Care for All Americans,* Washington, DC, Mar. 13, 1998 [http://www.hcqualitycommission.gov].

90 Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Promoting, Protecting, and Improving Health Care Quality," background paper.

Selected Readings in Health Care Purchasing

Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Quality First: Better Health Care for All Americans,* Washington, DC, March 13, 1998 [http://www.hcqualitycommission.gov].

Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Promoting, Protecting, and Improving Health Care Quality," background paper prepared by the Subcommittee on Roles and Responsibilities of Public/Private Purchasers and Quality Oversight Organizations," June 18, 1997 [http://www.hcqualitycommission.gov/jun25.26/test-role.htm].

Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, "Overview of Consumer Assessments of Health Plans Study (CAHPS)" [http://www.ahcpr.gov].

Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, "Drilling Down in Search of Value: A Closer Look at the Buyers Health Care Action Group (BHCAG) Purchasing Initiative," User Liaison Program, Rockville, MD, September 1997.

Caren Ginsburg, *In Pursuit of Value: Innovative State/Medicaid Purchasing Strategies,* summary of a conference conducted by the Alpha Center and the Center for Health Care Strategies and cosponsored by The Robert Wood Johnson Foundation, the Health Care Financing Administration, and the U.S. Department of Health and Human Services (Washington, DC: March 1997).

Carole Lee and Deborah Rogal, *Risk Adjustment: A Key to Changing Incentives in the Health Insurance Market—A Special Report,* produced for The Robert Wood Johnson Foundation's *Changes in Health Care Financing and Organization* (HCFO) program (Washington, DC: March 1997).

Lisa Belkin, "But What About Quality?" *New York Times Magazine,* p. 68-71, 101, 106, December 6, 1996.

Thomas Bodenheimer and Kip Sullivan, "How Large Employers Are Shaping the Health Care Marketplace," *New England Journal of Medicine* 338(14):1003-1007, 1998.

Center for the Study of Services, "CHECKBOOK's Guide to Health Insurance Plans for Federal Employees" [http://consumer.checkbook.org/consumer/hig/hig.htm].

Jon B. Christianson, "The Role of Employers in Community Health Care Systems," *Health Affairs,* pp. 158-164, July/August 1998.

Matthew L. Maciejewski, Bryan Dowd, and Roger Feldman, "How Do States Buy Health Insurance for Their Own Employees?" prepared under a Robert Wood Johnson Foundation grant. Institute for Health Services Research, School of Public Health, University of Minnesota, December 31, 1996.

James Maxwell, Forrest Brisco, Steven Davidson, Lisa Eisen, Mark Robbins, Peter Temin, and Cheryl Young, "Managed Competition in Practice: Value Purchasing by Fourteen Employers," *Health Affairs,* Volume 17, Number 3, 216-217, 1998.

Jack A. Meyer, Lise S. Rybowski, and Rena Eichler, Theory and Reality of Value-Based Purchasing: Lessons form the Pioneers, Agency for Health Care Policy and Research (Rockville, MD: 1997).

Jack A. Meyer, Elliot K. Wicks, Lise S. Rybowski, and Michael J. Perry, *Report on Report Cards: Initiatives of Health Coalitions and State Government Employers to Report on Health Plan Performance and Use Financial Incentives,* prepared for the Alpha Center with funding under The Robert Wood Johnson Foundation's *Changes in Health Care Financing and Organization* (HCFO) program. (Washington, DC: 1997).

Jack Meyer, Sharon Silow-Carroll, Ingrid A. Tillmann, Lise S. Rybowski, *Employer Coalition Initiatives In Health Care Purchasing,* Volumes 1 and 2, Economic and Social Research Institute. (Washington, DC: 1996).

Alain C. Enthoven, “The History and Principles of Managed Competition,” *Health Affairs* (Supplement): 24-48, 1993.

Health Care Financing Administration, U.S. Department of Health and Human Services, “HCFA: The Medicare and Medicaid Agency” [http://www.hcfa.gov].

G. Jensen, M. Morrisey, S. Gaffney, and D. Liston, "The New Dominance of Managed Care: Insurance Trends in the 1990s," *Heath Affairs*, pp. 125-136, January/February 1997.

Joint Commission on the Accreditation of Healthcare Organizations, “Facts About the Joint Commission” [http://www.jcaho.org/about_jc/mh_frm.htm].

Lewin-VHI, Inc., “Potential Cost Shifting Under Proposed Funding Reductions for Medicare And Medicaid: The Budget Reconciliation Act Of 1995,” prepared by John F. Sheils and Gary J. Claxton for the National Leadership Coalition on Health Care, Washington, DC, Dec. 6, 1995 [http:/www/nchc.org/lewinstudy.html].

Lauren A. McCormack, “Lessons From a HCFA-Funded Study of Consumer Information Needs in Choosing Health Plans,” presentation at *Value and Choice: Providing Consumers With Information on the Quality of Care*, conducted by Health Systems Research, Inc., for the U.S. Public Health Service’s Agency for Health Care Policy and Research and the Henry J. Kaiser Family Foundation, Washington, DC, Oct. 29-30, 1996.

Medical Outcomes Trust Source Pages: Foundation for Accountability (FACCT) [http://www.outcomes-trust.org/srcpages/pm5.htm].

Midwest Business Group on Health, "Public-Private Healthcare Purchasing Partnerships," Chicago, IL, 1997.

The Twentieth Century Fund, *Medicaid Reform, A Guide From The Twentieth Century Fund.* (New York, Twentieth Century Fund Press, 1995) [http://epn.org/tcf/tcmedi.html]).

The Twentieth Century Fund, *Medicare Reform, A Guide From The Twentieth Century Fund.* (New York: Twentieth Century Fund Press, 1995 [http://epn.org/tcf/tcmedi.html]).

U.S. General Accounting Office, *Health Insurance Management Strategies Used by Large Employers to Control Costs*, GAO/HEHS-97-71 (Washington, DC: May 1997).

Bruce Vladeck, Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, remarks at the Piper Jaffray Healthcare Services Conference, Sept. 6, 1995 [http://www.hcfa.gov/speech/s090695.htm].

ALPHA CENTER

1350 Connecticut Avenue, NW
Suite 1100
Washington, DC 20036
Phone: 202-296-1818
Fax: 202-296-1825
Internet: www.ac.org

The Alpha Center is a nonprofit health policy center specializing in the analysis and dissemination of health services research and demonstration findings to national, state, and local policymakers and health services researchers.

May 1999