

# Managed Competition In Practice: ‘Value Purchasing’ By Fourteen Employers

*Are large employers the new champions of managed competition?*

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**ABSTRACT:** Many large U.S. companies have transformed their procurement of health benefits in the 1990s by combining the principles of managed competition with other business tactics to create a business-savvy hybrid of the private sector’s own design, often referred to as “value purchasing.” Until recently, few policymakers or health care observers believed that large firms would be a force in health system reform. Yet to implement value purchasing, the large companies in this study created new organizational forms, provided employees with financial incen-

tives to select low-cost health plans, and used business tactics such as competitive bidding to negotiate more favorable rates and to improve quality among health plans. The financial results were impressive for the companies studied. In addition, the companies’ demands on the health care delivery system are multiplying as the interface between business firms and health care organizations changes. These demands will only increase as the practices we found become more widespread.

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**N**OW THAT MANAGED CARE is the dominant model of health care delivery in the United States, employers are purchasing the majority of their health insurance benefits for employees through managed care organizations (MCOs).<sup>1</sup> Many are conducting their purchasing by implementing “managed competition.” The literature examining this trend has focused largely on its implications for the delivery of health care services; little has been published about how and

why large companies have spearheaded this massive shift in purchasing practices.

Accordingly, our research examines in depth the activities of fourteen large U.S. companies that have transformed their purchasing of health care benefits. These innovative firms revised their health benefits by combining some of the principles of managed competition with other business tactics that they found applicable to health benefits procurement.<sup>2</sup> First, companies created new or-

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ganizational forms and recruited nontraditional expertise from finance and elsewhere to help manage their health benefits. Then, companies offered financial incentives to employees to encourage them to take cost into account when selecting their health plan and to spur competition among plans. Finally, companies employed business tactics such as competitive bidding and benchmarking, to negotiate more aggressively with health plans over premium prices and the quality of care.

The resulting system, often called "value purchasing," is a hybrid of the private sector's own design. Unlike the traditional purchasing system, in which health care was handled separately from other purchasing activities and was seen as the domain of the human resources department, value purchasing is now being financially and strategically integrated with the rest of the corporation. Health benefits are viewed as financial liabilities, just as any other business input, and are discussed in concert with other bottom-line considerations and strategies for increasing efficiency.

Understanding the purchasing system used by these large employers is important for several reasons. First, the practices of these companies represent one of the major forces driving systemwide changes in health care delivery. In addition, the new purchasing strategies have enormous potential effects on employees, who are being encouraged to assume greater financial and personal responsibility for their health plan choices. Finally, the purchasing practices of several large firms are being imitated by companies of all sizes and are spreading to public purchasers across the nation; this reportedly is achieving huge cost savings.<sup>3</sup>

The findings presented in this paper are based on an in-depth study of fourteen large purchasers of employee health care, selected for their reputations as innovative health care purchasers and as early movers in the shift to managed competition (Exhibit 1).<sup>4</sup> Together, the fourteen companies purchase health care for more than one million workers, retirees, and dependents and exert influence over more than two million more persons through pur-

chasing alliances. Each has substantial numbers of employees in one of four markets with high managed care penetration: Boston, San Francisco, Minneapolis, and Orlando. The companies in our study also tended to be older companies in mature industries, with higher health care expenditures and more complex benefits issues, rather than younger companies with younger workforces and less extensive employee and retiree commitments to manage.

For each company, we interviewed corporate staff who were responsible for health benefits policy. Using a standardized interview protocol, we covered the following topics: the history of each organization and its health care purchasing strategy; the company's choice of managed competition purchasing elements, methods of implementation, and motivations for selection; the company's relationships with MCOs; and the reported cost savings and employee satisfaction related to their programs. We also interviewed officials at the MCOs with which the companies contracted, as well as representatives of business coalitions in which they participated.

## THE NEW HEALTH BENEFITS PURCHASING PARADIGM

The traditional health benefits system, in place at large firms from the late 1940s to the 1980s, was characterized by corporate generosity, steadily expanding coverage, and a hands-off approach to health care delivery itself. Because it often involved health services delivery, health benefits purchasing was treated differently and handled separately from other corporate affairs. Senior management had little interest in health care benefits or their costs.<sup>5</sup> In most firms, including those in our study, health benefits were administered by specialized human resource managers, who viewed themselves as internal advocates for employees. In the postwar era of relative economic stability and growth, companies wanted to foster loyalty and a long-term relationship with employees; providing

**EXHIBIT 1**  
**Characteristics Of Companies Studied, By Market Area, 1995-1996**

<b>Market area/company</b>	<b>Revenue (billions)</b>	<b>Number of employees/distribution</b>
<b>Boston</b>		
GTE	\$21.3	102,000 worldwide (83,000 in U.S.)/dispersed
Digital Equipment	14.5	59,000/concentrated in Massachusetts
Raytheon	12.3	75,000 total/35,000 concentrated in Massachusetts
Bull Information Systems (member of Groupe Bull)	0.65	1,500/concentrated in Massachusetts
<b>Minneapolis</b>		
American Express	16.2	74,000 (51,000 in U.S.)/about 5,000 concentrated in Minnesota; others widely dispersed
General Mills	5.5	9,800/dispersed
3M (Minnesota Mining & Manufacturing)	14.2	45,000/about 23,000 concentrated in Minnesota
Minnesota Employee Group Insurance Program	- <sup>a</sup>	140,000 statewide
<b>Orlando</b>		
Disney	12.1	71,000 nationwide/40,000 concentrated in Orlando
Orange County Public Schools	- <sup>a</sup>	23,000/concentrated in Orlando
<b>Northern California</b>		
Union Bank of California	- <sup>a</sup>	8,000/concentrated in California
Lockheed Martin, Space and Missiles Division	7.8	19,000 in Space and Missiles Division, 165,000 worldwide in entire corporation
Pacific Telesis Group (PTG)	9.0	49,000/concentrated in California
Fireman's Fund Insurance	- <sup>a</sup>	8,000 nationwide/3,800 concentrated in California

**SOURCE:** Authors' compilation of corporate data.

<sup>a</sup> Not available.

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generous health benefits was one important way to achieve these objectives.

Since the early 1990s this traditional approach to purchasing corporate health benefits has been almost entirely transformed, in response to the rising costs of health care coverage and the increasing cost competition faced by firms in their core businesses. The debates surrounding the Clinton administration's health care reform proposal provided an important catalyst for change by raising corporate awareness of managed competition and motivating executives to search for a private-sector alternative to the proposed public system.

The result of these forces was a firm-level implementation of a new approach to purchasing. At the companies we studied, the new system's shape was that of a hybrid, combining managed competition principles with other business ideas applicable to health

benefits procurement. A central component of the new corporate purchasing system was the design of new organizational forms to facilitate the transfer of business expertise into the health benefits area. Although not generally discussed in the literature on managed competition, these moves were necessary to bring about the sweeping changes undertaken in health benefits practices. The human resource departments that had traditionally housed health benefits managers were downsized in many large organizations, and finance managers and senior executives with experience in managed care became more active in health benefits decision making. Expertise was applied from other internal areas as well, including procurement and marketing. These changes reflect the increasing integration of health benefits policy with organizations' overarching business decisions.

Companies also have changed their phi-

losophy of health benefits by stressing employees' individual responsibility for many areas previously handled by the firm. Employees have more market-oriented choices, which in the case of health insurance means the ability to select a health plan from among several, based on their personal and family needs and differences among plans in cost and quality.<sup>6</sup> The concept of individual responsibility is an essential component not only of value purchasing but also in other areas of employment relations.

### HOW COMPANIES IMPLEMENTED VALUE PURCHASING

The new purchasing system that we observed in firms addressed change at three levels: the organization, its relations with employees, and its relations with health care plans.

The theory of managed competition suggests that the organization's role is to be a "sponsor" by setting the rules of a marketplace between employees as buyers and health plans as sellers. In practice, however, these companies have taken a more active role in buying health care for their employees. In doing so, firms have had to change in three ways: (1) reorganize internal activities to reflect the new role; (2) establish a new relationship with employees through the use of financial incentives and by providing information on quality; and (3) establish a new relationship with health plans through evaluation and monitoring of quality and through procurement strategies such as competitive bidding and direct contracting.

■ **NEW ORGANIZATIONAL ARRANGEMENTS.** As firms sought to become more proactive purchasers, they recognized that they needed significant organizational changes. New kinds of expertise were needed to manage relations with health plans and to work with employees in a managed care setting. Most human resource professionals had neither the necessary financial expertise nor an adequate background in managed care to undertake these roles. Many of the firms we studied brought in executives with a financial

background to run their health benefits programs or to advise senior human resource managers. At 3M, Lockheed Space and Missiles, Digital Equipment, and the Minnesota Employee Group Insurance Program, financially trained executives assumed responsibility for managing health care programs in the early 1990s. At Pacific Telesis and Bull Information Systems, staff from the finance or accounting departments were assigned to work in teams with their counterparts in human resources to achieve the same results. Human resource executives at American Express and Fireman's Fund Insurance, on the other hand, already had strong financial backgrounds.

Managed care expertise often was brought into the firms by hiring executives from outside the organizations. GTE, for example, hired a manager who had served as executive director for managed care plans in Rhode Island and New Hampshire. Similarly, Union Bank of California recruited an experienced manager from Stanford University who had been actively involved in restructuring the university's health coverage through managed competition. Most of the other firms in our study relied on consultants or business coalitions for their expertise in managed care.

To manage relations with health care vendors, firms often created new organizational forms and reporting relations in the company. One prominent example was the creation of separate units for network management. GTE and 3M established "regional network managers," who were responsible for evaluating and negotiating contracts with managed care plans in particular geographic areas. In contrast, Digital hired its long-time insurer John Hancock as a network manager to oversee its contracting with more than eighty health plans throughout the country. American Express relied heavily on the William M. Mercer consulting firm and the National Business Coalition to oversee its relations with the contracting managed care plans. In these new arrangements, the network managers often were given multiple reporting relationships with business units and corporate functions such as finance and strategy.

These new organizational structures, stressing financial and managerial skills, are part of a wider move toward using financial skills in human resource management and developing methods of quantifying and marking the progress of the human resource function within a company. The focus on cost reduction has spurred many companies to analyze the costs and perceived rewards of each human resource component, including health benefits and other aspects of compensation.<sup>7</sup>

■ **FINANCIAL INCENTIVES FOR EMPLOYEES.** We found financial incentives to be the most widely used component of managed competition purchasing. Under managed competition, as envisioned by its principal architect Alain Enthoven, the lowest-cost plan that meets a company's required minimum standards is designated the "least-cost plan." The company sets its premium contributions in relation to that plan. Employees are required to bear the added cost of health plans that exceed the least-cost plan and thus are encouraged to weigh the differences in cost and quality among plans. The use of financial incentives encourages plans to compete for enrollees by cutting prices or improving quality for the same services.<sup>8</sup>

All of the companies in our study used financial incentives, and the majority have used them to shift significant premium costs onto employees. Nonetheless, the firms differed in the rate and extent to which they moved to a least-cost plan strategy. Some companies, such as Fireman's Fund Insurance, moved quickly to the simple structure of least-cost plans. Fireman's Fund, which already had the majority of its employees in managed care when it initiated this strategy in 1994, found 5 percent premium savings in the first year (while other regional purchasers continued to face high premium inflation) and additional savings thereafter.

Other companies, such as Union Bank of California, believed that a least-cost strategy was not necessary to move employees into managed care. Officials at Union Bank believed that as long as employees assumed a portion of the difference in health plan premi-

ums, they would have adequate incentives to shift into managed care. Other companies were constrained in their use of financial incentives because union contracts guaranteed full premium payments by these companies.

The use of employee financial incentives in managed competition purchasing is similar to other recently implemented employee compensation strategies, including the use of performance-based pay and the shift in pensions from a defined benefit to a defined contribution system.<sup>9</sup> All three practices seek to fix corporate financial liability by shifting some costs onto the employee. In health care, this goal is achieved by fixing employers' share of health insurance premiums to the least-cost plan. In pensions, the benefit is limited to a set contribution, which is then invested for the employee's retirement, rather than guaranteeing fixed payments on retirement. Performance-based compensation limits liability for wages by linking them to the company's overall profitability and performance. Health benefits are the most recent part of the compensation package to be revised in this way.

■ **QUALITY INFORMATION AND EDUCATION.** The companies in our study were shifting not only financial responsibility but also decision-making responsibility for health plan choices to employees. Companies no longer have large human-resource staffs to serve as advocates for employees within the company or with managed care plans. Employees often must interpret plan literature themselves. Once enrolled, employees can no longer rely on corporate staff to use their clout with health plans to help with problems they encounter. Once again, this shift is consistent with a broader corporate trend toward making employees assume responsibility for decisions related to their personal finances and professional development.

However, in an effort to promote educated decision making, many corporations and business groups are disseminating to employees a variety of comparisons of health plan quality and patient satisfaction. Measures based on employee satisfaction data include the Employee Health Care Value Survey,

sponsored by Xerox, GTE, and Digital Equipment; and the Pacific Business Group on Health's (PBGH's) Health Plan Value Check. These provide standardized data that allow employees to make comparisons across plans. Companies also are beginning to disseminate Health Plan Employer Data and Information Set (HEDIS) data as part of open enrollment packages. However, many representatives of managed care plans question whether employees are being provided with the kinds of information they most want or can use.<sup>10</sup>

Some of the companies in our study attempted to provide employees with information on new health plan designs. American Express, for instance, distributed video-cassettes to employees showing a mock focus group discussing issues commonly raised about managed care, and how their health maintenance organization (HMO), point-of-service (POS), and other health plan designs compared on these points. Such techniques are another example of human resource practices borrowed from other areas and applied to the transition to managed care. These techniques have become more common in recent years in response to concerns about workplace changes in the wake of downsizing and other corporate trends.

■ **HEALTH PLAN PROCUREMENT STRATEGIES.** The implementation of health care purchasing strategies involved the transfer of procurement strategies from general areas of services and components acquisition to health care purchasing. Benefits managers adopted one or more purchasing techniques, the most common of which was competitive bidding.

To encourage price competition among managed care plans, several of the firms in our study used competitive bidding similar to that used to purchase other goods and services. The bidding process begins with a formal announcement in which the purchaser speci-

fies the desired attributes of a health benefits package for employees. Suppliers are invited to propose a product that meets those attributes for a competitive price. Responses are compared, and the most favorable proposals may be selected or negotiated further. To ensure that competition is based on price rather than product differentiation, the employer defines a standard benefits package and rules guaranteeing fair competition.

*“Corporations have been the driving force behind the move to compare health care providers and plans based on performance.”*

A firm's ability to leverage the bidding process effectively depended on a number of factors, including its regional enrollment or market share and its willingness to negotiate aggressively with managed care plans. Some firms sought to maximize their purchasing power by contracting with a single vendor in each region. Raytheon, for example, its operations concentrated in Massachusetts, entered into a contract with the local Blue Cross/Blue Shield plan to provide health benefits designed especially for its workers at a discounted price. (Such winnowing of health plan choices is an example of how corporate purchasing can diverge from managed competition principles.)

Rather than relying on a single vendor, however, most of the corporations that we studied sought to narrow choices to a few managed care plans in each region. For example, in 1993 Lockheed Martin Space and Missiles issued a request for bids that was designed to limit its purchasing to four plans in Northern California. The use of the bidding process enabled Lockheed to obtain substantial discounts in its rates (14 percent in the first year) and to lock in multiyear rate guarantees in an already competitive California health care marketplace.

Lockheed Martin and Raytheon both adapted bidding techniques with which they were already familiar from defense industry procurement. These companies not only had extensive experience competing for federal

contracts using these mechanisms but also were skilled at using this process to select and manage their own preferred vendors and subcontractors.

Some companies are experimenting with Japanese-style just-in-time purchasing or total quality management (TQM) of suppliers in their overall purchasing of products and services. One company we studied had adopted the latter as a health benefits procurement strategy. Using this strategy, the purchaser and vendor work together to improve the quality of the services delivered. TQM requires a substantial commitment of resources because it involves an extended partnership with suppliers to work together to improve products or services. In the early 1990s managers at Digital Equipment applied the TQM principles used in purchasing electronic components to the purchase and delivery of health care services. The company's managers worked to develop long-term partnerships with managed care plans. Unlike other companies, which were concerned only with low premiums, Digital focused on quality improvements and believed that lower health care costs would follow. A major outcome of the Digital effort was the first TQM-based standards for evaluating and purchasing health care. As part of its TQM strategy, Digital required managed care plans to develop standards for their own suppliers. Thus, Digital encouraged improvements in management throughout the supply chain.

■ **EVALUATING AND IMPROVING QUALITY OF CARE.** Corporations have been the driving force behind the move to compare health care providers and plans based on performance. However, as other studies have, our study found that only a few corporations were conducting significant quality-oriented activities.<sup>11</sup> These companies have worked individually and collaboratively with health plans to produce information to support the assessment of quality of care. Some have begun to consider quality in their purchasing decisions. This parallels general trends in management to improve procurement practices and to hold suppliers accountable for their performance.

Large companies are applying techniques such as standard setting and benchmarking to health care.

Some companies have developed their own standards for health plan quality. Digital's performance standards include measurable specifications for care in the broad areas of access, quality, data, and financial stability. Digital regularly assesses health plan performance according to these standards and recommends areas in which improvements are needed.

Another approach to assessing quality as part of the purchasing process is to compare plans using a benchmark method. Benchmarking means comparing plans based on set criteria, using quantitative or qualitative methods similar to those used by *Consumer Reports*. Benchmarking can be a more aggressive approach than standard setting because it involves direct comparisons of practices across competing plans. However, benchmarking practices have been implemented cautiously to date because they are unfamiliar and expensive and because of difficulties with reliability and interpretability of data.

Companies such as GTE and Xerox have pioneered the use of comparative benchmarking in health plan selection and in providing comparative quality information to plans, other purchasers, and employees. GTE rates plans based on their quality measurements and then disseminates "report cards" to plans, other purchasers, and employees. Each year GTE requests HEDIS data from the more than two hundred plans with which it contracts and uses the data to compile the report cards.<sup>12</sup> Plans with low scores feel pressure to improve, because many purchasers and enrollees see the results. The data also are used to identify specific clinical procedures and outcomes (for example, cesarean section rates) for which health plans should target continuous quality improvements.

Standard setting and benchmarking are designed to improve incrementally the quality of HMO practices. A third focus of quality initiatives has been to emphasize disease management and demand-side management.

Employers are encouraging their managed care plans to promote healthy lifestyles among their workers and to design programs that more effectively manage chronic health problems such as diabetes or asthma.

Some corporate officials believe that workplace programs run by MCOs have the potential to reduce absenteeism and improve work performance. Managers at the Pacific Telesis Group (PTG), for example, believed that the cost of absenteeism (an estimated \$100 million a year) could be decreased through prevention programs. Raytheon and Massachusetts Blue Cross and Blue Shield have developed innovative case management and prevention programs that are designed to reduce Raytheon's total health care costs by nearly 10 percent.

Some companies believe that managed care plans need additional incentives to truly ensure quality improvement, so they reward plans financially for improving care. One way they do this is to alter the company's premium contributions according to quality criteria, thereby influencing employees to choose a particular plan. GTE has been the leader in linking quality benchmarking to the level of its premium contribution. Another option is to put a portion of the premium payment directly at risk to encourage plans to improve quality before the end of a given time period.

The quality components of managed competition purchasing have not been uniformly implemented across companies. In the companies we studied, quality programs varied considerably in design. Some companies chose to forgo them altogether, perhaps because they require multiyear corporate commitments and millions of dollars in annual expenditures to implement. Those companies that did invest in quality programs often combined different strategies. For example, PTG combined standard setting with disease man-

agement. Quality programs, while not the norm among businesses, have been spreading to business coalitions and other purchasers.<sup>13</sup>

■ **CONSOLIDATED PURCHASING.** Many companies are seeking to enhance their purchasing power by joining business coalitions. Each of the markets we studied has an active business coalition that enables individual companies to overcome some of the obstacles of purchasing alone. Joint purchasing activities have the potential to yield continued pre-

*“Competitive bidding and business coalitions can result in savings even for companies that have already made the transition to managed care.”*

mium savings after a company has exhausted those achievable on its own. They also can simplify in-house health benefits administration by using consultants to manage the health plan networks of several companies in a coalition. A coalition also can serve as a vehicle for coordinating or standardizing managed care plans' quality requirements.<sup>14</sup> Some coalitions facilitate Medicare risk contracting. Finally, some firm officials cite the simple benefits of sharing

experiences and ideas as motivation enough to participate in a coalition.

Business coalitions also can be a source of new problems for companies. One concern is that the premium reductions being driven by coalition negotiations are the result not of efficiency improvements but of cost shifting from large corporations participating in coalitions to smaller ones with less clout. Another concern is with the organizational sustainability of coalitions. A few have failed, and the challenges are many. Coalitions must agree on activities and must coordinate those activities with each firm's internal benefits administration.<sup>15</sup> Agreement is difficult because most companies have some benefits capabilities and characteristics that they would prefer to retain. The members of the PBGH, for example, had difficulty in agreeing on a common benefit design and administrative schedule for purchasing. In the end, some firms were forced to change their employee benefits

packages and purchasing schedules, thereby risking administrative and labor turmoil.

■ **DIRECT CONTRACTING.** Large employers can reap additional benefits in procurement by contracting directly with components of the health care delivery system, including physician groups, hospitals, mental health service providers, or pharmacy benefit managers. A few business coalitions have chosen to contract directly with provider groups for health care services. American Express, 3M, General Mills, and other employers participating in the Twin Cities purchasing coalition, the Buyers Health Care Action Group (BHCAG), have created a system of direct contracting with exclusive provider groups. After having already achieved substantial cost savings in the region through consolidated purchasing, the BHCAG developed a "care systems" model of delivery in 1997. In this model, large provider groups composed of physicians and clinics compete for the enrollment of the participating companies' employees. Large employers in Orlando also have contracted directly with large hospital-based integrated delivery systems to provide comprehensive services for their employees.<sup>16</sup>

Many firms are contracting out for mental health coverage and pharmacy benefits apart from other managed care services. Specialized carve-out companies have developed to provide these services. Many companies are purchasing directly from these organizations rather than through their managed care plans. Fireman's Fund, for example, has contracted out both mental health and pharmacy benefits since 1992, and General Mills began contracting for pharmacy benefits in 1996.

## RESULTS FOR FIRMS AND WORKERS

The predominant focus of our study was on understanding the implementation of purchasing practices, but we also collected some information that sheds light on the consequences of new purchasing techniques for firms and workers. For firms themselves, the use of financial incentives has encouraged the

rapid migration of employees into managed care. For example, at Digital the proportion of employees in HMOs rose from less than 30 percent in 1990 to more than 80 percent by 1995. Digital reported company savings of \$765 per employee in 1995 and overall savings of approximately \$100 million over the five-year period. Similarly, GTE predicts that three-fourths of eligible employees and their dependents will be enrolled in managed care by the year 2000, up from less than one-quarter in 1989. This shift has produced savings for GTE estimated at \$75 million through 1995. These private-sector savings have shown up in nationally aggregated data that indicate a temporary slowing of the spiraling health care costs that employers faced throughout the 1980s.<sup>17</sup> (Despite corporate pressures, the rate of increase in managed care premiums appears to be rising in some markets.)

Evidence from our study suggests that strategies such as competitive bidding and participation in business coalitions can result in savings even for companies that have already made the transition to managed care. The long experience of the Minnesota Employee Group Insurance Program indicates that premium price competition still holds potential savings even in mature managed care markets like Minneapolis. Companies as diverse as Fireman's Fund, Union Bank, 3M, General Mills, and Dayton Hudson have obtained premium savings from their participation in the PBGH or BHCAG.<sup>18</sup> Nonetheless, additional premium savings may be harder to achieve once the "low-lying fruit" has been picked.

For workers, the results of these new purchasing systems are more difficult to judge. Employees now have more personal and financial responsibility than they had before. They must pay a portion of their health benefits costs and often must decide among competing health plan choices with limited information. Many corporate executives in our study reported that surveyed employees were at least as satisfied in managed care plans as in indemnity coverage. However, such surveys conducted by corporations themselves reflect

the views of largely healthy employees rather than the opinions of the sick who use the system heavily. In addition, confidential focus groups at major corporations suggest that some employees are skeptical about the quality of care in managed care plans and view changes to their health benefits as "take-aways." Further, while the potential exists for employees to gain from both lower overall health inflation and higher-quality care resulting from competition among vendors, these advantages may take time to materialize.

## CONCLUSIONS

As more companies move to new purchasing systems, the demands on the health care delivery system are likely to multiply. Some companies and business groups will seek to intervene directly in the delivery system by working with hospitals or physician groups. Others will pressure managed care plans to shape health care providers' behavior on their behalf. As attention at large firms turns to improving management of supplies in all aspects of business, the depth and frequency of health care delivery system intervention will increase.

The corporate purchasing practices described here are disseminating rapidly to other large firms. For this reason, additional research is needed to document the extent and nature of changes taking place in large corporations as a group. The practices of early innovators may not be generalizable across all large firms or sustainable over time. In addition, small and medium-size companies may lack the resources to adopt these practices independently. Equally important, innovations in corporate health purchasing deserve further study to understand what constitutes "best practices" and the extent to which they might be spread to other companies and to public purchasers.

Policymakers and researchers alike need to address the implications of new purchasing techniques for both workers and dependents and for the health care system as a whole. Although new corporate purchasing practices have the potential to benefit employees, they have sometimes been accompanied by cut-

backs in coverage, choice, and employer contributions without compensating increases in wages. Dependents and retirees have been subject to other cutbacks.<sup>19</sup> Large employers have negotiated strongly with health plans for price reductions, but the source of these cost savings and their long-run consequences on the plans' capacity to deliver effective medical care are not clear. As more corporations move to market-oriented purchasing practices, policymakers may be increasingly challenged by such issues.

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## NOTES

1. The portion of workers enrolled in managed care plans rose from 51 percent in 1993 to 73 percent in 1995, according to a survey conducted by KPMG Peat Marwick. See G.A. Jensen et al., "The New Dominance of Managed Care: Insurance Trends in the 1990s," *Health Affairs* (January/February 1997): 125-136.
2. For a description of the principles of managed competition, see A.C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (Supplement 1993): 24-48.
3. L. Etheredge, S.B. Jones, and L. Lewin, "What Is Driving Health System Change?" *Health Affairs* (Winter 1996): 93-104. Also see U.S. General Accounting Office, *Health Insurance: Management Strategies Used by Large Employers to Control Costs*, Pub. no. GAO/HEHS-97-71 (Washington: GAO, May 1997).
4. J. Maxwell et al., *Corporate Approaches to Implementing Managed Competition: Final Report to the Robert Wood Johnson Foundation* (Boston: JSI Research and Training Institute, March 1997).
5. Corporate officers at large U.S. firms were not concerned about health care benefits control or costs in 1981, according to a survey reported in H. Sapolsky et al., "Corporate Attitudes toward Health Care Costs," *Milbank Memorial Fund Quarterly/Health and Society* 59, no. 4 (1981): 561-585.
6. This emphasis on employee responsibility has also become prevalent in other aspects of employee relations. See J. Maxwell et al., "Corporate Health Care Purchasing and the Revised Social Contract with Workers" (Unpublished paper, 1997).
7. See *Human Resource Management*, Special Issue: Measuring Human Resource Effectiveness and Impact (Fall 1997).
8. Enthoven, "The History and Principles of Managed Competition," 32.
9. For a discussion of how components of the employment contract are changing, see P. Cappelli et al., *Change at Work* (New York: Oxford University Press, 1997).
10. Interviews with representatives from CIGNA and other health plans, April 1996.
11. D.J. Lipson and J.M. De Sa, "Impact of Purchasing Strategies on Local Health Care Systems," *Health Affairs* (Summer 1996): 62-76.
12. H.S. Luft, "Modifying Managed Competition to Address Cost and Quality," *Health Affairs* (Spring 1996): 23-38.
13. Three examples help to illustrate the process of dissemination from these companies to their counterparts in industry. GTE's managed competition strategy has been spread by the relocation of its principal architect, Bruce Bradley, to the largest private purchaser in the nation, General Motors. Likewise, Digital's approach to purchasing was brought to the public sector when its champion, Michael Bailit, was hired by Massachusetts Medicaid. American Express's quality practices have been adapted for a national coalition of purchasers in which it participates.
14. M.D. Friedman, M. Bailit, and J. Michel, "Vendor Management: A Model for Collaboration and Quality Improvement," *Joint Commission Journal on Quality Improvement* (November 1995): 635-645.
15. See J. Meyer et al., *Employer Coalition Initiatives in Health Care Purchasing*, vol. 1 (Washington: Economic and Social Research Institute, February 1996).
16. John Snow, Inc., *Health Benefits Purchasers: Orlando*, Report to the Florida Agency for Health Care Administration and the Robert Wood Johnson Foundation (Boston: JSI, 1997).
17. The rate of increase in health insurance costs remained low in the last few years, at least until June 1996. See "A Look at Employers' Costs of Providing Health Benefits" (Washington: U.S. Department of Labor, 31 July 1996).
18. A few examples illustrate the cost savings from coalition participation. As a result of participating in the Pacific Business Group on Health, Fireman's Fund lowered its premiums in California by 5 percent in the initial year of group negotiations (1994). Because it joined the Buyers Health Care Action Group, General Mills's per capita costs barely increased from \$4,053 in 1993 to \$4,121 in 1995 (a decline when adjusted for inflation).
19. U.S. General Accounting Office, *Retiree Health Insurance: Erosion in Employer-Based Health Benefits for Early Retirees*, Pub. no. GAO/HEHS-97-150 (Washington: GAO, 1997); and GAO, *Health Insurance: Coverage Leads to Increased Health Care Access for Children*, Pub. no. GAO/HEHS-98-14 (Washington: GAO, 1997).