

MARKET WATCH

Private Health Purchasing Practices In The Public Sector: A Comparison Of State Employers And The Fortune 500

Today's budget crisis may force states to adopt purchasing practices that are standard in the private sector.

by James Maxwell, Peter Temin, and Tanaz Petigara

ABSTRACT: State governments are influential purchasers of health benefits but have not been studied extensively. In a recent survey of senior benefit managers, we examine the extent to which states have followed the private-sector approach to purchasing health care. We found that states have adopted "industrial purchasing" practices similar to those of large private employers but offer greater choice of carriers and pay a higher percentage of premiums. Unions continue to influence health care purchasing in both the public and private sectors. Double-digit increases in health costs and the current budget crisis may force states to align their purchasing practices with the private sector to cut costs.

DURING THE PAST DECADE large private employers transformed their health care purchasing by adopting market-oriented approaches, including tough negotiating techniques and competitive bidding to obtain the lowest prices from health carriers. At the same time, they used financial incentives to encourage employees to select less costly carriers and managed care products. In their contracting with carriers, large private employers set minimum standards for quality.¹

We refer to large private-sector employers' use of these business practices as an "industrial purchasing" model. Fortune 500 companies use competitive bidding to purchase health coverage as they would other inputs to their production processes. The corporation is the primary decisionmaker that aggressively

bids for and selects a smaller number of carriers, to obtain the lowest rate. This differs from consumer models in which responsibility for carrier selection and cost control is placed on the consumer.

In our earlier work, we documented the reliance on the industrial purchasing model among both the Fortune 500 and medium-size manufacturing firms.² However, no study has explicitly examined the spread of these practices to the public sector. The small number of studies have only suggested that public purchasers are more constrained in their purchasing than private purchasers because of strong unions, public procurement regulations, and politics.³

Understanding state employers' purchasing practices and the degree to which they can adopt private methods is vital because these

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purchasers shape the choices available to states in responding to today's budgetary and health care crises. Market-oriented purchasing approaches are being discussed widely in the public sector not only because of the experience of private firms, but also because of recent Medicare reform legislation.

Since state governments are often the largest employers in their respective states and among the largest in the country, the effects of their responses are far-reaching. Our data show that states purchase health care for more than four million employees and retirees and millions more dependents.⁴ They also purchase on behalf of other public agencies such as state universities and municipalities.

In this paper we present the results of our survey of state employee groups in comparison to results from a similar survey of the Fortune 500. We explore the extent to which state employer groups have adopted the key elements of the industrial purchasing model.⁵ We examine the context within which public employers operate and how they have adapted industrial purchasing to suit that environment. We also discuss how unionization and other human-resource issues influence the spread of these purchasing practices.

Study Methods

Data on state employer groups were collected during spring 2002, using a thirty-minute telephone interview that targeted the state official with the most responsibility and detailed knowledge of health benefits. Pretests were conducted among twelve municipal governments to test and refine the questionnaire. We then surveyed all fifty states and the District of Columbia for a 100 percent response rate.

Comparative data on the Fortune 500 were collected during the winter and spring of 1999–2000. The methods for our study of the Fortune 500 have been described in detail elsewhere.⁶ We surveyed 411 out of 489 companies for an 84 percent response rate. The number of employees in these firms ranged from 1,850 to 204,250.

The number of state employees ranged from

8,200 to 554,558; their average age was forty-four. On average, 25,984 retirees were enrolled in state health insurance programs, with a range of zero to 179,353. Of those retirees, 52 percent on average were over age sixty-five. Altogether, there were 3,523,616 state employees and 1,247,232 enrolled retirees.

Twenty-four states bought health insurance for municipal and county employees. Colleges and universities were the second most common recipients. Five states purchased coverage for children in state-subsidized programs. Together, states purchased for 1,463,717 enrollees from other public agencies or public insurance programs.

■ **Measures.** We rely upon many of the same measures in our studies of state governments and the Fortune 500.⁷ Our interviews included questions on health plan types, carrier choice, contribution levels, suppliers' relations strategies, bidding practices, quality measurement and management, and cost outcomes of purchasing.

We asked about states' and the Fortune 500's purchasing of health insurance "carriers" in their largest metropolitan area. Carriers refer to companies such as Aetna, CIGNA, and Kaiser Permanente that offer health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS), and other types of plans. We also asked for the average contribution level to individual and family/dependent coverage across carriers.

We use descriptive statistics to compare key purchasing practices between state employers and the Fortune 500. Because the survey response rate was 84 percent for the Fortune 500 and 100 percent for state employers, the samples are nearly complete representations of the study populations. We use chi-square tests in an exploratory analysis to examine the association of unions with contribution levels for individual and family coverage.

Study Results

■ **Rising health care costs.** The rise in health care costs during the past few years amounts to a cost crisis for state employers. Forty-five percent of state employers faced per

capita health care cost increases of greater than 12 percent in the past year (2001), compared with 25 percent who saw such a rise over the past five years (1997–2001).⁸ States expect double-digit increases to be the rule rather than the exception in the coming years. Among states, the average annual per capita premium cost for individual coverage in the preceding year was \$4,469, contributing to states' cost pressures.

Drug costs are a key factor in the rise in overall health care costs. In the past decade, the demand for prescription drugs has been driven by extensive advertising, the proliferation of new drugs, and an aging workforce that requires maintenance drugs for illnesses such as asthma, diabetes, and heart disease.⁹ Among state employer groups, drug costs increased at a higher rate than overall health care costs, with the majority of states reporting increases of more than 13 percent. More than a third of state employers faced drug cost increases of greater than 19 percent in the past year, compared with only one-fifth during the past five years.

State employers expect these overall increases to continue. Nearly all respondents (98 percent) cited overall costs as the greatest challenge facing state employers in the future. Rising health care costs are particularly important to state governments because they confront these costs in the context of fixed and declining budgets. As health care costs continue to escalate, state revenues are also falling

precipitously because of the prolonged economic downturn. According to the National Governors Association, the current state deficit for 2003 is about \$30 billion and is projected to be about \$82 billion in 2004.¹⁰ Thirty-seven states reduced their fiscal year 2003 budgets by nearly \$14.5 billion.¹¹ Unlike the federal government and private employers, state employers are required by law to balance their budgets annually. The combined effects of rising health care costs and state budgetary crises may force states to consider more radical changes in the health benefits they offer.

■ **Purchasing process, carrier selection, and contract period.** Almost all state employers rely on request-for-proposals (RFP) bidding, the standard method among private-sector firms, to purchase health benefits for their employees (Exhibit 1). More than two-thirds of state employers and 62 percent of the Fortune 500 are required to regularly re-bid all of their health care carrier business. Both states and the Fortune 500 also use bidding to purchase coverage for pharmacy benefits and mental health services and to select administrators for self-insured plans.

State governments are even more oriented toward bidding than the Fortune 500. This may be attributable to state laws mandating the use of bidding. However, the bidding processes of state employer groups and the Fortune 500 differ in important ways. Bidding involves an explicit comparison of different suppliers on their products and prices, and sends a sig-

EXHIBIT 1
Comparison Of The Use Of Major Health Care Purchasing Practices Between Fortune 500 Companies And State Employers, 1999 And 2001

	Fortune 500, 1999 (%)	States, 2001 (%)
Any RFP bidding	89 ^a	98
RFP for all new health carrier business	63 ^a	82
RFP for new components (such as mental health)	41	55
Percent self-insuring	94 ^a	73
Carve-outs for mental health/substance abuse	43	44
Carve-outs for prescription drug benefits	69 ^a	50

SOURCES: JSI Corporate Health Care Purchasing Survey, 2000; and JSI State Employer Health Care Purchasing Survey, 2002.

NOTE: RFP is request for proposals.

^a Fortune 500 versus states comparison significantly different at the .05 level.

nal to current vendors that their relationship is not guaranteed over the long term. The extent of this implicit threat differs between states and large corporations.

We found that states are not as aggressive as the Fortune 500 in selecting or dropping carriers during the bidding process. This is apparent in the greater choice of carriers and longer contract periods among state employer groups than the Fortune 500. In the Fortune 500, the competitive bidding process is often accompanied by short-term contracts, usually one year long, between companies and carriers.¹² Competitive bidding is more effective on premium prices if fewer carriers are selected and are under threat of being dropped.

Seventy percent of state governments offer a choice of two or more health insurance carriers to their employees, compared with 66 percent of Fortune 500 companies. Seventy percent of state employers offer a choice of two or more carriers to more than 80 percent of their workers, compared with only 49 percent of the Fortune 500. State employees continue to have a wide array of choices despite the trend toward market consolidation among carriers.¹³ Sixty-one percent of states reported average contract lengths of three years or more, as opposed to the annual contracts that are the norm among the Fortune 500.

The California Public Employees' Retirement System (CalPERS), however, is an example of a public purchaser that does use its considerable clout to influence premium prices in a manner similar to the Fortune 500. In response to recent increases in premium prices, CalPERS has reduced the number of carriers offered to its employees and is considering a further reduction.¹⁴ CalPERS' willingness to drop carriers is a result of its size and its culture of being both a pension manager and a health benefit purchaser.¹⁵ CalPERS has a history of aggressively managing financial assets in its pension funds and frequently switches vendors. Its tactics are also a result of its particular market context that allows it to take advantage of one of the most mature managed care systems in one of the most competitive U.S. markets. CalPERS has capitalized on both

of these factors, which are more present in California than in other states.

■ **Employer-contribution strategy.** To reduce costs, Fortune 500 employers traditionally place pressure primarily on carrier rates through competitive bidding rather than shifting the cost burden onto employees. Only 24 percent of Fortune 500 employers use a fixed-dollar strategy to shift the full cost differential between carriers onto employees. Most private employers pay a fixed percentage of premiums to subsidize the premiums of employees in high-cost carriers. They may do so because of adverse selection and other human-resource concerns.

State employers' contribution strategy is similar to that of the Fortune 500. Only a third of states have moved to a defined-contribution strategy, in which they pay a fixed-dollar amount regardless of insurance premium. Were state employers to accompany a wide choice of carriers with a financial incentive for employees to choose less costly plans, the competitive bidding process would be a less important instrument of cost control. Yet two-thirds of states that offer three or more carriers to employees do not use a defined-contribution strategy.

The Massachusetts Group Insurance Commission (GIC), which purchases health benefits for active and retired state employees, provides an example of why a state does not use such a strategy. The GIC is required to provide an indemnity plan to employees and contend with adverse selection and retention. Should the GIC introduce a defined-contribution strategy, the high-cost indemnity plan would likely be eliminated. Thus, not only is the GIC required to offer a wide choice of carriers, but it also is unable to steer its employees into more cost-effective carriers because of its inability to pass on the full cost differential between carriers.¹⁶

■ **Employers' contribution levels and re-tiree coverage.** States and other public employers pay a much higher percentage of premiums for individual coverage than do private firms of similar size: 89 percent of premiums across all health carrier offerings for individual

coverage versus 82 percent among the Fortune 500. More than half of states contribute 90 percent or more toward premiums for individual coverage, compared with one-third of the Fortune 500 (Exhibit 2). Since the data were collected two years apart, one might even expect larger differences in contribution levels to individual coverage today. Although states may find it easiest to economize on family coverage, they are still more generous than the private sector. On average, states contribute 77 percent of the premium for family coverage. Other studies of the private sector have indicated a smaller contribution to family coverage than is offered by state employers.¹⁷

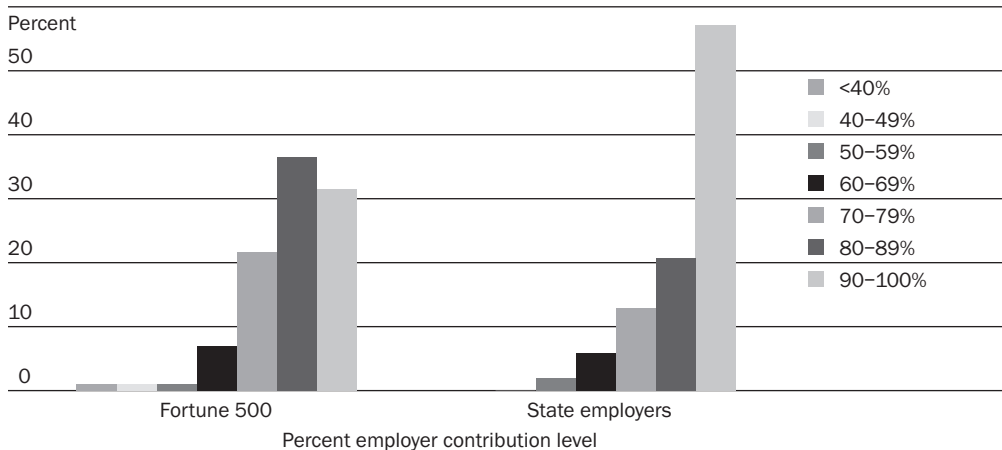
States are also much more likely than their private-sector counterparts to offer and contribute to retiree coverage. Our data show that forty-five states offer retiree coverage to their employees; nearly two-thirds of states contribute to retiree coverage.¹⁸ In contrast, only 34 percent of large private-sector companies offered retiree coverage in 2001.¹⁹ Proposed regulations from the Government Accounting Standards Board (GASB), which require government employers to report the cost of retiree benefits, however, might prompt public employers to reduce retiree benefits. The poten-

tial impact of GASB regulations is based on the decline of retiree coverage in the private sector following similar Financial Accounting Standards Board (FASB) regulations in 1993.²⁰

■ **Quality management.** In quality management, state employers closely resemble their counterparts in the private sector. Nearly all states and Fortune 500 companies routinely collect quality information, from a wide variety of sources (Exhibit 3). They also rely on similar sources for quality information. Fortune 500 companies, however, rely more on consultants than state employer groups do. States are significantly more likely than Fortune 500 employers are to collect information on customer satisfaction. In keeping with the industrial purchasing practice where employers, rather than employees, make many of the choices among health carriers, fewer than half of state employers and one-third of Fortune 500 companies disseminate some quality information to employees. Nearly all state employers (88 percent) and Fortune 500 companies (83 percent) require some form of quality performance in their contracts with carriers, and both clearly emphasize standards for customer service over clinical quality (Exhibit 3).

More than 70 percent of state employers re-

EXHIBIT 2
Comparison Of Percentage Contribution Levels Toward Individual Coverage Between Fortune 500 And State Employers, 1999 And 2001



SOURCES: JSI Corporate Health Care Purchasing Survey (Fortune 500), 2000; and JSI State Employer Health Care Purchasing Survey, 2002.

NOTE: States versus Fortune 500 comparison significantly different at the .05 level for 90–100 percent contribution level.

**EXHIBIT 3
Comparison Of Collection And Dissemination Of Quality Data And Their Use In
Contracting Between Fortune 500 Companies And State Employers, 1999 And 2001**

	Fortune 500 (%)	States (%)
Collect any quality information	99	94
Accreditation by NCQA or other	55	68
Customer satisfaction survey	58 ^a	76
HEDIS	53	64
Consultants	79 ^a	60
Disseminate any quality information	35	42
Use quality criteria in carrier selection	83	88
Require NCQA accreditation	67 ^a	46
Requirements for network composition	61	64
Annual improvements in clinical quality	32	34
Customer service standards in contract	86	88

SOURCES: JSI Corporate Health Care Purchasing Survey, 2000; and JSI State Employer Health Care Purchasing Survey, 2002.

NOTES: NCQA is National Committee for Quality Assurance. HEDIS is Health Plan Employer Data and Information Set.

^aStates versus Fortune 500 comparison significantly different at the .05 level.

ported setting requirements for quality in contracts with carriers five years ago. This suggests that a first generation of quality initiatives, directed at health insurance carriers, is well institutionalized among states. Today, several innovative states are following the Leapfrog Group in ushering in a new generation of quality initiatives that extend quality requirements from carriers to providers. In addition to many Fortune 500 companies, the States of Kansas, Maine, Massachusetts, New Jersey, Washington, and Wisconsin are members of the Leapfrog Group.²¹

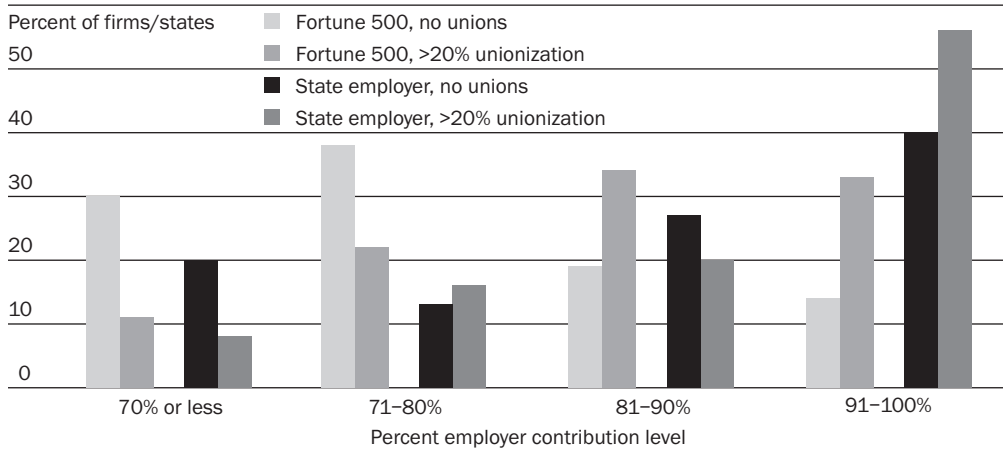
■ Unions and other human-resource concerns. Unions and human-resource concerns continue to affect the provision of health benefits. States reported that unions influenced various aspects of health coverage during the collective bargaining process, especially contribution levels (69 percent). Nonunionized states are more likely to have contribution levels for individual coverage of 70 percent or less. Conversely, the presence of unions is associated with much higher levels of employer contribution. More than half of states having more than 20 percent unionization have contribution levels for individual coverage of 90 percent or more. Similarly, non-unionized Fortune 500 companies were more

likely to have contribution levels for individual coverage of 70 percent or less (Exhibit 4). We found that unions have a statistically significant effect on contributions toward individual coverage among the Fortune 500 but not among state governments. This may be because of the higher levels of contributions already provided by states. Thirty-three percent of Fortune 500 companies with more than 20 percent unionization had contribution levels of 90 percent or more.

Unions have similar effects on contributions to family coverage. Forty-seven percent of nonunionized states had contribution levels of 70 percent or less toward family coverage. Conversely, 32 percent of states with contribution levels of 90 percent or more were more than 20 percent unionized. Although data on employers' contributions to family coverage were not collected among the Fortune 500, the effect of unions on contribution levels is consistent with another recent study of private manufacturing firms.²²

While unions in the public and private sectors have similar health benefit goals, their stronger presence in the public sector increases their effect on health benefits. The effects of unions on employers' premium contributions are consistent with earlier studies of

EXHIBIT 4 Comparison Of Contributions Toward Individual Coverage Between Fortune 500 And State Employers, By Unionization, 1999 And 2001



SOURCES: JSI Corporate Health Care Purchasing Survey, 2000; and JSI State Employer Health Care Purchasing Survey, 2002.

the private sector that show rates of unionization to be strongly associated with higher employer premium contributions and lower copayments.²³

We also collected supplementary information from in-person interviews on other human-resource concerns that affect health benefits. State employers often emphasized a culture of public employment characterized by an inclusive employment policy and a generous benefit package. Yet the current cost crisis puts the generosity of public employers at odds with cost-cutting measures. According to Dolores Mitchell of the Massachusetts GIC, "Traditional wisdom has it that, in comparison to the private sector, lower salaries and richer benefits characterize the culture of public employment. Rising health care costs threaten this prevailing culture."²⁴

Similarly, California's fiscal crisis is having far-reaching effects in the public sector. California's public employees are likely to bear the full costs of increasing health insurance premiums in 2004, while their wages remain fixed. This poses a hardship particularly for low-income state workers who have come to depend on a rich health benefit package. These increases may have long-term effects on health benefits and employment policy among state

employer groups.²⁵

Study limitations. We recognize that this study has several limitations. One limitation is that the Fortune 500 and state employer groups differ in the geographic characteristics of their workforces. Fortune 500 companies tend to be more national in scope with employees across the country. While state employers can also be dispersed across a state or neighboring states, they usually have a more geographically concentrated workforce. A second limitation is that benefit managers in both sectors have difficulty identifying their overall contribution strategy, leading to sizable amounts of missing data. Other studies have confronted this problem.²⁶ Finally, the data for state employer groups and the Fortune 500 were collected two years apart, although using the same measures. The results nevertheless are consistent with each other and other studies that compare the public to the private sector.²⁷

Summary And Concluding Remarks

States have moved toward the tough bidding and negotiating tactics associated with large private employers. However, they are not as aggressive in dropping or otherwise disci-

plining their carriers on price. States also are unable to share costs with their employees as extensively as large private-sector employers can. Similar to past studies, we found that contribution levels tend to be higher among state governments than in the private sector.²⁸ Nearly a third of states still contribute 100 percent to individual coverage, compared with 8 percent of Fortune 500 companies. Strong unions coupled with human-resource concerns have made it difficult to reduce employers' contributions or increase employees' copayments.

Unions exert a strong influence on health benefits in both the public and private sectors. The major difference is that while unions remain strong in the public sector, they are in decline in the private sector. The public sector also has a different employment culture than the private sector.²⁹ Many state employees have come to expect long-term job security and rich benefits during their career and retirement, in lieu of the higher compensation that traditionally characterizes the private sector. These constraints on reducing contribution levels affect states' ability to steer their employees into low-cost carriers.

In the quality arena, the practices of states are more similar to those of the private sector. States have moved rapidly to collect quality information and incorporate it into their contracting practices with health carriers. Similar to large companies, states' emphasis in contracting has largely been on customer service rather than on clinical quality. States primarily collect quality data for use in their own decision making; they often do not share these data with their employees.

States' current budget crises may force them to align their purchasing practices with those of the private sector to cut costs. CalPERS' recent reduction of carriers and its proposal to reduce the number offered to just two is similar to large private employers that offer only one or two carriers to their employees. Gov. Mitt Romney of Massachusetts proposed a reduction from 85 percent to 75 percent in contribution levels for state employees.³⁰ He justified the cutback as bringing state employees in line with the private

sector. Only the worst state budget crisis since the Depression could have provoked such a powerful stimulus for change.

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