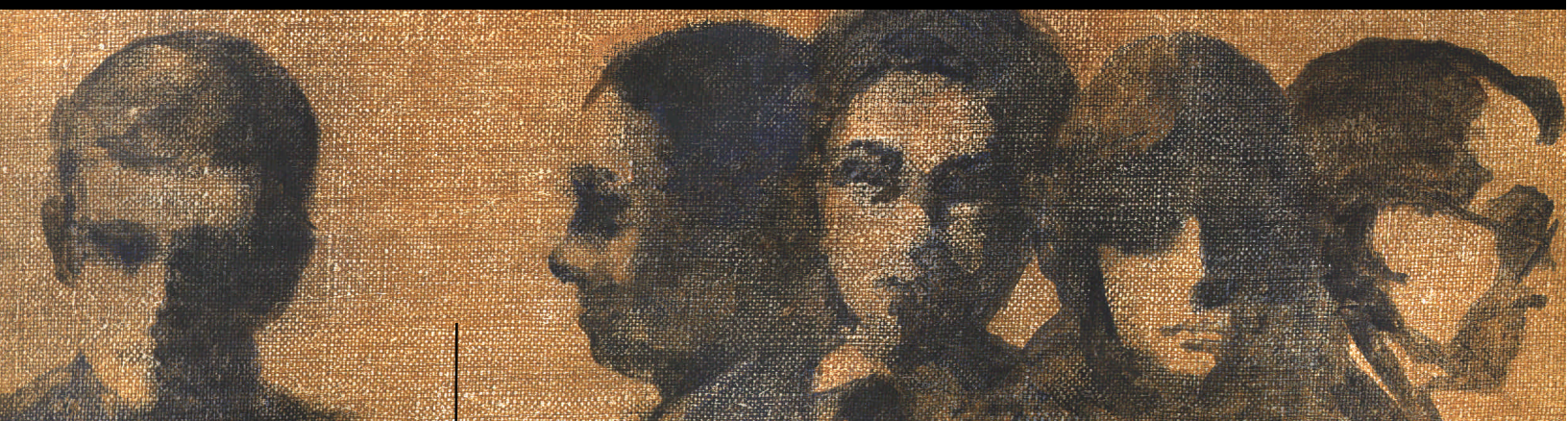


NATIONAL
HEALTH CARE
PURCHASING
INSTITUTE



What Is Unique About Public Purchasing?

Susan O'Loughlin Ward

An Initiative of The Robert Wood Johnson Foundation. March 2001

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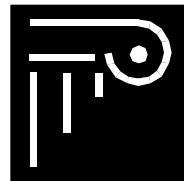
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INTRODUCTION

The last 10 years have witnessed a shift in how health care purchasers conduct business. Some innovations in purchasing have been shared in what one expert has characterized as “public/private leap frog,”¹ with each sector sometimes taking the lead, and sometimes adapting the innovations of the other. Public innovations in Medicare prospective payment systems and selective contracting, Medicaid managed care, and state employee benefit programs have been used by private purchasers, while private sector value-based purchasing, managed competition, and quality improvement models have been adopted by the public sector.²

Still, the real and perceived differences between public and private purchasers have impeded each adopting the strategies employed by the other.

Public purchasers have attributes that create barriers to innovation, but they also possess unique advantages. With more than 75 million people enrolled in Medicare and Medicaid, and millions more covered by public employers, the public sector has the chance to use its purchasing power to foster new levels of excellence in health care quality, efficiency, and service.

This paper explores the differences between government and private purchasers and evaluates to what extent the unique attributes of public purchasing pose barriers to the adoption of new purchasing approaches. This paper argues that:

1. The differences between public and private purchasers have been overstated. Private purchasers face many challenges analogous, if not identical, to those confronting their government counterparts.

2. While some constraints faced by public purchasers are inherent in the public sector, others arise from traditional government operating processes that can be changed.
3. While unique characteristics of public populations pose special challenges, effective strategies exist for bringing value-based purchasing to these groups.
4. Public purchasers have unique advantages over their private sector colleagues in implementing strategies for purchasing value in health care.
5. Tremendous opportunities exist for health care purchasers to use their combined market power to create a system that enhances value to consumers. Public and private purchasers should increase their efforts to develop relationships and share best practices, rather than allow their differences to impede collaboration.

The paper describes the unique environment in which public purchasers operate, analyzes the attributes of health care purchasing among different purchaser types and evaluates their differences, and identifies opportunities for the public sector to effectively engage in value-based purchasing. Sources of information include focus groups with consumer representatives, and federal, state, and local government purchasers; interviews with leading public and private purchasers; published works; and the author's own perspective as a former state purchaser.

PUBLIC PURCHASING ENVIRONMENT

The key difference between public and private purchasers is the environment in which they operate. The fishbowl in which government purchasers function presents them with a number of significant challenges:

- **Legislative/Congressional oversight:** Some private purchasers have likened HCFA's Congressional oversight to that of their own boards of directors, but that stretches the analogy too far. Congress' 535 members have disparate and often highly partisan agendas. Further, corporate directors are anxious to see their companies succeed, but such an objective is not necessarily shared by all members of Congress. Medicaid and public employers face similar challenges with their state legislatures.

Legislative oversight diminishes the willingness of public purchasers to take risks. Several private purchasing experts have noted that they never have sufficient information on which to base their decisions, and have to take risks to accomplish their goals. They expressed concern that public purchasers may have difficulty developing the legislative and public backing that is required to take such risks.³

- **Lack of control over programs:** Because they operate in a political environment, public programs can be significantly affected with each election. This inhibits long-range planning and creates morale problems for work forces that devote substantial energies to implementing new programs, which are sometimes dismantled or restructured by the next legislature or Congress.

Medicaid agencies and public employers sometimes find themselves mandated by legislators to cover new populations. These decisions are often made without a thorough understanding of the impact on risk pools and agency operating costs, and may have unrealistic time frames and insufficient administrative resources.

Statutory requirements governing plan design, contribution formulas, and cost-sharing also limit public purchasers' efforts to innovate.

- **Confusing authorizing environment:** In contrast to the autonomy enjoyed by private employers, public purchasers must coordinate their activities with other players at the state and federal levels. Turf battles and poor communication among different parts of government are common. The Medicaid program is only one of a number of state and local programs that provide health services to Medicaid recipients. Often, the interests of Medicaid directors in adopting new purchasing approaches are in direct opposition to their counterparts in other divisions and agencies. Because of Medicaid's federal match, some legislators and local government officials see the program as a vehicle for economic development and may resist the efforts of Medicaid officials to improve health purchasing.

■ **Civil service regulations:** One focus group participant reported that the change that would most help him become an effective health care purchaser would be a temporary suspension of civil service laws. While designed to protect employees from unfair management practices and political patronage, these laws are outdated and cumbersome. Particularly in an endeavor requiring sophisticated technical expertise, regulations that impede the hiring, reassignment, and promotion of talented people leave government purchasers doing their jobs with one hand tied. Most successful public leaders find ways to hire the skilled staff they need by working within civil service regulations, but it requires an investment of management time and energy that would be better spent on effective purchasing.

■ **Procurement statutes:** Rather than having the flexibility to respond proactively to a rapidly transforming health care market, public purchasers (especially Medicaid and Medicare) are bound by existing statutory requirements that may be politically difficult and procedurally cumbersome to alter. Many procurement and bidding regulations are leftovers from the bygone days when government procured generic goods and services on the basis of price. Even regulations promulgated by health purchasing agencies were developed for a completely different health care market than exists today.

Purchasing emphasizes the use of a contract as the primary vehicle for accountability. Problematic contractual provisions may be renegotiated at any time if both parties agree. This flexibility is critical in a rapidly changing health care market as both purchasers and the industry encounter unforeseen situations that need to be addressed in a timely way.

Federal and state procurement laws are not nearly so nimble. Public purchasing is governed by a complex set of rules and procedures. Contracts must be handled in an even-handed manner, with significant attention paid to due process for the bidders and contractors. Losers have recourse to courts to challenge the objective bases for decisions or failures to follow prescribed processes. Appeals can bog down contracting processes for months, and even years, as was the case with District of Columbia Medicaid's managed care contract awards.

The 1997 Balanced Budget Act mandated that HCFA offer a greater choice of products to beneficiaries through the creation of Medicare+Choice. The act gave the agency relatively little new purchasing authority, however, except on a demonstration basis. This has complicated HCFA's task enormously and has limited its ability to incorporate some of the most successful practices used by private and public employer purchasers.

- **Public disclosure laws:** Contract provisions and contract management actions may be subject to public disclosure, making it challenging to work with health plans on performance issues without appearing to be either heavy-handed or too soft.
- **Lack of front-end investment in staff training and beneficiary communications:** Effective purchasing requires the development of management capabilities. Businesses understand that successful contracting requires specialized expertise, including project management, design of specifications, an understanding of the supplier market, negotiation skills, performance measurement, financial expertise, and clearly defined accountability.⁴ Private corporations rarely attempt fundamental shifts in business strategies without building the core competencies to support the new activities, yet public agencies are chronically underfunded in work force training and development.

Corporate purchasers devote considerable resources to beneficiary communication on a per-member basis. Like other public purchasers, HCFA was given a minimal budget to communicate all the changes under Medicare+Choice to its beneficiaries. One of the areas that deserves more study is ascertaining what methods and types of information are most important to beneficiary choice, and ensuring that funding is sufficient for those strategies to be implemented.

The nature of budgeting cycles of federal and state governments make up-front investments for long-term gains politically difficult. Officials are challenged to justify large expenditures when no immediate cost savings can be included in the budget request.

ATTRIBUTES OF HEALTH CARE PURCHASING AND IMPLICATIONS FOR PRIVATE AND PUBLIC PURCHASERS

Health care purchasing is a broad term encompassing a variety of relationships and functions. A framework to analyze the attributes of purchasing that are unique in a public environment is provided in Table 1, and discussed in the following sections.

A. MISSION AND VALUES

The differences in the missions of public and private purchasers result in an orientation toward purchasing that is characterized by:

- **Differing definitions of “value”:** Private purchasers aim to maximize the benefits to their employees for the price paid. The private sector’s bottom line requires a trade-off between maximizing profits and doing a sufficiently effective job purchasing health care to retain employees. The metric for assessing value is based on employee and shareholder satisfaction. Public purchasers must balance the good of their beneficiaries with budget constraints and the tax burden on the public. Public purchasers also incorporate broad policy objectives (e.g., those related to access, cross-subsidies for medical education and clinical research, economic development, capacity in underserved areas, and public health) into their definition of value.

- **Greater emphasis on due process and equity in public purchaser and provider relationships:**

Private purchasers view health care providers just as they view any other supplier. They want to maximize value for price, and will hold providers accountable. They make decisions about quality and value on behalf of their employees, and offer only the best or lowest cost plans.

Public purchasers share the desire to purchase value, but also emphasize due process and equity for their contractors. As a result, public purchasers tend to offer many plans, ensuring that they meet minimum qualifications. Goals related to equity also make it more difficult for public purchasers to tailor individual contracts to achieve agency goals.

- **Need for public purchasers to balance their regulatory and purchasing responsibilities:**

HCFA and state Medicaid programs perform a large number of important regulatory functions, upon which they and private purchasers rely to ensure minimum standards of quality. Insurers and private purchasers often accept Medicare certification as a sufficient credentialing threshold for hospitals, and many rely on the substantial resources of the federal government to detect fraud and abuse.

Some observers see a fundamental conflict in philosophy and competition for resources between the purchasing and regulatory functions. Others (this author among them) argue that a public purchasing vision needs to be broad enough to recast existing regulatory responsibilities in a new light. Regulatory requirements may set the “floor” for participation, while competitive selection provides rewards for improved quality, service, and economy.

■ **Greater capacity for innovation by public purchasers due to dedicated professional staffs and larger administrative budgets:**

Government agencies typically feel beleaguered when they consider the staff and resources they have to accomplish their missions. At least in health purchasing agencies, however, they are better equipped than are most private purchasers. Public agencies have significant professional expertise in health services delivery, reimbursement methods, and clinical quality. Because health purchasing is not their organization’s mission, most private purchasers lack similar levels of dedicated resources.

B. SIZE/MARKET SHARE

The large market share of most public purchasers provides them with unique opportunities, but they must also be mindful of the market impact of their decisions.

■ **Impact of competitive purchasing:** The enormous purchasing power of public programs, particularly in oversupplied markets, represents an opportunity to reshape the health care system into one that delivers value to the consumer. Examples include HCFA’s selective contracting for tertiary centers of excellence (an approach that was adopted by several prominent corporations), and Washington’s joint health plan contracting process for its public employees, Basic Health Plan and Medicaid programs.

By their contracting decisions, public purchasers can almost single-handedly determine the fate of certain health plans and providers. Value-based purchasing approaches that create winners and losers thus present particular challenges for public purchasers, especially when they attempt to pursue other policy objectives.

■ **Access to databases:** Public purchasers have large and diverse populations as well as the resources to create data sets, which are useful for research and quality improvement. Most private purchasers are too small to provide useful data.

■ **Ability to run demonstration projects:** Public purchasers are large enough to support pilot projects as they test new purchasing methods.

C. BENEFICIARIES AND ELIGIBILITY

All purchasers deal with similar health problems within their populations, although the incidence of certain diseases and disabilities varies by age and other characteristics. Employers who offer continued coverage for Medicare retirees grapple with issues related to the elderly and disabled. Public and private employers also deal with special needs populations, although in much smaller numbers. And, many work forces include very low-wage employees who face some of the socioeconomic challenges of Medicaid recipients.

Despite these similarities, several differences exist among the covered populations of public and private purchasers that have significant implications for health care purchasing.

■ **Attractiveness to risk bearers:** Insurers typically find large public and private employers attractive customers. In contrast, Medicare and Medicaid eligibles are often riskier and more expensive to insure, due to age, pregnancy, disability, and/or socioeconomic factors related to their eligibility for these programs. While many health plans pursue Medicare and Medicaid business, others find these populations to be unprofitable under fixed premium arrangements and have terminated their relationships with these programs.

■ **Challenges related to special needs populations:** Medicare and Medicaid must include consideration of special needs populations in benefit packages, administrative procedures, enrollee communication, and health plan contracts. These populations have needs that may not be served well by existing players in the market, as evidenced by the difficulty of incorporating the Supplemental Security Income (SSI) population into Medicaid managed care programs.

■ **Ability of beneficiaries to maximize value under new purchasing paradigms:** Policymakers must exercise caution in assuming that what has worked effectively in the private sector (and even in public work forces) can be easily translated to other public programs. Examples include beneficiary communication strategies that rely on Internet access, work place ombudsmen, and complicated documents that require above-average literacy levels. Also, programs that rely on competitive bidding may prove to be more challenging for low-income, aged, and disabled beneficiaries than for employed work forces if high plan turnover results.⁵

D. FINANCING

Public purchasers receive their funding through legislative appropriations with all the politics that attend such processes. These programs are subject to financial pressures when budgets are tight. Private employers allocate financial resources to health benefits as one part of a comprehensive wage and benefit package that is reflective of an overall human resource strategy (albeit one that must factor in consideration of labor demands and the company's bottom line). Public employer health benefits purchasers usually make decisions that are separate from other aspects of human resources policy (e.g., salaries, leave, and pension) because these functions are organized in separate agencies. This means they do not have the same ability to make trade-offs between health and other benefits.

Public and private employers typically finance a majority of the costs of employee health insurance. Medicare beneficiaries face significant costs for their coverage, in the forms of Part B premiums, point-of-service cost sharing, and Medicare Supplement premiums. In fact, Medicare only pays half the health expenditures of the elderly (excluding premiums).⁶ The low income of most Medicaid enrollees precludes any widespread use of cost sharing as a method of financing the program, except in the case of extensive spend-down for long-term care.

The major implications for purchasing are:

- **Benefit design:** Public and private employers have the option of trading off the comprehensiveness of benefits with the participants' willingness to pay at both the premium and point-of-service levels. This approach is not an option for Medicaid programs.
- **Cost control:** Public and private employers have used point-of-service cost sharing to provide incentives to their employees for appropriate utilization of health services. Some leading purchasers have also used financial incentives at the point of health plan choice through managed competition schemes. The fee-for-service component of Medicare imposes Part B coinsurance and a hospital deductible. However, 92 percent of Medicare beneficiaries have supplemental coverage that pays some of these costs,⁷ dampening the cost-control potential. Because Medicaid programs cannot use widespread cost sharing, they must rely more heavily on utilization review and other non-financial incentives.
- **Attractiveness to contractors:** Medicare and Medicaid have typically been price-setters in both the fee-for-service and managed care markets. As a result, some providers no longer find it financially advantageous to participate in certain public programs. The American Association of Health Plans estimates that more than 711,000 Medicare beneficiaries will be affected by health plan terminations in 2001.

■ **Entitlement to an earned benefit:** To the extent that beneficiaries participate financially in the cost of their care (through premium contributions, point-of-service cost sharing, taxes, or by trading off wages for comprehensive benefits), they feel entitled to benefits. Witness the powerful senior citizens lobby for Medicare. Most Medicare beneficiaries consider their payment of social security taxes as premiums paid in advance to ensure their coverage at age 65, despite the fact that taxes paid today support those who are currently enrolled in Medicare.

Public employers face a special dilemma with employees who view their benefits as earned rights rather than as part of negotiated compensation packages. Public employees understandably resist strategies to advance state policy objectives that may have an adverse impact on their benefits or provider choice (e.g., attempts to require health plans serving public employees to contract with Medicaid).

Even the provider community has come to see Medicare (and for some providers, Medicaid) as an entitlement to a particular revenue stream.

E. PRODUCT

The products offered by different health purchasers vary by:

■ **Comprehensiveness of benefits:** All four types of purchasers provide broad coverage, although Medicare's benefit package is substantially less generous than the others. Medicaid coverage is the most comprehensive, although low provider payment levels sometimes limit access.

Government employers tend to be more generous than private companies in the scope of benefits, financial contribution, and eligibility provisions. These distinctions fade, however, when public and private employers of similar size are compared.

■ **Choice:** The majority of large employers offer a choice among multiple health plans, often with fee-for-service and/or point-of-service options. Eighty-six percent of private employees are enrolled in managed care plans, with the majority of these in point-of-service and PPO plans.⁸ While managed care plans are not new to Medicare, only 16 percent of beneficiaries are enrolled in them.⁹ Medicaid programs vary in their reliance on managed care, with the overall average enrollment at 50 percent.¹⁰ With the proliferation of Medicaid managed care programs and Medicare+Choice, public programs are likely to offer a greater range of choices to their beneficiaries in the future.

F. VENDORS/SUPPLIERS

The majority of health plans and providers participate in multiple lines of public and private business, but the whole landscape of doing business with public purchasers is in flux. Concerns about adverse risk and difficulties educating populations unfamiliar with managed care made many health plans initially reluctant to contract with Medicaid programs. Once the first few plans achieved success, others recognized a large source of new enrollment. The same pattern occurred with Medicare. The last few years, however, have seen the withdrawal of a number of players in Medicare and Medicaid managed care as plans struggle to keep these product lines profitable.

Public purchasers face several unique considerations in their supplier relationships:

- **Safety net providers:** Public purchasers, especially Medicaid, are concerned about maintaining the safety net of providers who have historically provided care to their clients. A current policy debate concerns to what extent public purchasing policy should include special protections for such providers. Medicare must also consider its disproportionate share and medical education financing policies in this context.

- **Selective contracting:** The success of Medicare selective contracting notwithstanding, most public sector contracting occurs in an environment that makes it difficult politically to have winners and losers. This is explained partly by policy objectives of choice and access for beneficiaries, and partly by economics. The latter is particularly important in rural areas, where providers may also be significant employers, and within the Medicare program, whose market share is so large that leaving a provider out may be tantamount to putting it out of business.

- **Politics:** Providers and beneficiaries are represented by state legislators, members of Congress, and organized interest groups. Even a legislator who has pushed Medicare or Medicaid to become more efficient balks when the solution harms a constituent. These political considerations are challenging, and solutions require contracting approaches that are sufficiently rigorous to withstand challenges.

Corporate purchasers are not immune to politics. They hear from employees and unions about leaving out “their” doctors, hospitals, or health plans. Corporate political objectives require sensitivity to the impact of decisions on their elected representatives. Still, government purchasers bear a larger burden dealing with politics than their private sector colleagues do.

THE CHALLENGE: HOW PUBLIC PURCHASERS CAN EXERCISE LEADERSHIP IN VALUE-BASED PURCHASING

The preceding analysis examined purchasing in its component pieces in an effort to challenge the conventional wisdom about the uniqueness of public purchasing. Public purchasers indeed face unique challenges, but not as many as they commonly assume. The remainder of this section will identify these challenges, and suggest ways to address them.

FACTORS THAT ARE INTRINSIC TO THE PUBLIC SECTOR

Certain attributes of public purchasers cannot be changed by exemptions from constraining statutes and regulations, or through new purchasing strategies. These include:

- **Doing business in the glare of the public spotlight:** Although public scrutiny presents government leaders with unique stakeholder management issues, it is also the primary vehicle for holding our governments accountable. Nonetheless, successfully managing contracts and demanding effective performance without contractors exercising political advantage is a challenge. Public purchasers must proceed with the knowledge that plans, providers, enrollees, and others can appeal adverse decisions to the legislative or judicial branches of government, which may or may not support the purchaser.

This challenge can be mitigated to some degree by giving potential contractors and beneficiaries due process, educating legislators about the rationale for decisions, and ensuring that the decisions are defensible.¹¹ Term limits in many states are creating unprecedented turnover rates in legislatures, making the education job even more challenging. Furthermore, the nature of politics means that no amount of solid technical information will ever fully protect public purchasers.

- **Competing policy agendas:** Public purchasers do not have the luxury of being single-minded in their devotion to their agency's mission. They must always consider the impact of their decisions on broader public policy agendas. Certain strategies that have been successfully employed by private purchasers will not be appropriate in the public sector. Examples include requiring hospitals to compete on the basis of price with no consideration of paying higher rates to teaching hospitals and those that provide a significant amount of charity care, and selectively contracting in ways that reduce capacity in underserved areas.

Public purchasers must exercise leadership in two ways. First, they must create a shared vision with their counterparts in other agencies. Second, they must think creatively about how to use their purchasing power to advance broad public policy goals.

■ **Special needs populations:** It is fundamental to the public mission to provide health care coverage for those most in need. Medicare and Medicaid purchasers have found that there is not a competitive market anxiously awaiting the opportunity to care for the chronically ill, disabled, and other special populations. Indeed, public programs have often been created because private markets have not served special needs groups well. Public purchasers must adapt their strategies to ensure access to high quality care for special needs groups.

Public purchasers must attempt to create service delivery markets that will effectively serve such patients. They can use their considerable economic power and research capabilities to create new strategies for the financing and provision of services to these populations, including risk adjustment, case management, centers of excellence, and service-specific carve-outs. Transitional purchasing arrangements, analogous to Medicaid's primary care case management approach, may be necessary.

FACTORS THAT ARE UNIQUELY PUBLIC, BUT CHANGEABLE

Some attributes of government bureaucracies have been with us so long, many see them as part of the fabric of public service. While some of the following suggestions may be difficult politically to accomplish, they are not impossible. And they are intentionally included so that readers will consider ways to restructure government to collaborate more closely with the private sector.

- **Reform civil service laws:** While these laws are difficult to change, some states have passed civil service reforms that give public managers greater flexibility.
- **Update purchasing regulations and contracting laws:** While these laws may also be difficult to change, initial relief in the form of expanded demonstration project authority would allow HCFA and state agencies to engage in pilot projects and learn from these experiments.
- **Provide appropriate training and beneficiary communication budgets:** Congress and state legislatures must adopt a longer term perspective regarding the need for up-front investments in these areas.
- **Allow for realistic implementation time frames:** Private sector purchasers have emphasized the importance of having realistic implementation schedules, patience, and long-term relationships rather than a short-term view. Without sufficient time to plan, implement, and educate stakeholders, public purchasers are handicapped in their pursuit of value-based purchasing. Changing the expectations of public and legislatures is a tall order, and it will require substantial adaptations in appropriations and contracting processes.¹²

UNIQUE OPPORTUNITIES FOR PUBLIC PURCHASERS

While public purchasers face special challenges that their counterparts in the private sector do not, they are better positioned to advance the state of the art in several respects. These include:

- **Quality research and dissemination of best practices:** Public purchasers are in a unique position to sponsor research in quality improvement and best practices in clinical and service delivery areas. They have access to significant databases and also to fellow agencies (e.g., Agency for Healthcare Research and Quality, Centers for Disease Control, National Institutes of Health). Pooling data from different public and private purchasers would enable researchers to ascertain the extent to which characteristics of the population should determine the best courses of treatment.
- **Development and dissemination of health plan report cards:** Many purchasers and researchers are currently involved in efforts to assess quality at health plans and provider groups. The National Committee for Quality Assurance, the Foundation for Accountability, and the research consortium developing the Consumer Assessment of Health Plans Study (CAHPS) are among those working in this area. Some duplication of effort is beneficial as these groups break new ground in measurement approaches. Greater coordination among purchasers, however, offers the potential to reduce confusion and administrative expenses.

At a minimum, public purchasers could disseminate what is working for their own populations. At the other extreme, purchasers could sponsor a cooperative approach to develop a standard set of performance reports as a public service (similar to the government automobile crash tests). A major challenge is the need for valid measurements, particularly with a public dissemination process that could have an enormous impact on the market.

- **Dissemination of successes:** Because nearly everything public purchasers do resides in the public domain, their successes are available to be adapted by other purchasers. This reduces the costs of development in the overall health care system. Diagnosis Related Groups (DRGs) and the Resource Based Relative Value Scale (RBRVS) fee schedule were initially adopted by the Medicare program. They are now widely used among other public and private purchasers. When Washington state adapted these payment methods for its major public programs (Medicaid, workers' compensation, and public employees), requests for the fee schedules from private purchasers and insurers arrived before the contracts were even completed.

■ **Incorporation of the best techniques from managed care to improve fee-for-service:**

Sometimes lost in all of the journal articles and media exposés on managed care is the fact that Medicare and Medicaid still have a significant portion of their beneficiaries enrolled in fee-for-service systems. In the short run, fee-for-service may be the only way to purchase care for certain special needs populations for whom no competitive managed care market yet exists. Because freedom of provider choice is a value held dear by many people, there may always be a place in public programs for fee-for-service alternatives.

Public purchasers have been the innovators in the fee-for-service market and have the expertise and the incentives to continue their efforts in this area. They should take the lead in developing “managed fee-for-service,” incorporating best practices from managed care while maintaining the freedom of provider choice that characterizes fee-for-service. HCFA has already done this with the incentives built into its DRG and RBRVS payment systems. Coupling these managed payment schemes with strategies such as provider profiling, pharmacy utilization programs, and case management for high-cost patients, as some purchasers have, offers the potential to keep fee-for-service options in place as long as they fill a need. Operating both fee-for-service and managed care contracting programs also provides research opportunities to investigate the differences in quality, patient characteristics, and member behavior in the two systems.

HCFA and Medicaid programs should view the operation of their fee-for-service programs as analogous to the relationship a health plan has with its providers. This will help them develop a cohesive purchasing vision rather than one that pits managed care against fee-for-service. Furthermore, this orientation will help public purchasers understand at least some of the business functions and dynamics operating in their contracting managed care plans.

■ **Innovations in caring for special needs populations:**

Public purchasers are unique in their responsibilities for special needs populations. These populations, however, are not limited to Medicare and Medicaid programs; private employers provide insurance to many disabled, chronically and mentally ill employees and dependents. The challenge for private purchasers and health plans is that they rarely have sufficient numbers of such patients to justify their investment in improving systems of care for them. Public purchasers have the opportunity to create competitive markets to serve these patients.

Demonstration projects are one key tool that government agencies can use to develop effective care systems for special populations. Not long ago, no competitive market existed to provide managed care to Medicaid recipients. Public purchasers developed that market, in some cases starting with limited pilot programs, and in others developing transitional approaches. HCFA and state Medicaid programs have the expertise within their agencies to develop innovative solutions for these populations (such as combinations of fee-for-service and capitation payments, centers of excellence, and service-specific carve-outs). And with dual eligibles accounting for one-third of the expenditures of both programs, they have an enormous incentive to collaborate.

■ **Provider training and supply:** Provider surpluses and shortages have significant impacts on health care costs and access. As the major financiers of provider training, government programs have used a number of strategies to influence the supply and distribution of providers over the years. Public purchasers can add to these efforts by using their purchasing power (through contractual requirements and incentive payments) to encourage hospitals and managed care plans to train the types of providers that the rapidly evolving system needs.

CONCLUSION

While some very real impediments to effective purchasing exist, the challenge for all purchasers, public and private, is to look for opportunities to learn from one another and

work collaboratively to shape the health care system into one that provides enhanced value to Americans.

TABLES AND EXHIBITS

TABLE 1: ATTRIBUTES OF PRIVATE AND PUBLIC PURCHASERS

ATTRIBUTE	PRIVATE EMPLOYER	MEDICARE	MEDICAID	STATE/LOCAL GOVERNMENT EMPLOYER
Mission/Values	Mission defined as purchasing value for employees. Health benefits viewed as component of total compensation. Some employers include improving the health of their work force.	Share private mission to purchase value for beneficiaries, but add public sector emphasis on equity, rights, and due process for beneficiaries and suppliers. Also see mission as furthering broader policy goals for all citizens (e.g., access, research, provider training, rural development).	Same as Medicare.	Same as Medicare and Medicaid, but with a narrower range of policy goals emphasized.
Size/Market Share	Varies from small businesses to large multi-national corporations; also includes several large employer purchasing groups.	Largest purchaser in U.S. 39 million beneficiaries (6 million dually eligible for Medicaid ¹³), and expenditures of \$217 billion, which is 19% of all U.S. health spending. ¹⁴	Often one of the largest purchasers in the state. Thirty-six million total beneficiaries, ¹⁵ including 6 million dual eligibles. Total federal and state spending is \$171 billion, which is 15% of all U.S. health expenditures. ¹⁶	Varies by state. Often one of the largest purchasers in the state.
Beneficiaries/Eligibility	Employees and dependents, sometimes including retirees and dependents. Eligibility based on employment relationship.	Generally U.S. citizens or permanent residents at least 65 years old; also includes some disabled persons and those with end-stage renal disease. Eligibility based on entitlement.	Low-income and/or disabled state residents, including special needs and long-term care population. Eligibility based on entitlement determined by categorical and income requirements.	Same as private employer.
Financing	Primarily employer-financed, ¹⁷ with contribution from employees in the form of premium and point-of-service cost-sharing. Part of total compensation determined within broader human resources strategy. Can be thought of as including a federal share due to the business income.	Primarily federally financed through general revenues and Social Security taxes. Beneficiaries contribute via their share of Social Security taxes paid while they were employed, through Part B premiums (\$45.50 per month ¹⁸), and substantial point-of-service cost-sharing.	Shared financing between the state and federal governments, with share ranging from 50-77% depending on the state. Overall average is 57% federal, 43% state. ¹⁹ Deductibles and coinsurance are permitted for some populations, but uncommon given low incomes of recipients.	Primarily employer-financed (state or local government), with some contribution from employees in the form of premium and point-of-service cost-sharing. Appropriation for health benefits usually separate from other employee benefits due to separate agency structure.

TABLE 1: (cont.)

ATTRIBUTE	PRIVATE EMPLOYER	MEDICARE	MEDICAID	STATE/LOCAL GOVERNMENT EMPLOYER
Product	Comprehensive health insurance coverage, usually with cost-sharing.	Broad health insurance coverage, but significantly less comprehensive than Medicaid or employer-sponsored insurance. Involves substantial cost-sharing (e.g., \$100 Part B deductible, \$776 per episode inpatient hospital deductible, \$194/day hospital copayment for stays between 60 and 90 days, 20% coinsurance on many Part B services). ²⁰	Comprehensive health insurance coverage, with little or no cost-sharing.	Similar to private employer.
Vendors/Suppliers	Broad array of mostly private providers/suppliers of health care services. Some public suppliers (e.g., county hospitals). HMOs and other managed health plans have 86% market share. ²¹	Same as private employers, except that HMOs and other managed health plans have much smaller market share in Medicare (6.2 million, which is 16% of enrollees). ²² Some Medicare-only health plans (e.g., PSOs) exist.	Same as private employers, with managed care plan market share of 54%. ²³ Medicaid programs also often contract with providers and health plans that serve only Medicaid recipients. Dominant purchaser of long-term care, especially nursing home care.	Same as private employers.
Process	Relationships established via contracts, often with competitive bidding involved.	Relationships established largely through application process and maintained via regulatory approaches.	Varies by state. Often a combination of contractual approach for managed care (with regulations applied) and Medicare-like approach for fee-for-service.	Similar to private employers, but with more state regulations involved.

Note: When private and public employers are compared, the focus is on large employers, since state governments are often among the largest employers in their states. The Federal Employees Health Benefits Program (FEHBP) is omitted, but may be thought of as similar to state and local government employer programs.

ENDNOTES

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