Purchasing State Employee Health Benefits:
An Overview and Options for Change

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EXECUTIVE SUMMARY

Health care costs are expected to account for a disproportionate share of growth in the state budget during the upcoming 2001–03 biennium. In response to this trend, Washington State's fiscal year 2001 supplemental budget directed the Washington State Institute for Public Policy to "analyze strategies for containing state health care expenditures."[1] As one part of that analysis, this report examines the process used by the Public Employee Benefits Board (PEBB) to purchase state employee health benefits.

Key Findings

- Growth in PEBB premiums appears to exceed that of some, but not all, other health care purchasers, implying that potential exists to reduce costs.
- Adopting policies which encourage lower premium growth may result in greater numbers of enrollees needing to change health plans.
- Three options having the potential to improve decision-making and reduce costs are identified:
  - Requiring the bidding process to occur before the state budget is passed;
  - Limiting the number of accepted bids in a geographic area based on cost (that is, premium amount); and
  - Requesting annual and multi-year bids.
- Any proposed changes to the procurement process should consider *impacts on health care access* and the *potential for unintended consequences*, such as higher costs if employees switch from managed care to fee-for-service health plans.

[1] Section 607(6), EHB 2487

I. INTRODUCTION

Although they make up 27 percent of the total state budget, health care expenditures are expected to account for 85 percent of the allowable growth in the state general fund budget for the 2001–03 biennium.[2] This disproportionate growth has prompted a renewed focus on strategies to contain state health care costs. The fiscal year 2001 supplemental budget directs the Washington State Institute for Public Policy to "analyze strategies for containing state health care expenditures."[3]

Discussions with an advisory group of legislative staff narrowed the focus of this effort to two areas, one of which is discussed here:[4] the process used to purchase managed care health benefits for state employees through the Public Employees Benefits Board (PEBB). Based on research and information from a wide variety of sources, including the Washington State Health Care Authority, the Medical Assistance Administration of the Department of Social and Health Services, and legislative staff, this report addresses the following:

- Section II, **PEBB Responsibilities**, provides a brief description of the role of the PEBB.
- Section III, **Recent Trends in Health Insurance Premiums**, examines these trends and compares them with PEBB experience.
- Section IV, **PEBB Bidding Process**, covers the process used to award health insurance contracts to managed care plans.
- Section V, **Comparing Bidding Processes: PEBB and MAA**, looks at differences between the two processes.
- Section VI, **Potential Changes to the PEBB Bidding Process**, discusses options for reducing costs.

[2] Information prepared by Senate Ways and Means Committee staff.
[3] Section 607(6), EHB 2487
[4] See Steve Lerch and Jim Mayfield, *High-Cost Medicaid Clients: Targeting Diseases for Case Management* (Olympia, WA: Washington State Institute for Public Policy, 2000) for the other area investigated under this legislative mandate.

II. PEBB RESPONSIBILITIES

State employees in Washington, like many workers throughout the United States, receive health insurance from their employers.[5] State employee health benefits are administered by the Public Employees Benefits Board (PEBB) and subject to overall spending levels established by the state legislature.[6] State employees can choose to receive their health care coverage from a managed care plan or through the PEBB-operated Uniform Medical Plan (UMP).[7]

The PEBB enters into contracts with managed care plans.[8] A limited network of physicians and restrictions on access to specialists characterize these plans.[9] Most services require a co-payment by patients, but there is no annual deductible amount. A contract with a managed care plan specifies a fixed monthly amount to be paid by the PEBB for each enrolled state employee. The payment is independent of the amount of actual health care services received by the enrolled individuals. Costs associated with managed care plans and the contract bidding process used by the PEBB are the focus of this report.

The PEBB also provides health care benefits to state employees through the UMP.[10] State employees enrolled in the UMP have few limitations on their choice of physicians and no restrictions on access to specialists. The UMP negotiates payment rates with a statewide network of physicians, and enrollees who see one of these network physicians generally pay a co-insurance amount equal to 10 percent of this negotiated rate. UMP enrollees may also see physicians who are not part of the network, but enrollees are likely to pay higher out-of-pocket costs. In addition to co-insurance, UMP enrollees are responsible for an annual deductible amount of $200 for an individual or $600 for a family. PEBB payments to health care providers under the UMP are on a per service basis and are directly related to the amount of health care services received by plan enrollees.

[5] Depending upon the state, 66 to 86 percent of adults receive health care coverage through employers. See Stephen Zuckerman, et al., *Snapshots of America's Families: Variation in Health Care Across States*, (Urban Institute Discussion Paper 99-18, December 1999).

[6] In addition to state employees, some K-12 school district and local government employees receive health benefits through the PEBB. The PEBB is also responsible for providing life insurance and disability insurance benefits to eligible employees, but this report focuses solely on the role of the PEBB in providing state employee health benefits.

[7] Depending on their county of residence, state employees may have a choice among one or more managed care plans; the Uniform Medical Plan is available in all counties.

[8] Most states offer health insurance to their employees through both "fee-for-service" (like the Uniform Medical Plan) and managed care plans. See Matthew Maciejewski, et al., "How Do States Buy Health Insurance for Their Own Employees?" *Managed Care Quarterly* 5, no. 3 (1997).

[9] Some PEBB managed care plans allow enrollees to "self-refer" to specialists but at an additional cost.

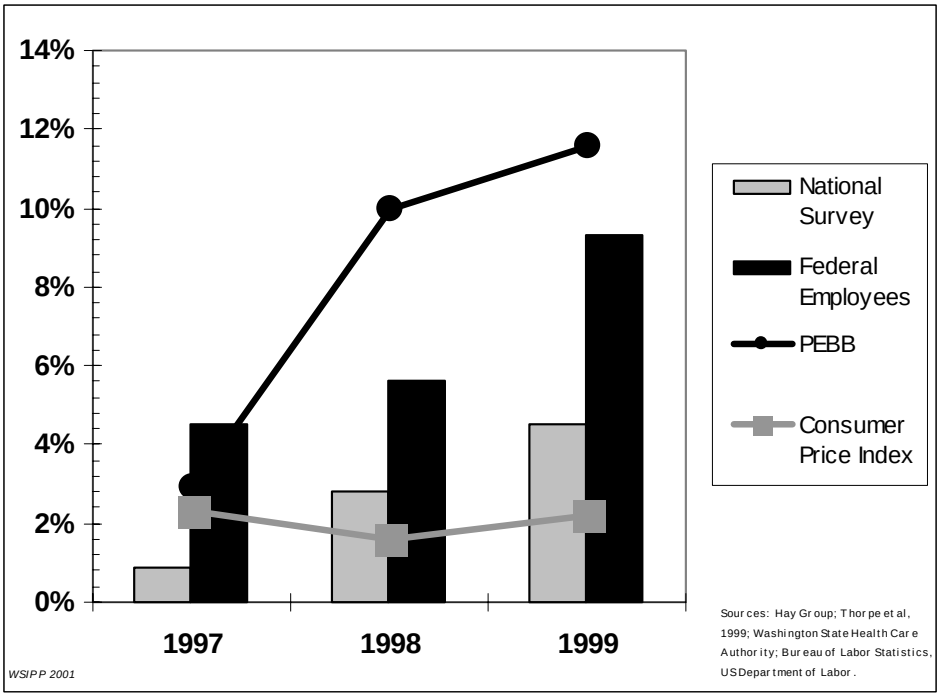
[10] The Uniform Medical Plan is administered by Washington State Health Care Authority, which is the parent agency of the PEBB.

III. RECENT TRENDS IN HEALTH INSURANCE PREMIUMS

As a starting point in examining the costs associated with PEBB health benefits, it is useful to look at the recent experience of other health care purchasers. Drawing conclusions from any comparison of health costs must be done cautiously. Differences across health care purchasers with regard to services covered, number and characteristics of individuals insured, and other factors can lead to justifiable differences in costs. We focus on the growth rate of overall premiums, rather than on actual dollar amounts, to provide greater comparability across health care purchasers.[11]

Exhibit 1 displays annual percentage changes in premiums for health maintenance organizations (HMOs) between 1997 and 1999 from a national survey of private firms and state and local governments,[12] the Federal Employees Health Benefits Program (FEHBP),[13] and the PEBB. As a point of reference, the inflation rate (measured by the Consumer Price Index) is also included. As the graph indicates, insurance premiums have been rising faster than inflation since 1997.

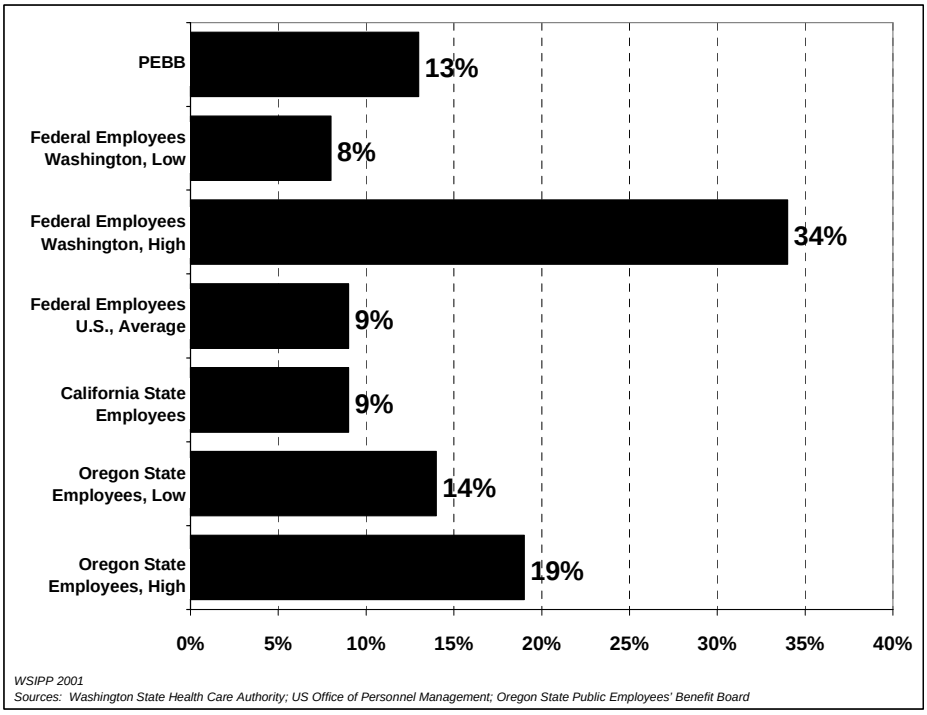
Exhibit 1
Managed Care Premium Growth Rates and Inflation, 1997–1999



[11] For example, if Employer A covers vision services but Employer B does not, the difference in premium amounts may reflect only the difference in covered services. However, the growth in premiums for each employer reflects the change in their health care expenditures, which is largely independent of differences in benefit packages as long as no covered services are added or deleted.
[12] These data are from an annual survey conducted by the Hay Group benefits consultants and available online at http://www.haygroup.com/studies/hbr.asp.
[13] Average premium growth rates for HMOs available to federal employees are from Kenneth W. Thorpe, et al., "Market Incentives, Plan Choice, and Price Increases," *Health Affairs* (November/December 1999).

Exhibit 2 displays the expected premium increases, based on signed contracts, for 2001 for state employees in Washington (PEBB), for two nearby states (Oregon and California), and for federal employees both nationally and in Washington State. Premium growth ranges from a low of 8 percent to a high of 34 percent.

Exhibit 2
Managed Care Premium Growth Rates, 2001



WSIPP 2001
Sources: Washington State Health Care Authority; US Office of Personnel Management; Oregon State Public Employees' Benefit Board

Over the 1997–1999 period, Exhibit 1 suggests that average PEBB premium growth has tended to run somewhat above the experiences of other health care purchasers.[14] However, for the current period, the picture is a bit more mixed. Based on contracts in effect for 2001, the average growth rate for federal employees across the country (9 percent) and for California state employees (9 percent) are below the PEBB growth rate of 13 percent. On the other hand, the lowest premium growth rate among HMOs available to Oregon state employees is 14 percent. For HMOs available to federal employees in Washington State, premium growth rates are as low as 8 percent and as high as 34 percent.

As noted above, differences in the environments faced by health care purchasers suggest caution in any comparisons of premium growth rates. Nonetheless, the information in Exhibits 1 and 2 suggests that, while the growth in PEBB premiums is below that for some health care purchasers, it is also above growth rates experienced by some national and regional employers. This implies that some cost savings may be available by modifying PEBB procurement processes and practices.

[14] Based on a national survey of private and public employers, this trend would appear to be true for 2000 as well; the PEBB growth rate for 2000 is 12 percent, while the comparable figure for HMOs from the Kaiser Family Foundation survey is 8 percent. See *Employer Health Benefits 2000 Annual Survey* available online at http://www.kff.org/content/2000/20000907a/.

IV. PEBB BIDDING PROCESS

Interested managed care plans submit bids to the PEBB for health insurance coverage for state employees and their dependents. Each bid covers the same set of health care services.

Plans specify the counties they will cover and the premium amount they require to provide health insurance to an average state employee.[15] Regardless of which counties or the number of counties a plan will cover, it may submit only one premium amount for its bid.

Co-Payments

The PEBB sets the fees, referred to as co-payments, which must be paid by managed care plan enrollees at the time a health care service is received. For example, $10 is the current co-payment charged for a physician office visit.

Co-payment amounts affect the revenue managed care plans receive, and, therefore, the premiums they charge the PEBB for health insurance. PEBB bid requests specify the co-payment to be charged for each service. They may also ask that plans submit separate premium bids for several different co-payment scenarios. The PEBB considers the change in premiums and the corresponding impact on out-of-pocket expenses for state employees in choosing a set of co-payments.

Analysis of Bids

Health plans must include the data and assumptions used to develop their bid. Actuaries from the Washington State Health Care Authority (HCA) and each health plan meet to analyze and verify this information. The financial stability of health plans and the quality of services they provide are also considered in the analysis of bids. In instances where HCA actuaries[16] disagree with assumptions or analytic methods, plan representatives are asked to recalculate their submitted premiums.

This process, of course, does not necessarily lead to identical bids across health plans. Costs of providing health care will differ across plans for a variety of reasons, and these differences will be reflected in premium bids. If a plan can defend its bid based on data and reasonable assumptions, it receives further consideration.

If a plan submits a bid that, although justified on actuarial grounds, is considered by the PEBB as too expensive with respect to funding or compared with other plans, it will be asked to submit a lower bid. Following this second round of bids, the PEBB will offer a

[15] Health plans are requested to submit a premium bid for a single individual. Premium amounts for employees with spouses and children are then calculated based on the individual premium. See the Health Care Authority's publication, "PEBB General Rate Instructions and Forms."
[16] HCA receives actuarial services through a contract with William M. Mercer.

contract to each plan that has submitted a "reasonable" and actuarially sound premium for all counties in which it bid.

Adjustment for Enrollee Health Risk

Health plans contracting with the PEBB are not paid the premiums stated in their final bids. The actual premium to be paid to each plan is adjusted to account for the health status of each plan's enrollees.[17] This process is referred to as "risk adjustment."

Risk adjustment acknowledges that some plans may have relatively healthy enrollees while others may have a relatively unhealthy pool. Because bids are intended to reflect the costs of providing health care coverage to the average state employee, a plan with healthier-than-average (low risk) enrollees would be overpaid while a plan with sicker-than-average (high risk) enrollees would be underpaid. Without risk adjustment, health plans with high-risk enrollees would accumulate losses and eventually drop out of the state employee market, reducing competition and access to health care.

To avoid this problem, the health risk of each state employee (and covered family members) is established based on their recent use of health care services. Premiums are increased to plans that enroll high-risk individuals and reduced to plans that enroll healthier low-risk individuals. The risk adjustment process is designed so that the statewide amount of premium increases equals the statewide amount of premium reductions. This budget-neutral design ensures that total premiums across all plans remain the same as they would without any adjustment for enrollee health risk.

Adjustment for Geographic Incentives

Seven Washington counties (Asotin, Clallam, Garfield, Jefferson, Klickitat, Pacific, and Skamania) had no or only one managed care plan with a PEBB contract for calendar year 2000. To encourage plans to bid in these counties for 2001, increased premiums are offered to plans with an above-average share of enrollees in these seven counties. As is the case with the risk adjustment, the geographic incentives are designed to be budget neutral.

"Index Premium" and Employee Co-Premiums

Using the overall funding level for state employee health benefits established in the biennial budget, the PEBB calculates an "index premium." The index premium is the per employee amount, based on the funds appropriated by the legislature and other PEBB sources, that is available to pay for health insurance.[18]

[17] The risk adjustment process occurs in January after each plan's enrollment for the coming year has been finalized.

[18] The PEBB has the authority to use available funds beyond the legislative appropriation for state employee health benefits to increase the index premium and thereby reduce co-premiums.

This amount then serves as a benchmark in the bidding process—the costs for any managed care plan that bids at or below the index premium are fully paid with state funds, and employees are not required to pay a share of the monthly premium (often referred to as a co-premium). Likewise, the costs for any plan that bids above the index premium cannot be fully covered with state funds and will thus require a monthly employee co-premium equal to the difference between the plan's premium bid and the index premium.

Two key points concerning employee co-premiums should be noted:

- Each autumn, state employees have the option to change health plans. Some employees will switch to a new plan based on the co-premium amount, providing plans with an incentive to submit lower bids. The higher the index premium, the smaller will be the difference in co-premiums across plans and, presumably, the smaller will be the incentive for plans to submit low bids.
- Because the legislative appropriation for employee health benefits is made before health plans submit bids, the legislature has a limited ability to define employee co-premiums.

V. COMPARING BIDDING PROCESSES: PEBB AND MAA

It is difficult to obtain detailed information on how health care purchasers other than the PEBB negotiate contracts with managed care plans.[19] However, the Medical Assistance Administration (MAA) of the Department of Social and Health Services, a major state purchaser of health care, has recently completed its bidding process for the Medicaid program. This section provides a comparison of the PEBB and MAA bidding processes.

Most individuals receiving health care coverage through the Medicaid program in Washington State are enrolled in a managed care plan. Each year, the MAA solicits bids from managed care plans to provide coverage to Medicaid recipients through its Healthy Options program.

Although there are substantial differences in the missions of the PEBB and the MAA and in the populations they serve,[20] a comparison of the two bidding processes is useful.

In soliciting bids from health plans for calendar year 2001, MAA introduced several new standards and selection criteria. It established a maximum premium, such that bids above the maximum would not be accepted. It also published a guaranteed acceptance premium, with any bid at or below this amount automatically accepted.

Based on the number of bidders in a region,[21] MAA determined the minimum number of bids it would accept. For example, if four plans submitted bids below the maximum level in a region, MAA would contract with at least two plans. The following steps are used to determine which plans would receive contracts:

Step 1: All plans bidding at or below the guaranteed acceptance level receive a contract; if the desired minimum number of plans receive a contract, no more contracts are offered.

Step 2: If fewer than the desired minimum number of plans received contracts in Step 1, the MAA contracts with plans bidding above the guaranteed acceptance level, starting with the lowest premium bids, until the desired number of contracts are awarded.

Step 3: Any plan whose bid is rejected in Steps 1 and 2 is offered a contract at 2 percent below the lowest accepted bid in the region.

One result of this three-step process was very aggressive bidding by plans. Eleven of 12 regions had one or more plans bid at the guaranteed acceptance level. The overall impact was a contracted premium growth rate of 4 percent for Medicaid managed care plans in

[19] In a survey of 14 large U.S. corporations, James Maxwell, et al., suggest that competitive bidding and designing employee co-premiums to create incentives to choose lower cost plans are becoming more common in private sector health care purchasing. See "Managed Competition in Practice: 'Value Purchasing' by Fourteen Employers," *Health Affairs* 17, no. 1, 217-226.

[20] Through Medicaid Healthy Options, MAA provides free health care to qualifying low-income persons, primarily women and children. The PEBB provides health insurance to state employees and their families as part of overall compensation.

[21] MAA established 12 regions within the state; health plans could bid on any or all of the 12.

Washington State for 2001, well below the growth rates experienced by most other health care purchasers (as demonstrated in Exhibit 2).

A second result, however, is that many Medicaid recipients will need to change health plans for 2001. Some health plans did not receive contracts in areas they served in 2000, and one county will not have any managed care plans in 2001. The combined impact of these changes will require 139,000 Medicaid-managed care enrollees (30 percent) to switch health plans next year, although not all of these individuals will have to switch physicians.

In comparing the PEBB and MAA bidding processes, it is important to consider several key differences that may affect the applicability of MAA bidding strategies to the PEBB process. Medicaid has many more enrollees than the PEBB—roughly 455,000[22] compared with 300,000. Because of this size difference, health plans are likely to compete more vigorously and be more willing to submit lower bids for MAA Medicaid contracts than for PEBB contracts.

Another important difference concerns the availability of managed care coverage across the state. If the PEBB were unable to successfully contract with a managed care plan for a particular county, the alternative would be for state employees to join the fee-for-service Uniform Medical Plan (UMP). Given the reimbursement rates and employee cost-sharing for the UMP, this could result in higher expenses for the PEBB, state employees, or both relative to a managed care plan.

The alternative to managed care under Medicaid is somewhat different than for the PEBB. If no managed care plan was willing to bid below the MAA-established maximum premium in a county, Medicaid enrollees would receive care on a fee-for-service basis. Because they do not pay any out-of-pocket expenses for health care, this would not financially impact enrollees. Medicaid fee-for-service reimbursement is relatively low compared with other insurers, so the difference in financial impact between managed care and fee-for-service for MAA is unlikely to be as large as for PEBB. However, access to health care may become more difficult compared with managed care, as the relatively low Medicaid fee-for-service reimbursement means that some providers will be unwilling to see Medicaid patients.

Finally, the differences in the PEBB and MAA bidding processes underscore an important trade-off between cost and enrollee choice. Overall premium growth for PEBB contracts in 2001 is 13 percent. However, nearly all the plans available to state employees in 2000 are also available in 2001, so only 6,600 enrollees (about 2 percent) need to switch plans. In contrast, MAA premium growth is a much lower 4 percent, but 139,000 enrollees (30 percent) must switch health plans.

Because of the dissimilarities between the two programs, it is unlikely that the PEBB could adopt the MAA bidding process and expect a similar degree of savings. In addition, the impacts of any change to the PEBB bidding process should be evaluated in terms of both cost savings and changes in enrollee choice. However, there are several areas worth consideration for future rounds of bidding.

[22] This excludes Medicaid aged and disabled populations that are not enrolled in managed care plans.

VI. POTENTIAL CHANGES TO THE PEBB BIDDING PROCESS

The following three options provide opportunities to improve the budgeting process for state employee health benefits and have the potential to reduce costs:

- Require the bidding process to occur before the state budget is passed.
- Limit the number of accepted bids based on premium amount.
- Request plans to submit annual and multi-year bids.

Require the Bidding Process to Occur Before the State Budget Is Passed

Currently, the PEBB contracts with health plans annually based on a bidding process that occurs after biennial and supplemental budgets are passed each year. Therefore, the legislature funds state employee health benefits based on estimated rather than actual costs. As a result, the amount of employee cost-sharing increases or decreases depending upon whether actual costs are above or below the estimate. This arrangement makes it difficult for the legislature to set overall employee compensation, because it cannot coordinate health benefit cost sharing with salary increases.

By moving up the timing of the bidding process and starting the annual contract period in July, the legislature would know actual employee health care costs prior to passage of the budget. This option is advantageous because health plans would not have advance knowledge of the appropriations level; therefore, bidding could theoretically be more competitive if conducted prior to passage of the budget.

The potential difficulties with this option also have to do with timing. Most employers contract with health plans on a calendar year basis, starting in January. Therefore, PEBB contracts with a July start date may impose some additional administrative burdens on health plans that could be reflected in premium bids.

The advantages to this option relate more to improving the information available to the legislature for budget considerations rather than to directly producing cost savings. Establishing a bidding process prior to completion of the budget, and therefore before health plans have information about health benefit appropriations, may restrain premiums. However, the required actuarial analysis of bids under the current process means that such savings are likely to be limited.

Limit the Number of Accepted Bids Based on Premium Amount

Subject to PEBB analysis establishing that bids are actuarially sound and within a "reasonable" range, there is no limit to the number of plans with which the PEBB will contract. One option that could result in cost savings is for the PEBB to contract with only the lowest bidders in each county.

The potential savings from this approach would come from two sources. First, health plans have a greater incentive to restrain their bids under such a policy to increase their likelihood of obtaining a contract. This should reduce the overall growth in premiums. Second, by contracting with only those plans that submit the lowest bids, costs will be lower simply by having excluded the higher-priced plans.

The difficulty with this option relates to problems in contracting with health plans in rural counties. Few plans are interested in operating in smaller rural counties, so it is desirable to contract with any plan willing to cover those areas. However, if a plan that bids in a rural county were to have its bid rejected in a larger urban county, the plan may be unwilling to accept a bid for only the rural county.

One way to avoid this problem is to create a link between contracts for rural and urban counties. For example, any plan bidding on specified rural counties could be guaranteed a contract for any non-rural county in which they also bid. This would avoid the potential loss of health plans in rural areas but would also likely diminish the cost savings available from implementing the overall option.

Request Plans to Submit Annual and Multi-Year Bids

PEBB contracts have typically been annual or, if they cover multiple years, call for annual renegotiation of premiums.[23] In general, health plans have been reluctant to enter into multi-year contracts with fixed premiums. With increasing uncertainty in the health care market, this appears to be especially true at present.[24]

Multi-year contracts with annual premium renegotiation do little to reduce PEBB administrative costs since much of the contract administration expense relates to analyzing and negotiating premiums. However, health plans do receive a benefit from such contracts. For those health plans that have signed a multi-year contract, potential competitors are excluded from contracting with the PEBB during the life of the contract. This helps to ensure the share of the state employee market available to contracting health plans.

This rather one-sided benefit suggests that the PEBB should consider requesting plans submit bids for both an annual and a multi-year contract. If the plans value the protection associated with a multi-year contract, they should be willing to bid a lower premium (at least in the first year of the contract) than for an annual premium. However, because a multi-year contract does reduce competition in the subsequent years of the contract, the PEBB will need to be especially vigilant during premium renegotiations.

For the near future, HCA staff and actuaries expect few, if any, new health plans to compete for PEBB contracts, limiting the savings from this option. However, over time, market conditions will change, and new plans are likely to emerge to compete for PEBB business.

[23] The one exception to this was a two-year contract during 1996 and 1997 with fixed premiums.

[24] In an October 10, 2000, telephone conversation, actuaries James Matthisen and Dave Frazzini of William M. Mercer indicated that most private sector health plan contracts cover a single year; they did not believe any health plans would agree to a multi-year contract without a provision to annually renegotiate premiums.

In addition, any changes to the bidding process which limit the number of accepted bids will also increase the value of a multi-year contract to health plans. Therefore, implementing this option is likely to produce benefits for the future rather than the near-term.

Requesting both annual and multi-year bids should add little, if any, new costs to the PEBB or to health plans. Those plan representatives who believe multi-year contracts are in their best interest will submit slightly lower bids than for an annual contract, while those who are indifferent will submit identical multi-year and annual bids. The PEBB could continue to use its current process to verify the data and assumptions used to generate bids but then choose to enter into either multi-year or annual contracts depending upon which is less expensive across all bidders.

VII. CONCLUSION

The comparison of premium growth between the PEBB and other health care purchasers over the last three years and for 2001 suggests that cost-saving changes to the bidding process may be possible. This report suggests three options that may improve budgeting and reduce costs for state employee health benefits:[25]

- Complete the bidding process before the state budget process;
- Limit the number of contracts offered in an area based on premium amount; and
- Require plans to submit bids for both annual and multi-year contracts.

However, modifications to the bidding process must be carefully considered and the potential impacts weighed. For example, any changes that result in a county losing access to managed care will increase enrollment in the Uniform Medical Plan and may increase costs in that county for the PEBB, state employees, or both.

The comparison with the MAA bidding process suggests that premium savings may require at least some enrollees to change health plans. Physicians may have contracts with multiple health plans, so changing health plans may or may not require changing physicians. Nonetheless, switching health plans can be confusing and upsetting to enrollees.

Therefore, while it appears that the potential for savings exists, a *thorough analysis of bidding process changes will be necessary* before proceeding. Identifying how managed care plans will respond to a specific change is difficult, so the true impacts of any change are likely to be revealed only after plans have responded to a modified procurement process. This means that the PEBB must be prepared to respond to a range of responses as they implement bidding process changes.

[25] To assist the PEBB in monitoring the impact of any changes to the bidding process, it will be desirable to maintain a database containing the health plans' initial bid, final bid, and counties covered for each procurement.