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Corporate Health Care Purchasing and the Revised Social Contract With Workers

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The implicit social contract between large companies and their employees has been recently revised to emphasize workforce flexibility and the financial responsibility of individual employees for their own employment and benefits-related decisions. The most recent aspect of this social contract to be significantly changed is health care benefits. On the basis of in-depth case studies of health benefits purchasing at 15 large United States employers, the authors found that the reported use of a purchasing technique called *managed competition* has enabled firms to bring health benefits purchasing in line with other elements of the revised social contract. An important minority of companies in our study appear to have retained a different, "employer responsibility" approach toward employee health benefits, leading them to move more gradually to managed competition purchasing and refrain from instituting heavy premium cost sharing or cutting coverage for their employees. These findings are preliminary and deserve further study as to their generalizability and persistence.

Since the middle of the 20th century, an implicit social contract has governed relations between large companies and their employees. The contract was characterized by long-term job security, a "living wage," and generous health insurance and pension benefits for employees and their dependents (Cappelli et al., 1997; Kochan, 1999). In the 1980s, however, in response to mounting business competition and other pressures, managers at many large firms told their employees that they could no longer afford to guarantee long-term employment. Soon thereafter, many companies curtailed other employee benefits such as retiree pensions. A new

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social contract was emerging, emphasizing workforce flexibility and the responsibility of individual employees for their own employment and benefits-related decisions (Burack, 1993; Cappelli, 1999).

The most recent aspect of the social contract to be revised has been health care benefits. The widespread application of a purchasing technique called *managed competition* has allowed health benefits purchasing to be brought in line with other elements of the revised social contract. Managed competition uses employee premium cost sharing to sensitize employees to the costs of their health plan choices. Under the theory, a company sets the employer premium contribution to a fixed level (e.g., 70% of the lowest cost plan) and requires the employee to bear any additional premium costs (Enthoven, 1989). As a result, managed competition leads employees to choose more cost-effective forms of health care delivery, such as HMOs and other types of managed care. (*Managed competition* is a way to organize the market for health care to emphasize consumer choice between forms of health care delivery, one of which is managed care.)

This article explores the relationship between the revised social contract and changes in health benefits. Managed competition's explicit reliance on market principles was found to fit logically with previously revised components of the social contract, many of which emphasized the financial and decision-making autonomy of the employee. Through these changes in health benefits, companies fixed their financial liabilities and shifted costs and other responsibilities to employees. These changes mirror earlier moves toward defined contribution pensions and variable compensation. They are also connected to broader changes in employment including downsizing and contingency work, which affected the rates and strategies used to implement the changes. This article does not focus on changes in purchasing strategies themselves (e.g., the use of financial incentives, competitive bidding, or quality programs) or the changing organization of purchasing within the firm (e.g., the use of finance or procurement staff), which we have covered elsewhere (Briscoe & Maxwell, 1999; Maxwell et al., 1998). Instead, we place health care purchasing in the overall strategy of large firms.

The remainder of the article is organized into four major sections. First, we review our methods. The next section provides background on the older social contract between large employers and employees, and on the origins of managed competition in the private sector. In the third section, we argue that changes in health care purchasing are linked to the wider transformation of the social contract. Two important aspects of this link, the challenge of downsizing and evidence of an alternative approach that retains commitment to employees, are described in more detail. The final

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Table 1
Characteristics of Companies Studied

Company	*Revenue (billions, 1996)*	*Number of Employees in United States / Distribution*
Boston, Massachusetts		
GTE Corporation	21.3	83,000 in United States/dispersed
Digital Equipment Corporation	14.5	59,000 / concentrated in Massachusetts
Raytheon Company	12.3	75,000 total / concentrated in Massachusetts
Bull Information Systems (member of Groupe Bull)	0.7	1,500 / concentrated in Massachusetts
Orlando, Florida		
Disney	12.1	71,000 / concentrated
Orange County Public Schools	1.0 budget	23,000 / concentrated in Florida
Minneapolis, Minnesota		
American Express	16.2	51,000 in United States/ concentrated in Minnesota + dispersed
General Mills	5.5	9,800 / dispersed
3M (Minnesota Mining & Manufacturing Company)	14.2	45,000 / concentrated in Minnesota
Dayton Hudson Company	28	150,000 / dispersed
Minnesota State Employees	NA	140,000 / concentrated in Minnesota
Northern California		
Union Bank	0.2	8,000 / concentrated in California
Lockheed Martin–Space and Missiles Division	7.8	19,000 in division / concentrated in California
Pacific Telesis	9.0	49,000 / dispersed
Fireman's Fund Insurance	NA	8,000 / concentrated in California

Note: NA = not applicable.

section explores some of the implications of these changes for firms, workers, and public policy.

METHOD

Our findings are based on a study of health care purchasing at 13 of the largest American firms and two public organizations, selected for their strong reputations as front-runners in the move to managed care (see Table 1). In combination, the diverse firms in our study purchased health care for more than 1.6 million workers, retirees, and dependents and exert influence over more than 2 million more through purchasing alliances.

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We limited our selection to purchasers that had substantial numbers of employees in one of four managed-care markets: Boston, San Francisco, Minneapolis, and Orlando. Each of these markets had been shaped, in part, by the practices of large purchasers, both independently and through business coalitions. These are all mature managed-care markets. Orlando differs somewhat from the other three markets, however, in that managed care arrived later to the region but has developed very rapidly in recent years.

We selected the firms within the four regions to fit the following criteria. We started with a set of companies that held high profiles as early innovators in the move to managed care. These companies figured prominently in trade press and in the available academic literature. In selecting companies, we also took care to include a balance of manufacturing and service firms. The firms selected were diverse in their geographic presence, industry, financial performance, and size (see Table 1). They ranged in size from the telecommunications giant GTE with more than 250,000 employees and dependents, to Bull Information Systems that recently downsized from 10,000 to roughly 1500 employees, to American Express that has banded together with 10 other large purchasers to buy benefits for millions of employees and dependents. They represent firms operating in diverse sectors, including retail, manufacturing, service, and finance and insurance. In addition to 13 private purchasers, the sample included 2 innovative public purchasers that are included in our analysis where appropriate.

In just the few years since the firms in our study began changing their health care purchasing practices, thousands of other large and small companies have followed suit. This is evidenced by the rising portion of workers enrolled in managed-care plans (from 48% in 1992 to 87% in 1998), according to a recent study conducted by the Employee Benefit Research Institute (McDonnell & Fronstin, 1999).

The data for this study come from interviews with 91 officials of the sample companies themselves, the health plans they contracted with, health care purchasing coalitions they participated in, and health benefits consultants they retained. The interviews were semistructured and followed a written protocol. At least one study author was present during all of the interviews to ensure consistency across the interviews. The initial company interviews were almost always conducted on-site at the corporate headquarters and lasted from 1 to 2 hours. Follow-up discussions were conducted with representatives of all 15 organizations during the weeks following the initial interview. In some cases, several follow-up discussions were conducted.

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We interviewed 25 senior managerial staff at the 15 participating organizations. These included 12 health benefits managers, 3 senior executives with responsibility for health benefits (director or vice president level), 7 senior executives with responsibilities broader than health benefits (such as vice president for human resources, director of compensation and benefits, and worldwide benefits director), 2 finance managers (involved in health benefits purchasing), 1 former health benefits manager (now doing independent work in health benefits purchasing), and 9 consultants who worked on a long-term basis with these companies.

We also interviewed 49 officials at 17 regional and national health plans about the health purchasing practices at specific corporations. These interviews provided another valuable perspective on individual corporate practices. Interviewees included health plan directors, medical directors, senior staff responsible for clinical quality, and marketing managers (corporate account representatives). Finally, we interviewed 8 officials from six business coalitions in which the firms participated.

In addition to interview records, we obtained documents from each company in the study. We specifically requested standardized data on benefit design, health plan premium costs, and enrollment for recent years. In some cases, this information proved to be noncomparable across firms.

The link between the revised social contract and changes in health benefits emerged directly from our 15 case studies. The specific characteristics of this hypothesized link were observable at the corporate level through our detailed case studies. However, the resulting changes in health benefits are also emerging in nationwide trends found in the health and human resource literature, cited throughout this article. Our work on this subject is preliminary in nature and deserves further substantiation through more systematic means, as discussed in the conclusions.

BACKGROUND

The Implicit Social Contract and Health Care Benefits

For nearly four decades following World War II, an implicit social contract governed relations between large corporations and their employees (Jacoby, 1998; Kochan, 1999).[1] This implicit contract with workers was characterized by long-term job security and the prospect for career development and promotion within the company. It also ensured a "living wage," which was usually sufficient to buy a house and save for the future, as well as generous health and retirement benefits in the form of health care insurance for the whole family and a company-sponsored old-age

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pension (Cappelli et al., 1997; Kochan, 1996). Health care benefits were an essential and popular component of this social contract (Sapolsky, Altman, Greene, & Moore, 1981).[2] Although the social contract by no means covered all of American industry, it did provide stability and a high quality of life for a large segment of the workforce (Institute for Work and Employment Research, 1998). In addition, considerable variation has always existed both across and within industries and employers.

By the 1980s, many U.S. corporations confronted a new business environment that encouraged radical changes in the social contract with employees. Increasing competition had begun to undercut the market share of U.S. firms in some industries, while the globalization of financial markets favored investment in new opportunities overseas. Also, the ever-increasing occurrence of hostile takeovers encouraged shorter term managerial decision making.

All of these factors led to an increased pressure to cut costs and gain flexibility (Blair, 1995; Scherer, 1995). As a result, corporations began to revise the social contract with their employees, favoring a more flexible, lower-commitment relationship (Kaysen, 1996).[3] One index of change in the social contract was the replacement of defined benefit pension plans with defined contribution pension plans and 401ks.

Changes were being made to the basic social contract, but health benefits remained relatively unaltered. However, independent pressures were making health care benefits an increasingly costly and worrisome liability for employers. This is documented by rising company expenditures for health care benefits throughout the 1970s and 1980s. The increase in health care costs was due, in part, to the expansion of extensive insurance coverage and the widespread application of costly medical technologies, such as neonatal intensive care units, CT scanners, and magnetic resonance imaging (U.S. Office of Technology Assessment, 1995a, 1995b, 1995c).[4] Faced with these pressures, many corporate managers felt that they could no longer absorb health insurance premium costs that were escalating at double-digit annual rates in the late 1980s.

One might have expected corporate officials to address the rising costs of health care in tandem with other aspects of the social contract like pensions, but employer-sponsored health care clearly was a sensitive topic to labor representatives, lawmakers, and the general public (Enthoven & Singer, 1996; Sapolsky, 1991). As a result, companies tried smaller incremental steps such as the use of co-payments and self-insurance to curb health care expenditures rather than wholesale revision of health benefits. Although these measures may have moderated costs temporarily, they failed to affect the underlying rate of health care inflation. Corporate officials concluded that more radical measures would be necessary to halt the

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ever-rising cost of health care. Companies sought a way of reducing these expensive commitments to their employees, dependents, and retirees.

The Elevation of Managed Competition in the Political and Business Arenas

In the early 1990s, the Clinton health care reform proposals provided a possible solution to spiraling corporate health care costs. The Clinton reforms set forth a version of managed competition to be implemented under a public regulatory framework, an action that many companies opposed.[5] However, during the highly publicized debates and associated meetings of concerned corporate officials, the visibility of "managed competition" was raised in the political and business arenas and legitimated as a means of achieving cost control in health care.[6] If the government was seriously considering managed competition as a means of controlling health care costs for all citizens, surely individual companies could safely approach the subject with regard to their employees.[7] In the end, a private-sector transformation of corporate benefits purchasing occurred, but it had been set in motion by events and ideas from the public arena.

The core concept of managed competition involves offering employees the option of purchasing health benefits from a selected set of differently priced health plans (Enthoven, 1980, 1989, 1993). Consumers (employees) keep down the cost of health care by forcing health plans to compete among themselves, just as the producers of other goods and services do. The cost to employees is determined by tying employee premium contributions for all plans to the price of the least-cost plan. To facilitate employee choice among plans, employers provide information to them on quality and consumer satisfaction at health plans. This encourages premium price competition among health plans by sensitizing employees to the costs of differently priced plans. Paid on a capitated basis, health plans compete for subscribers by cutting costs and premium prices. Companies take on an active role as employee benefits "sponsors" by forcing the standardization of health plan offerings through a competitive bidding process.[8]

The private-sector version of managed competition appealed to benefits managers for several reasons. Most important, the scheme promised to save employers large sums of money. In addition, it seemed easy to implement. Managed competition provided a set of tools to use in moving from higher-cost benefits coverage to a managed-care benefits system. As described above, employee premium cost sharing was the primary vehicle for achieving cost savings. Many large companies also implemented competitive bidding to enhance their negotiating clout with managed-care organizations. Many of these techniques, such as bidding, outsourcing,

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and total quality management, were already familiar to managers from other areas of business.

Within the health care system, these changes achieved cost savings, but initially not in the ways hoped for. Managed-care officials report that their cost savings did not arise from fundamental restructuring of the way in which heath care is delivered but rather by squeezing the payments made to hospitals and physicians. Managed-care plans passed on some of the premium reductions to these "upstream vendors" by exploiting excess hospital and physician-specialist capacity. They did this by putting physicians, hospitals, and pharmaceutical companies at greater financial risk or by discounting their fees. Managed-care plans based their negotiating leverage to obtain these savings on steadily growing enrollments (Maxwell, Briscoe, Davidson, et al., 1997).

CHANGES IN HEALTH BENEFITS FIT THE REVISED SOCIAL CONTRACT

Health benefits officials were impressed by the potential of managed competition because it seemed philosophically and logically consistent with other aspects of the revised social contract.[9] The revised social contract is based on an "individual responsibility" policy in which the corporate commitment to workers is short-term and where all or part of the financial responsibility for benefits is shifted to the employee (Burack, 1993; Cappelli, 1999; Noer, 1993). Pension contributions, for example, have been modified so that employers are only obligated to provide a regularly scheduled "defined contribution" to a pension fund during the period of employment, rather than promising a "defined benefit" at some future time (Clark, 1999; Mitchell, 1998). In this way, firms avoid having to provide future cash disbursements of an uncertain value to retirees, greatly limiting corporate fixed liabilities (Acs & Steuerle, 1997). With lower fixed costs for pensions, firms could be more flexible in responding to new business opportunities.

Ten of 13 companies in our study followed this new individual responsibility policy, seeing advantages in having a flexible and lower-commitment contract with their workforces (two of the remaining five organizations were public-sector organizations and were therefore under different constraints). Those firms subscribing to this approach found the new health benefits policy to be consistent with an overall human resource policy of individual responsibility in two ways. First, changes in health benefits were *cognitively aligned* with the new social contract because they relied on the "individual responsibility" of employees for their own

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decisions. Individual responsibility emphasizes the employee's role as that of an empowered consumer rather than an entitled recipient with regard to health care and other benefits (just as the employee is an empowered supplier of work rather than entitled recipient of a corporate job). In interviews at 5 of 13 companies, officials described their health benefits, as well as other aspects of compensation, as being explicitly aligned with the new social contract.

Second, changes in health benefits were *functionally equivalent* to other changes because they fixed future financial liabilities for the firm, shifting them to employees. Specifically, through the use of employee premium cost sharing, the central component of managed competition, individual employees would share financial responsibility for the costs of their health benefits. The purest form of premium cost sharing requires companies to fix their contribution to premiums, allowing any cost differences among plans to be borne by employees. Cost differences from year to year can also be shifted to the employee, because the company has discretion over how much it will increase the flat-dollar premium contribution level in any given year.

Another functionally analogous aspect of the changes in health benefits concerns flexibility. Once employee premium cost sharing had been implemented, future changes in the benefits contribution strategy could be undertaken more easily (e.g., by modifying the percentage employee premium contribution). Corporate officials could plan their health benefits outlays and policies years in advance, with much more certainty (e.g., by deciding to limit the firm's dollar contribution to health benefits premiums for 3 years). This parallels the flexibility in pensions afforded by the ability to adjust the company's pension contribution levels.

Employee premium cost sharing also had an immediate advantage for firms implementing it. Almost all of the employers we studied (at least 12 of 15) had previously paid health care premium costs in full but under managed competition had scaled back the company contribution an average of 70% to 75% of premiums.[10] For companies, this meant a direct savings in benefit payment obligations that they did not necessarily have to make up in employee wages. Some individual-responsibility companies may be increasing wages to compensate for the added expense to employees (to stay competitive in the labor market), but we did not see evidence of this in our interviews. Eleven out of 13 companies in our study reduced their corporate premium contribution by $300 to $1,000 per person annually, raising employee contributions proportionally so that employees choosing even relatively low-cost plan options were faced with significant additional costs.[11] These companies were largely the same as those following the new individual-responsibility policy.

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Companies that have chosen to curtail employee health benefits have often concurrently made changes to retiree and dependent health coverage, as well as mental health coverage for all eligibles. Two of 13 companies in our study had cut health coverage for future and even some current retirees, reflecting a widespread trend documented elsewhere (Hewitt Associates LTC, 1997; U.S. General Accounting Office [US GAO], 1997c). For example, Bull Information Systems, a firm that has shifted many of its benefits decisions and financial burdens to employees, eliminated corporate sponsorship altogether for retiree benefits. Four other companies increased employee contributions for retiree coverage or sought to encourage retirees to move into managed care through other means.

Another area of health benefits, revised under the new social contract but not explicitly focused on in our research, is dependent coverage. Large firms have long claimed that they subsidize other employers by providing more generous dependent coverage, which is chosen over the alternative available through their spouse. We found 2 of 13 companies in our research to have dropped dependent premium contributions completely, a trend supported by national data (Hewitt Associates LTC, 1997; US GAOa & b). Mental health coverage was also curtailed by at least three employers in our study, and this trend is becoming increasingly visible in national data (Jensen, Rost, Burton, & Bulycheva, 1998).

In looking across these types of coverage, we found that companies that cut their employer contributions by a significant amount were more likely to reduce their retiree, dependent, and mental health coverage, but there were several exceptions. One company, for example, considered it important to maintain existing employer contributions even if it meant cutting retiree or dependent coverage. This is an area that deserves further investigation.

The companies in our study implemented the individual-responsibility approach to health benefits with varying degrees of constraint. The following three examples illustrate how some firms have acted in relatively unconstrained ways. First, one firm in our study cut two health plans from their California health plan offerings at once. As a result, 40% of employees in the region had to switch health plans, a move that forced many employees to find new family physicians.

Another example involved a company that relied heavily on contract workers who received few if any employee benefits. This firm decided to keep commitments to existing employees by providing them with generous health benefits. Company officials believed that this strategy would help maintain the morale of existing employees. In addition, these managers held the traditional view that health benefits were critical for employee motivation. To make this strategy possible, however, the company had to

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increase employment flexibility in a segment of its workforce, which it achieved through the use of contract workers who received little or no benefits (also see Uchitelle, 1996).

A third firm used the threat of relocation to drive acceptance of changes in the social contract for health benefits. Raytheon Corporation warned that it would have to move its facilities from eastern Massachusetts to lower-cost Tennessee if a number of the firm's needs were not met, including lower health benefits costs. The company requested that Raytheon employees accept modifications that would include a complete shift from indemnity coverage to managed care, as well as the introduction of employee cost sharing. Management asked that Blue Cross & Blue Shield of Massachusetts, the sole provider of health coverage for Raytheon, to share the financial risk of lowering the company's health care costs.

Most individual-responsibility-oriented purchasers, however, are in some way constrained from fully adopting a flexible, low-cost approach to purchasing of health benefits. For example, most firms avoided moving immediately to a least-cost-plan premium contribution strategy (only 2 of 15 employers did so). The majority moved more gradually, finding that even when employees bear only a *portion* of premium costs, they will still switch to less costly health plans. Various factors were cited as influencing these companies' choice of a more constrained implementation, including the presence of unions or other human resource considerations such as concurrent downsizing.

The Downsizing Challenge

Perhaps the most vexing constraint to changes in health benefits was concurrent downsizing. The turmoil of downsizing sensitized workers to any further changes in the employment contract. Firms chose to deal with this situation differently, depending on the extent to which they were committed to the new human resource policy of individual responsibility and how constrained they were from implementing this policy.

We identified several ways in which downsizing and the move to managed care affected each other in the firms we studied. First, downsizing complicated the transition to managed care because of the changes it brought about for those remaining at the firm. Second, downsizing often led to increased health care costs for both physical and mental health care. In some cases, this put pressure on corporate officials to speed up the move to more affordable managed care. Increasing costs also led some firms to look more closely at the relationship between specific diseases that were costly to treat and workplace issues such as disability, absenteeism, and productivity.

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Of the companies that we interviewed, 10 of 13 private employers had downsized to some significant degree. In these companies, downsizing complicated the transition to managed care. "Survivors" of downsizing at some firms have resisted suggested changes, particularly when they involve blatant reductions in benefits (e.g., cutting corporate-funded retiree benefits or reducing mental health coverage). Opposition often comes from unions and even has included strikes at companies such as Pacific Telesis, NYNEX, and AT&T. Employees at some of the companies we studied viewed managed care with suspicion, seeing it as another mechanism of corporate cost reduction that undermined the trust and loyalty between workers and their firms.

The experience of Bull Information Systems, the American subsidiary of France's state-owned Bull Groupe, provides an example of the complications of making the transition to managed care while undergoing significant downsizing. Bull's United States–based employment fell from 11,000 in the early 1990s to less than 1,500 in 1996, and nearly all of those remaining were shifted into managed care in the same period. Fewer workers meant less purchasing power, and those who remained also tended to be older and were viewed by health plans as higher risk. As Bull's human resource staff was cut from 25 to 4, Bull also had to curtail efforts to advocate for employees who had problems with their managed-care plans (Maxwell, Briscoe, Young, Robbins, & Davidson, 1997).

Some companies subscribing to the individual-responsibility strategy saw health problems resulting from downsizing as a reason to speed the transition to managed care. Downsizing increases the stress and mental health problems of the "surviving" workers involved, driving mental health usage up and increasing disability claims (Brockner et al., 1993; Lopez, 1996).

For example, the surviving employees at one firm in our study were distressed by changes in their workplace and as a result increased their use of mental health services dramatically. These manufacturing workers had been employed for dozens of years carrying out the same routine tasks but being paid relatively high wages. Their jobs became increasingly demanding and varied following successive rounds of downsizing. At the same time, they faced the likely prospect that they or their coworkers would be next to be downsized. According to representatives for their insurer, utilization of mental health and substance abuse services were much higher than at similarly sized companies whose stronger economic performance had avoided the need to downsize. Disability claims of individuals who have left the workplace as a result of mental health and substance abuse problems also increased.

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These trends are leading some downsized companies (2 of 13 companies in our study) that are still concerned with labor costs to look at the *total cost* of disease. Total cost takes into consideration the effect of a disease on absenteeism, disability claims, at-work productivity, and other labor costs that decrease "labor productivity" (Berndt, Finkelstein, & Greenberg, 1995; Watson Wyatt, 1997). Examples of interventions that target high total-cost diseases include diabetes management, depression treatment, substance abuse prevention, and lower back pain management. The incidence of such practices is growing among large companies (Washington Business Group on Health, 1998). One recently downsized firm in our study identified depression and associated substance abuse as a critical topic for disease prevention with their employees. They worked with their long-time health plan partner to institute educational campaigns tailored for the company's employees, identified high-risk individuals using claims analysis, and developed intensive case management practices to use with targeted individuals. Other firms are considering cuts in disability benefits as a solution to controlling total costs.

An Alternative Approach

Three of 13 companies in our study relied on a markedly different approach to their health benefits and human resource policies. Rather than viewing employees as a cost to be minimized, these "employer responsibility" firms appear to believe that investing in employees will produce returns in terms of improved employee productivity and corporate performance.[12]

These firms may be related to the high-commitment organizations identified in the human resources literature. Such firms are distinguished for taking an internally consistent approach to employees that emphasizes long-term employment relationships and mutual commitment between employer and employee. The employer offers job security and relatively generous compensation and benefits in exchange for hard work, loyalty, and in many cases employee involvement in decision making (Kochan & Osterman, 1994; Pil & MacDuffie, 1996).

Several companies in our study had applied an overarching employer responsibility policy to their health benefits practices. One employer responsibility–oriented firm maintained corporate benefits commitments even in the face of worsening economic strains. The company implemented a managed competition purchasing strategy at the same time as it was undergoing a massive corporate downsizing program. While financial incentives for employees were used to shift to managed care, a soft approach was used that did not cut substantially the company's contribution to insurance

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coverage for current or recently downsized employees. Rather than adopting a least-cost strategy immediately, only a portion of the differences in health plan costs were passed on to employees in the first several years, the rest of the costs being borne by the firm. At the same time, the company invested in one of the most ambitious quality programs in industry to ensure that its employees obtained value from their managed-care plans.

At this firm, corporate officials saw the influence of downsizing on the remaining workers at the organization as reason for caution in implementing their new purchasing strategy. The trauma of downsizing represented all the more reason to treat the "survivors" well. The firm pursued this reasoning through human resource and health benefits policies that attempted to deal proactively with the survivors' stress and mental health problems arising from the downsizing. Recognizing the limitations of mental health programs in HMOs, company officials actively sought to improve these programs through their purchasing practices. Behavioral health specialists hired by the company designed standards to expand access, base treatment on clinical need rather than benefits limitations, improve case management services, and integrate physical and mental health services. Improvements in service, as a result of the new behavioral health program, are being measured through studies of treatment efficacy and behavioral health–specific patient satisfaction surveys (Maxwell, Briscoe, Young, et al., 1997).

Another example of an employer responsibility firm is the Disney Company. Disney enjoyed a financial cushion that enabled it to provide full- and part-time workers a generous benefits package that is rarely found in the low-wage service sector. Disney officials believe that its policy of providing generous health and other benefits to employees and dependents, including part-time workers, helps it excel in serving its theme park guests. Generous benefit packages help to attract the highest quality service workers for the Disneyworld theme park in Orlando's tight labor market. The benefits also help to retain workers, evidenced by an annual employee turnover rate well below the service sector average (30% vs. 100%) (Maxwell, Briscoe, Young, et al., 1997).

Some other companies are moving toward an employer responsibility viewpoint because they believe that they previously cut employee commitments too far in their quest for cost savings. Some firms are considering restoring some benefits and raising their commitment to employees to regain lost ground in the quality of customer service or employee productivity. Payless Shoe Source and Delta Airlines are two recent examples of companies (not in our study) facing this situation. Payless cut employee benefits dramatically in the early 1990s, but this move resulted in subsequent difficulties attracting and maintaining reliable consumer-friendly

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staff. Current management believes that reinstating generous health benefits will improve the quality of the company's sales staff and help Payless to differentiate itself from competing shoe retailers (Ihrie, 1997). At Delta Airlines, customer satisfaction fell, in part as a result of benefits cutbacks and concurrent workforce restructuring. Managers have since restored some benefits, hoping to find a level at which employees and customers are once again satisfied with the airline (Bryant, 1997).

Our research suggests a number of hypotheses about the institutional and economic forces that lead companies to select either the individual-responsibility or the employer responsibility view of employment and health care benefits. It is likely that companies competing heavily on price or following a least-cost competitive strategy may be more likely to assume an individual-responsibility approach. Alternatively, some firms with specific labor needs or strategies will rely on the employer responsibility approach. Rather than viewing employees as a cost to be minimized, these firms see them as assets that create value. Management values and the extent of union strength also influence these decisions (e.g., Block, Beck, & Kruger, 1996). Important questions also exist as to the long-term sustainability of the employer responsibility approach, through good and bad economic cycles, industry maturation, and workforce aging and restructuring.

CONSEQUENCES OF THE NEW SOCIAL CONTRACT FOR HEALTH BENEFITS

The widespread adoption of managed competition purchasing appears to have been a key factor in reforming the health care system (United States Department of Labor, 1996). Thirteen of 15 organizations in our study significantly increased their managed-care enrollment in the 5 years prior to 1997. The extent of the increase depended on existing enrollment and regional maturity of managed-care systems. These increases led to cost savings on an impressive scale for the companies in the study. However, cost figures are hard to compare across companies and many firms in our study also had incomplete or sensitive data. Some firms, in fact, had hired actuarial firms to estimate potential savings from managed competition strategies. Here we report some examples of the cost savings reported in interviews.

At one firm, the number of employees in managed care rose from less than 30% in 1990 to more than 80% by 1995. This company reported company savings of $765 per employee in 1995, for an overall savings of approximately $100 million during the preceding 5 years (Maxwell, Briscoe, Young, et al., 1997). Similarly, GTE predicts that three fourths of

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eligible employees and their dependents will be enrolled in managed care in the year 2000, up from less than one quarter in 1989. This shift has produced total savings for GTE estimated at $75 million through 1995 (Maxwell, Briscoe, Young, et al., 1997). Some companies have continued to save money after moving to managed care, often by encouraging more plan competition, increasing leverage over plans, or by the expanded use of employee premium cost sharing.

For employees as recipients of health care benefits, the effects of managed competition are more difficult to judge. With a few notable exceptions, corporate strategies are designed to reduce premium costs. In theory, these reductions can benefit employees as well as employers if they are passed on in the form of lower premiums or higher wages (Brailer & Van Horn, 1993). However, this practice has not become widely evident among those companies we studied. In addition, there are concerns about price pressures resulting in a lower quality of health care.

Fourteen of 15 organizations in our study have sponsored, on their own or with a coalition, in-depth surveys to evaluate employee satisfaction with managed care. One common finding is that employees tend to be as satisfied with managed care as with indemnity plans, although such surveys of largely healthy employees may mask the opinions of those sick employees who are heavy users of the system. From their evaluations of health plan quality, many corporate managers argue that some of the highest quality managed-care plans are also the most cost-effective. Managers also cite the RAND Health Insurance Experiment in support of managed care and the use of cost sharing. In this 15-year, multimillion-dollar experiment, researchers at RAND found that managed-care and indemnity plan enrollees had comparable health status levels at the end of the study. They concluded that increasing the amount of cost sharing did not result in poorer health (Newhouse, 1993).

Despite these encouraging signs from a variety of sources, evidence from focus groups at major corporations suggests that some employees are, in fact, skeptical about the quality of care in managed-care plans and view the changes to their health benefits as take-aways. Other employees see a connection between the changes in their health and other benefits to wider restructuring, erosion of trust between workers and management, and the revision of the social contract.[13]

CONCLUSIONS

The restructuring of corporate health benefits represents the latest step in the revision of the social contract with employees. Our study of health

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benefits purchasing suggests that many large companies are moving toward an individual-responsibility policy for health benefits, a trend that is consistent with the revised social contract. Many companies find that the individual-responsibility approach fits logically with previously revised components of the social contract that emphasize many of which emphasize the financial and decision-making autonomy of the employee. From the corporate perspective, managed competition presents an appealing innovation, offering immediate cost savings through reduced company premium contributions, and longer-term savings through the disciplining force of market competition applied to their health care vendors. The former shifts some burden to employees, who assume a larger portion of the costs for their health benefits, and the latter increases pressure on health plan vendors to reduce costs as a result of the increased competition among health plans. However, the cost savings achieved by firms may be difficult to sustain in the long term.

For employees, dependents, and retirees, however, changes in benefits purchasing hold both advantages and drawbacks. The potential exists for users of the health care system to gain as a result of both lower overall inflation in health care costs and higher quality of care delivery due to competition among vendors. The drawback is the requirement that employees now pay a portion of their health benefits costs and must often decide among competing health plan choices with limited information. In addition, many employees need to switch family doctors to stay covered under their employer's changing health plan options. Overall, the individual-responsibility approach shifts more responsibilities and risks onto workers. They have more choices and must bear the consequences of their selections. This new process may be good for some workers and bad for others.

The individual-responsibility approach can have drawbacks if implemented in an unconstrained manner. Although our research indicates that many companies are constrained in their movement toward an individual-responsibility strategy by both external factors and internal human resource concerns, it appears that the major forces limiting such movement are weakening. Organized labor, historically a champion of generous benefits and job security, has declined in strength during the past 20 years. Trade barriers, used in some industries to shield firms from international competition with lower labor costs, are being dismantled.

The federal government remains the most potent force to create a safety net below which employers will be unable to drive health care benefits. Without federal intervention, some benefits managers feel that they will be forced to make ever-deeper cuts in health benefits in the name of cutting costs.[14] Furthermore, if businesses do continue to cut benefits, the

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federal government may be forced to fill resulting gaps in insurance coverage through publicly funded programs or by mandating coverage through employer plans. The Kassenbaum-Kennedy legislation is an example of such public intervention (United States Congress, 1996). The legislation prevented medical underwriting for preexisting conditions and mandated that employee health benefits be portable. Federal activity to establish a safety net has been limited thus far.

The corporate purchasing practices described here are disseminating rapidly to other large firms. For this reason, additional research is needed to document the extent and nature of changes taking place in large corporations as a group. We would like to know if the practices of the early innovators are generalizable across all large firms. More research is needed to explore systematically the generalizability of our findings. For example, are companies explicitly aligning their health benefits to the new social contract, or are they adopting functionally equivalent techniques in compensation, other benefits, and human resources generally?

Two other findings from our study deserve more in-depth investigation because they suggest a significant countertrend in corporate health benefits policy. The first finding is the discovery of firms that have recently taken the revised social contract too far and are retracing their steps. By overcutting jobs and benefits, some firms found customer service and productivity to have suffered. As a result, they have added benefits back and reconsidered their employment policies.

The second finding is the significant presence of employer responsibility firms that retain most of the previous social contract because they believe it to be a profitable long-term strategy. Our research also indicates that the actions taken by employer responsibility firms are having spillover effects by influencing the markets in which these firms purchase care. By raising the standards for health benefits in a market, employer responsibility firms improve the level of benefits and the quality of health care for the employees of other local purchasers as well (Maxwell, Briscoe, Young, et al., 1997).

Future research should focus on the incidence of such countertrends, as well as the prevalence of employers who are following the general trend of adopting the new social contract in their benefits programs—either cognitively, functionally, or both. An assessment of the frequency with which employers are adopting either individual- or employer-based responsibility approaches, as well as an analysis of the results of relying on the different approaches, will aid in the development of future approaches that companies adopt toward their benefits programs.

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NOTES

1. The stable generous social contract offered by large firms in the postwar era may have been an exception rather than the rule in America if one takes a longer view (Jacoby, 1998).

2. In a contest with unions for employee loyalty, management expanded coverage from just paying for hospital care to covering physician visits, major medical (catastrophic coverage), drugs, and dental care. The expansion in coverage was encouraged by tax rulings that permitted companies to deduct their expenditures for health benefits.

3. The extreme example of the new human resource environment is a contract worker relationship, in which a fixed sum of money is paid for specified services from the worker during only a short period of time. The commitment of both parties is kept to a minimum, and the flexibility to change the relationship as business or employment conditions change is ever present.

4. Another factor raising the visibility of corporate health care costs was the decision of the Financial Accounting Standards Board (FASB) to require retiree health care liabilities to be considered on corporate balance sheets. This process exposed the large, ballooning, and unpredictable future financial liabilities related to retiree commitments and led many large purchasers to reconsider the wisdom of their retiree health benefits policies.

5. Company officials were divided on how to approach the Clinton reform proposals. Officials at Chrysler and some other large corporations argued for government-sponsored health insurance that would shift the financial burden for health coverage to the public sector. Other large firms, in addition to the majority of small employers, were against a public-sector solution and favored the development of private-sector alternatives (Congressional Record, 1991).

6. The corporate meetings exposed many managers to the principles of managed competition and to its principal architects, Alain Enthoven and Paul Ellwood. Officials from Lockheed Martin and Union Bank, for example, were involved in business roundtable discussions drawing on the work of Alain Enthoven and others.

7. Several companies we interviewed described their involvement in events related to the Clinton health reform proposals. Several corporate officials, opposed to a nationalized health care system, lobbied and spoke publicly in favor of an alternative based in private-sector flexibility but that could harness the principles of managed competition that were suggested as part of the Clinton proposals.

8. In the managed care framework, as conceived by Enthoven (1989), the lowest cost plan is favored through the use of financial incentives. Companies contribute a set amount equal to all or a portion of the premium cost of the lowest cost plan. An employee choosing to enroll in a plan offering with a higher premium is required to make up the cost difference through his or her employee contribution. Some companies moved slower than others toward a true "market" in which employees bear the whole price differences among plans.

9. Much of the information in this section was based on interviews with the numerous corporate benefits directors and the human resource executive at our case study companies. For reasons of confidentiality, detailed attribution has been withheld where necessary.

10. Recent empirical evidence of a rise in employee premiums comes from a survey by KPMG Peat Marwick. The portion of health insurance premiums paid by employees in sampled firms with more than 1,000 employees rose from 25% to 33% from 1993 to 1995 (Jensen, Morrisey, Gaffney, & Liston, 1997).

11. Health economists have advanced the notion that total employee compensation will adjust to labor market demand in the long run, and therefore changes in the value of company health benefit contributions will be offset by corresponding changes in wages. One

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implication of this theory would be a rise in wages as employers shifted some health insurance cost onto workers (Pauly, 1998). However, available empirical evidence does not support the assertion that wages offset changes in benefits in the short run. Pauly (1998) points out that as benefits costs increased in the mid-1990s, wages stagnated rather than compensated for this trend (p. 156).

12. This management concept corresponds to the economic concept of the efficiency wage.

13. For example, when asked about their company's health benefits policies, employees of one firm in our study explained that "I don't trust the Company . . . to make my medical plan decisions for me—the number one problem here is a lack of trust"; "How can we trust Senior Management when they say one thing and do something else. They should start practicing what to preach"; and "In order for me to feel like an asset, you'd have to offer a little more stability. You tell me I'm important, but everything you do tells me I'm not important" (Employee Focus Group Results, 1995).

14. Human resource and benefits directors at two companies in our studies revealed this concern in interviews.

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