



**Grand Valley Metro Council
Legislative Committee**

Agenda

**September 9, 2009
8:30 a.m.**

New GVMC Offices – 678 Front Ave. NW, Suite 200 - Grand Rapids, MI 49504

- 1. Call to Order**
- 2. Approval of Minutes from July 30, 2009 meeting**
- 3. Discussion and recommendation on House Speaker Andy Dillon's proposal to consolidate health care coverage for public employees and retirees**
- 4. Status of County Revenue Sharing**
- 5. Update on FY 2010 state budget negotiations**
- 6. Other Issues**



Grand Valley Metropolitan Council

MEMORANDUM

To: GVMC Legislative Committee

From: Donald J. Stypula, Executive Director

RE: September 9, 2009 GVMC Legislative Committee

Date: September 8, 2009

Attached are the agenda and support documents for the next meeting of the **GVMC Legislative Committee – scheduled for 8:30 AM, this Wednesday – September 9, 2009 -- at the new GVMC Offices located at Riverview Center, 678 Front Ave. NW, corner of Sixth St., in Grand Rapids.**

We'll focus on two major items this month – House Speaker Andy Dillon's proposal to establish a statewide pool for public employee and retiree healthcare and efforts by the Governor and legislative leaders to renege on a promise to restore county revenue sharing. I will also bring the latest information on the negotiations in Lansing to resolve the FY 2010 state budget.

We'll start by reviewing and approving the minutes from our special July 30, 2009 meeting. I will send those to you later today.

PROPOSAL TO ESTABLISH STATE-ADMINISTERED MASTER HEALTH CARE SYSTEM FOR PUBLIC EMPLOYEES AND RETIREES

Last Thursday, at the first meeting of the newly-appointed House Committee on Public Employee Health Care Reform, House Speaker Andy Dillon said his idea for a single health care pool for public employees could leverage better prices for insurance, inject healthier living standards and reduce spending on wasteful procedures. With more than 100 people in attendance at the hearing in the House Appropriations room, the leader emphasized the need to correct structural problems within state spending and how health care costs play a role in that change.

"When you look at cost of health care in the private sector, Michigan is actually an affordable state. But when you look at the public sector, that's not the case, which is telling me we aren't purchasing correctly," he told the panel members.

As outlined in his Draft A legislation (attached), Mr. Dillon's plan calls for a 13-member board, mainly appointed by the governor, to create four to six health insurance options that would be made available to public employees across all forms of government, including counties, townships, cities and villages.

"The purchasing power this pool would have would be the largest in the state of Michigan. We will all be treated the same here," he said.

Mr. Dillon left the hearing after his speech in order to return to budget negotiations, but his policy adviser, Kate Kohn-Parrott, told lawmakers the plan is modeled after successes of other programs both in and out of Michigan.

Ms. Kohn-Parrott, a former director of Chrysler LLC's health care and disability program, said the University of Michigan has shown a value-based insurance program that invests in wellness and preventative care pays off for both employers and employees. She said examples of this kind of system could include charging less expensive co-pays for certain medications or generic drugs and accessing less expensive procedures early on, such as blood testing, to detect any emerging health issues.

Ms. Kohn-Parrott also talked about studies that show 20 percent of patients have something go wrong with their diagnosis or treatment and that an insurance system that uses clinical advocates could cut down on costs related to unnecessary treatment.

For example, the University of Southern California's Voluntary Employee Benefits Association (VEBA) found it was spending \$40 million a year treating illnesses employees didn't have. By using clinical advocates who are essentially a panel of experts who give a second opinion on a person's diagnosis and treatment plan, the school has seen a four-to-one return on its investment, Ms. Kohn-Parrott said.

But Rep. Michael Lahti, a Democrat from Hancock, said savings from clinical advocates and use of best health care practices are difficult to measure and he questioned whether some employee plans already include some of those services. Ms. Kohn-Parrott said she is sure some plans include those programs, particularly wellness services, but they aren't as robust as they should be.

Rep. Pam Byrnes (D-Chelsea), chair of the committee, asked whether mental health services will be part of the benefit plan structure, but Ms. Kohn-Parrott said that would be up to the committee.

And Saugatuck Republican Bob Genetski (the only member of the committee from the GVMC area) questioned whether a more accountable vetting process can be built into the board's

structure given that "a lot of power" rests with those members who will decide what the benefit plans will look like. Ms. Kohn-Parrott said while legislative leaders can appoint some of the board members it would be possible to consider other accountability measures.

While promoting a robust wellness program and access to quality health care is part of Speaker Dillon's proposal, the other significant savings projected will come from pooling and Ms. Kohn-Parrott said that could include dental, vision and life insurance benefits offered to employees. Pooling those benefits, which account for about 12 percent of all benefit costs, could save \$30 million alone, she said.

Critics of Mr. Dillon's proposal have said pools already exist for health care and additional savings from a larger pool would be limited, but Ms. Kohn-Parrott said there is a difference between risk pools and leverage pools and it is the latter the legislation seeks to implement.

While she acknowledged that having current pools in place could alter the overall savings of a larger pool, Ms. Kohn-Parrott said there would still be significant leverage in a larger pool, particularly in the area of prescription drug costs.

Throughout testimony, people questioned whether Mr. Dillon would require government retirees to be included in the pool and Ms. Kohn-Parrott said it is still an area up for discussion as they continue to look at how retirees' benefits are structured under labor contracts.

Rep. Phil Pavlov (R-St. Clair) asked whether the state would be liable for the unfunded costs of retiree health care benefits across Michigan should the plan run into a deficit, as was the case in North Carolina, where lawmakers recently had to appropriate \$250 million to bring the pool into balance. But Ms. Kohn-Parrott said Michigan would bill other public employers for their employee costs throughout operation of the benefit plan so every government would still shoulder its own liabilities.

Opponents of Mr. Dillon's proposal have used North Carolina as an example of what can go wrong with a statewide pooling option, but Ms. Kohn-Parrott said officials here are trying to learn from those mistakes, including starting out with better actuarial data. She said auditors in North Carolina alerted officials about the inaccurate data being used to determine premiums, but nothing was changed and "that's what created the financial disaster."

Given that the North Carolina system also does not include many employee or union voices, she said, "It doesn't represent a model Michigan would want to adopt."

After hearing from GVMC members (at our August 13 meeting) about the need to recognize cost savings already put in place by county and local governments, Rep. Tim Melton (D-Auburn Hills) asked whether creating an opt-in system for local governments had been considered given that cost of living standards and access to care are different across the state.

Ms. Kohn-Parrott said those considerations would have to be taken into account by the board, but an opt-out system is expected to work more efficiently because it would allow everyone to share in the pool's savings.

Lawmakers also hit on the concern that government employees have been making concessions in their health care and wages and they questioned whether the costs of the uniform pool would simply shift more burdens to the workforce. Ms. Kohn-Parrott said if the plan is implemented properly, it should result in a lowering of insurance premium costs.

She said how the plan costs are shared between employers and employees, as well as which benefit program government entities go with, would be up to negotiators at the local level.

"That's not to say there will not be some shifting, but that would be the last resort," she said.

The Committee reconvenes at 2 p.m. this afternoon (Tuesday) to hear testimony from the Center for Michigan President Phil Power, whose organization has analyzed health care pooling in other states (see the attached report and spreadsheet). Also on tap for testimony today is Mitch Bean, Director of the non-partisan House Fiscal Agency, who will discuss the proposed costs savings claimed in the Dillon proposal.

GVMC's APPROACH TO THIS ISSUE

Our time to offer comments and suggestions to the House Committee is drawing near. The question we need to answer on Wednesday morning is: Can GVMC support this concept if our concerns about local flexibility and opt-out provisions are addressed? While we have publicly praised the Speaker for his bold and politically gutsy initiative, we will be invited to offer formal testimony and, at that time, we will be asked directly if the Grand Valley Metro Council supports the proposal, and we must be prepared to offer specific suggestions that ensure maximum flexibility for our diverse membership.

Bring your thoughts, ideas and specific suggestions to the GVMC Legislative Committee on Wednesday and we'll use the white board to get everyone's wish list on paper.

In addition to the materials from the Center for Michigan, I have attached Speaker Dillon's draft bill and a copy of his PowerPoint slides from his presentation to the House Committee last week.

STATUS OF COUNTY REVENUE SHARING

There is a time-honored adage around Lansing that one Legislature cannot bind a future Legislature to support a particular statute, decision or policy. That is now clearly evident as today's lawmakers are preparing to break a promise made to counties regarding revenue sharing.

Back in 2004, to patch together a state budget deal for FY 2005, lawmakers asked Michigan's 83 counties to agree to use some of their December property tax levies to set up a reserve account to withdraw funding from while the state completely eliminated \$183 million in statutory revenue sharing payments made to those entities. The understanding with that Legislature was that county revenue sharing would eventually be restored to each county as the reserve accounts were depleted. Now, facing a projected deficit of \$2.7 million the Governor and this Legislature are preparing to renege on that promise.

Under legislation being considered by the House Appropriations Committee in Lansing the state is looking to save a little more than \$23 million if it holds counties to receiving funding through their reserve accounts or through the state at fiscal year 2003-04 levels.

Amending the deal struck with Governor Granholm and lawmakers in 2004 drew ire from the Michigan Association of Counties, with Legislative Director Tom Hickson saying the bills would break a promise to counties that have already helped out the state in tight times. With cities, villages and townships scaling back services and relying more on counties, particularly in the area of public safety, Mr. Hickson said the legislation would further strain the services offered by his member counties.

Robert White, fiscal services director for Kent County, said the bills would amount to a \$1.7 million hit for the county. In Saginaw County, officials have already laid off employees, frozen salaries and reduced health care benefits. The bill being considered by House appropriators would impact counties across the state to varying degrees.

The counties stepped up to help the state in 2004. Now I think it's appropriate for the state to honor its commitment to help counties as their reserve funds are depleted. Therefore, I am requesting authorization to tell our legislators to oppose legislation that reneges on the state's promise to the counties.

UPDATE ON FY 2010 STATE BUDGET NEGOTIATIONS

Too many fast-paced twists and turns to accurately report on the negotiations at this juncture. I'll bring you the latest on what Lansing pundits are calling "Countdown to another shutdown" at our meeting tomorrow.

I'm looking forward to seeing you and having a productive meeting on Wednesday morning. As always, if you have any questions, or if we can be of further assistance, please call me directly at 776-7604, on my cell at 450-4217, at home at 257-3372 or via email at stypulad@gvmc.org.

SPECIAL REPORT: Health care pools offer savings in other states

By [John Bebow](#) – Center for Michigan
September 2, 2009

Michigan House Speaker Andy Dillon proposes to create a statewide health insurance pool for a wide range of active and retired employees of state and local governments, K-12 school districts, community colleges and universities.

A special legislative committee will begin hearing testimony on the idea this week. Among the factors policy makers will consider is cost savings.

Could pooling save money for Michigan taxpayers?

To shed light on that question, The Center for Michigan benchmarked the costs of public health care benefits pools in seven key comparison states.

Overall, benchmarking suggests that states with pools may be finding cost-effective ways to provide health insurance to public employees, potentially leaving tax revenue on the table for other strategic public priorities.

Three main conclusions:

1. LOWER COSTS IN OTHER STATES: Seven key benchmark states that offer health care pooling for public employees experience lower costs than Michigan does for state workers. Taxpayers spend an average of \$6,435 per enrollee in those states' public health care pools. In comparison, Michigan taxpayers spent \$9,836 per enrollee for state employee and retiree health care in 2008. That is 53 % higher cost for state workers and retirees in Michigan than for the enrollees in other states' pools. Even after increased premium sharing for State of Michigan workers in 2009, taxpayer costs for each enrollee will likely be more than 40 % higher than what taxpayers cover in those pooling states.

2. PUBLIC EMPLOYEES PAY A GREATER SHARE ELSEWHERE: State of Michigan workers saw their premium co-pays double from 5 % to 10% in the past year. Their share remains lower than their peers in pooling states:

STATE EMPLOYEE SHARE OF PREMIUMS

California 16 %

Georgia 25 % (Governor recommends hiking to 30%)

Massachusetts 17%

North Carolina 20%

Washington 15%
Wisconsin 7%

3. BIG INSURANCE POOLS ARE POSSIBLE: There are concerns that Michigan's patchwork of thousands of schools and local governments is too unwieldy to pool into a large insurance plan. Yet, big pools are operating in some other states. A quarter-million enrollees in California's public worker plan do not come from state government. The North Carolina pool insures the families of 250,000 public schools, college, and municipal workers in addition to state employees – the non-state enrollees there outnumber the state enrollees.

COMMENTARY

First, we caution that full explanations for the lower taxpayer insurance costs in pooling states are unclear. We have not, for example, benchmarked the very complex layers of benefits available in each state's pooling plan and compared those benefits levels to what Michigan workers receive. Our main concern was to examine costs, not benefits levels. We viewed this benchmarking through the eyes of Michigan taxpayers who are, in effect, the employers of public workers. Through that lens, it is clear that taxpayers in pooling states are paying less than Michigan pays for its state workers' benefits. In that respect, Michigan is arguably not cost-competitive with the pooling states examined. And cost competitiveness is an intensely important issue in our state where interest groups from all corners are competing for a state budget pie that is ever-shrinking due to the state's lagging economy and outdated tax code.

Second, we acknowledge that the benchmarking contained in this report is not a complete apples-to-apples comparison because: 1) apples-to-apples data are not, to our knowledge, available; and, 2) every state's experience is different. For example, neither we nor, as we understand it, Speaker Dillon's research team has found clear and comprehensive data for the costs and premium co-pay levels in the current patchwork of health care plans available to hundreds of thousands of workers in Michigan local government, schools, community colleges and universities. Would adding those coverage and co-pay rates to the base of state employees increase or decrease the per-enrollee cost to Michigan taxpayers? We simply don't know.

In short, a main goal of this brief report is to spur further questions among policy makers who will now consider Dillon's proposed pooling legislation. Those questions include:

- How are pooling states able to provide health care benefits more affordably than the State of Michigan?
- What are the fairest levels of coverage for public workers in today's Michigan economy?

- Have the State of Michigan and other education and local government agencies in our state done all they can to cut costs through efficiencies and use their considerable buying power in negotiation with insurers and health care providers?

Finally, a word about why The Center for Michigan has attempted this benchmarking... Almost three years ago, a bipartisan commission of state budget experts urged the state to benchmark the costs and best practices of Michigan government, including health care. Since then, no state agency has, to our knowledge, taken up the call. This report is, in our view, consistent with what those budget experts wanted to see.

METHODOLOGY

This report was written by Center for Michigan executive director John Bebow and researched by Bebow and Scott Rasmussen, a master's degree holder from the University of Michigan's Ford School of Public Policy.

We have researched the pooling states of California, Delaware, Georgia, Massachusetts, North Carolina, Washington, and Wisconsin because those are the states whose insurance pool structures Speaker Dillon, the Michigan Legislative Services Bureau, and/or the Michigan Education Special Services Association (MESSA) have researched for comparison purposes.

For each state, we used annual reports, public budget documents, and confirming phone and email interviews to determine:

- Total annual taxpayer-funded costs for the health care benefits pool.
- Total number of enrollees, defined as the employee or retiree who obtains the insurance for his/her dependents. The number of enrollees is also known as the number of individual insurance contracts.
- The total number of people covered (enrollees plus dependents)
- The total taxpayer cost per enrollee
- The total employer (taxpayer) share of premiums paid
- The total cost of premiums
- The enrollee percentage share of premiums paid
- The percentage of the pools enrollees who came from state government vs. other public agencies.

[The state-by-state answers to these questions are summarized in the attached spreadsheet.](#) Copies of the public documents and email correspondence used to compile each data point are available for inspection. Any interested party may obtain that documentation by emailing the Center at info@thecenterformichigan.net.

STATE HEALTH CARE POOLS -- COST COMPARISONS

	TOTAL TAXPAYER-FUNDED COST OF HEALTH CARE BENEFITS POOL	TOTAL ENROLLEES	TOTAL PEOPLE COVERED ENROLLEES PLUS DEPENDENTS	TAXPAYER COST PER ENROLLEE	TAXPAYER COST PER PERSON COVERED	EMPLOYEE SHARE OF PREMIUMS
CALIFORNIA (August 2009)	\$ 4,821,960,000	607,570	1,285,558	\$7,936	\$3,750.87	\$ 898,040,000
DELAWARE (Jan 2008)	\$ 380,000,000	58,967	110,230	\$6,444	\$3,447.34	
GEORGIA (July 1, 2009)	\$ 1,911,000,000	350,395	693,179	\$5,454	\$2,756.86	\$ 624,000,000
MASSACHUSETTS (FY08)	\$ 1,105,878,988	153,200	275,231	\$7,219	\$4,018.00	\$ 221,584,381
NORTH CAROLINA (March 2009)	\$ 1,890,000,000	481,129	667,980	\$3,928	\$2,829.43	\$ 480,000,000
WASHINGTON (July 2009)	\$ 1,300,000,000	178,416	335,309	\$7,286	\$3,877.02	\$ 195,000,000
WISCONSIN (2008)	\$ 1,043,580,000	105,345	239,000	\$9,906	\$4,366.44	\$ 74,856,000
TOTALS	\$ 12,452,418,988	1,935,022	3,606,487	\$6,435	\$3,452.78	
MI STATE EMPLOYEES (2008) ACTIVES & RETIREES	\$ 921,000,000	93,631		\$9,836		
		% above other states' pools		53%		
MI STATE EMPLOYEES (2008) ACTIVES ONLY	\$ 560,100,000	48,080		\$11,649		\$ 17,700,000
MI STATE EMPLOYEES (2009) ACTIVES ONLY	\$ 534,400,000	48,080 (est.)		\$11,115		\$ 46,100,000
			Increased out-of-pocket cost per enrollee			\$ 959
MI STATE EMPLOYEES (2009) ACTIVES & RETIREES (est.) (Note: Estimate. Full data not yet available.)	\$ 876,400,000	93,631		\$9,360		
		% above other states' pools		45%		
		(Note: Estimate. Full data not yet available.)				
MI SCHOOL EMPLOYEES ('08) ACTIVES & RETIREES	\$ 2,387,000,000	NOTE: Dollar estimates by House Speaker Andy Dillon. Full enrollment data not entirely clear				
MI LOCALGOV EMPLOYEES ACTIVES & RETIREES ('08)	\$ 1,460,000,000	NOTE: Dollar estimates by House Speaker Andy Dillon. Full enrollment data not entirely clear				

EDITOR'S NOTES ON DATA:

NOTE: Sources for each data point for other states included in accompanying files.

CALIFORNIA: \$4.82B figure in cell B6 extrapolates 85.5% taxpayer share for state employees to estimate taxpayer costs for other public employees

GEORGIA: Non-state employee estimate is from Michigan Legislative Service Bureau

MASSACHUSETTS: Taxpayer cost figure in cell B9 comes from cell B9 of attached "MASS_2" spreadsheet. Earlier number of more than \$1.3B included employee contributions. TWO ADDITIONAL MASS. NOTES: The figures above do not include another \$80M in taxpayer cost for retired teacher health care -- to include that amount we also need to know how many retired teachers are covered. More importantly Massachusetts' annual report for FY08 indicated that 3,000 municipal contracts could be added to the pool as of July 1, 2008 -- but early reports are only about 30 have joined the state system.

WASHINGTON: Extrapolates 15 % copay for state employees to locals covered.

MICHIGAN (2008 STATE EMPLOYEES): Total taxpayer cost is from Dillon's report, updated and revised by Citizens Research Council State Director Craig Theil after further discussions with Michigan Civil Service Commission. Total enrollees includes 45,551 retirees cited in Dillon's report plus 48,080 active employees (this is Theil's quarterly rolling average, deemed more accurate than Dillon's 48,529 figure.) State of Michigan active employee only data also comes from Civil Service via CRC Michigan.

MICHIGAN (2008 SCHOOL EMPLOYEES): Dollar figures from Speaker Andy Dillon's health care plan, page 6.

MICHIGAN (2008 LOCAL GOV'T EMPLOYEES): Dollar figures represent midpoint of Speaker Dillon's estimates onpage 8 of his report.

TOTAL COST OF PREMIUMS	ENROLLEE % SHARE OF PREMIUMS	NON- STATE GOV'T ENROLLEES	% NON- STATE GOV'T ENROLLEES
\$ 5,720,000,000	16%	241,920	40%
\$ 2,535,000,000	25%		78% +
\$ 1,327,463,369	17%		
\$ 2,370,000,000	20%	249,431	52%
\$ 1,495,000,000	15%	41,523	23%
\$ 1,118,436,000	7%	13,741	13%
	5%		
\$ 577,800,000	3%		
\$ 580,500,000	8%		

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Understanding the Proposed MI Health Benefits Program

Presentation to the Public Employee
Health Care Reform Committee
Michigan House of Representatives

September 3, 2009

MI Health Benefits Program Fundamentals of the Proposal

- Consolidation of the planning, delivery and administration of health benefits for Michigan's public sector employees and retirees in order to
 - Streamline administrative services
 - Leverage purchasing and economies of scale

- Promote and ensure:
 - Adoption of wellness, prevention and other programs designed to optimize health
 - Access to quality health care
 - Conformance to best practices in health care delivery
 - Availability of clinical advocates
 - Management of prescription drug use
 - Standardization of employee benefits

MI Health Benefits Program **A Pro-Worker, Pro-Taxpayer Solution**

- Reinforces the State's commitment to provide fair and competitive benefits to public employees and retirees
- Covers all public employees and retirees, including elected officials ("from the local school bus driver to the Governor"), who are offered health benefits
- Preserves collective bargaining
- Engages both public employees and public employers in the design of health benefit plans
- Balances the health care benefit needs of public employees and retirees with the State's and other public employers' fiduciary responsibilities to manage cost and wisely spend taxpayer dollars
- Allows participants to choose the provider(s) that best meets their needs

MI Health Benefits Program
A Pro-Worker, Pro-Taxpayer Solution

- Recognizes the importance of investing in the health of the State's public employees by providing wellness and prevention programs and by focusing on education, awareness and personal responsibility
- Encourages the use of best medical practices
- Leverages the power of private insurance carriers to negotiate cost-effective provider discounts while offering broad provider networks
- Gives the State a stronger voice and more clout in encouraging private insurers to craft innovative programs aimed at improving health care quality, containing cost and modifying provider payment practices to promote collaborative care instead of fee-for-service treatment

MI Health Benefits Program **A Pro-Worker, Pro-Taxpayer Solution**

- Aligns as appropriate the amount paid by Michigan's public employers for employee and retiree health benefits with the amounts paid by public employers in other states (subject to income-means testing)
- Uses as a benchmark for comparative purposes the cost paid by Michigan's private employers for employee and retiree health benefits (subject to means testing)
- Will be made available to Michigan's private sector once the program is operational
- Creates systemic change to help address Michigan's perennial budget problems
 - This is not a panacea but rather one of many reforms needed to make Michigan financially viable
- Exempts any government units that can demonstrate that the cost of their health plans is lower

MI Health Benefits Program
Scope and Scale of Michigan's Public Sector

<u>Type of Governmental Unit</u>	<u>Number</u>
State ^a	6
Public Universities	15
Community Colleges	29
Counties	83
Cities	> 630
Townships	> 1,250
School Districts	839
Other Local ^b	hundreds

^a Classified Civil Servants; Elected Officials; Department Heads, Exempt positions in the Governor's Office and within departments, and certain Executive Officers and Members of Boards and Commissions; Employees of Courts of Record; Legislative Employees; and State Armed Forces Employees

^b Includes Municipal Courts, Libraries, Road Commissions and Community Health Agencies

MI Health Benefits Program
Michigan Public-sector Employment (2007 Census Data)

<u>Public Sector</u>	<u>Full-time</u>	<u>Part-time</u>	<u>Total</u>	<u>Full-time Equivalents</u>
State ^a	64,896	9,534	74,430	71,966
State University	53,771	54,453	108,224	72,841
Local Government ^b	108,350	57,825	166,175	125,231
School District	<u>184,642</u>	<u>91,064</u>	<u>275,706</u>	<u>223,428</u>
Total	411,659	212,876	624,535	493,466

^a Classified Civil Servants; Elected Officials; Department Heads, Exempt positions in the Governor's Office and within departments, and certain Executive Officers and Members of Boards and Commissions; Employees of Courts of Record; Legislative Employees; and State Armed Forces Employees

^b Includes Counties, Cities, Townships, Villages, and other Municipal Units

MI Health Benefits Program
Estimated 2008 Cost of Health Care Benefits Across Michigan's Public Sector

Type of Health Care Coverage	2008 Total Annual Cost Paid by the State and School Districts \$(millions)	Other Public Sector \$880 million = 75% of total Other Public Sector Cost \$(millions)	Other Public Sector \$880 million = 50% of total Other Public Sector Cost \$(millions)
Active State	\$552		
Retired State	\$361		
Active School	\$1,727		
Retired School	\$660		
Total	\$3,300	\$1,150	\$1,650
Range For All	\$3,300	\$4,450	\$4,950

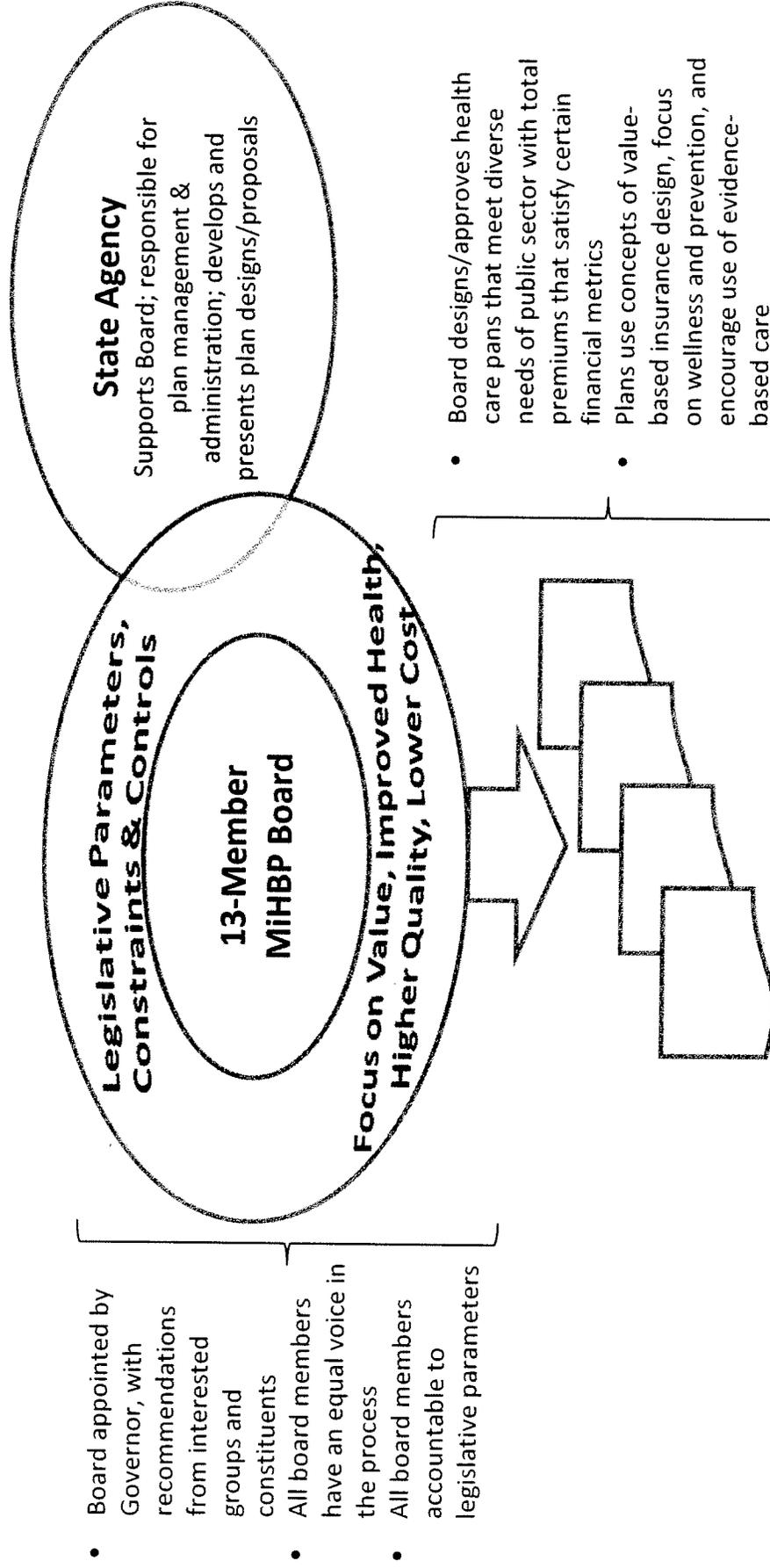
MI Health Benefits Program
Savings to be Realized from the MI Health Benefits Program

- Administrative Savings = \$65 to \$75 million annually
- Economies of Scale/Leveraged Purchasing = \$100 to \$200 million annually
- Adoption of wellness, prevention and other programs designed to optimize health; access to quality health care; conformance to best practices in health care delivery; use of clinical advocates; management of prescription drug use; and standardization of employee benefits = \$400 to \$600 million annually

MI Health Benefits Program
Average Premium Cost of Health Care Benefits

	<u>Total</u> Premium \$	<u>Employer</u> Premium \$	<u>Employee</u> Premium \$	<u>Employee</u> Premium %
State of Michigan Employees^a	\$11,887	\$10,900	\$987	8.3%
U.S. National All Employers ^b	\$9,375	\$7,112	\$2,263	24.1%
Midwest Employers ^b	\$9,458	\$7,370	\$2,088	22.1%
State & Local Gov't – National Avg. ^b	\$9,839	\$7,974	\$1,865	19.0%
East North Central State Gov'ts ^c	\$10,704	\$9,505	\$1,199	11.2%
Michigan Private (1,000+ employees) ^d	\$8,747	\$6,931	\$1,816	20.8%
State of Michigan "Teachers" ^e	n/a	\$11,451	n/a	n/a

MI Health Benefits Program Proposed Governance and Collective Bargaining Model



- Board appointed by Governor, with recommendations from interested groups and constituents
- All board members have an equal voice in the process
- All board members accountable to legislative parameters

- Board designs/approves health care plans that meet diverse needs of public sector with total premiums that satisfy certain financial metrics
- Plans use concepts of value-based insurance design, focus on wellness and prevention, and encourage use of evidence-based care

- Bargaining units and public employers negotiate on
 - Which plans to accept
 - Premium share
 - Eligibility

MI Health Benefits Program (notes for cost charts)

- * Cost is limited to premiums only and does not include other employee out-of-pocket costs; “All Plans” includes PPO, HMO, Point-of-Service (POS) and High Deductible Health Plans (HDHP) for National, Midwest, East North Central and Michigan Private Sector; PPO, HMO and catastrophic plans make up the “All Plans” category for State of Michigan Employees; all averages (except “teachers” are calculated using the State of Michigan Civil Service enrollment for the period October 5, 2008 – October 3, 2009
- ^a Michigan Civil Service website; fiscal year 2008-09 Health Insurance Premium Rates, effective October 5, 2008
- ^b 2008 Kaiser Health Benefits Survey
- ^c Data is from the 2006 Medical Expenditure Panel Report published by the Agency of Health Care Research and Quality, adjusted for 2 years of inflation at 5% compounded annually
- ^d 2009 Medical Expenditure Panel Report published by the Agency for Health Care Research and Quality; July 2009
- ^e Data is from the 2007-08 Expenditure Report-All Districts, Financial Information Database (www.michigan.gov/cepi); based on 2008 spend of \$1,212,853,356 @ 87.9% (using all sources of health care funds in the “Instructor” category adjusted for the cost of dental, vision, life and disability insurance) divided by 93,097 (all employees in the “Instructor” category); however, this average cost is likely understated because some of the employees in the “Instructor” category may not be “Teachers” and some may not be enrolled in the health care benefit programs offered by their school district employer; further, only the employer premium is reported as the funds represent the portion paid by the State or school district; total premium, employee premium cost and employee premium share are not available for the category “Teacher”

Kate Kohn-Parrott

Kate Kohn-Parrott is a noted health care expert and analyst who serves as a consultant to the Michigan House of Representatives. She owns and operates an independent firm called KKP Consulting in Novi. As Director of Integrated Health Care and Disability for Chrysler LLC from 2004 to 2008, Kohn-Parrott developed and managed cost-effective, competitive health and wellness programs that covered 350,000 people at an annual cost of \$2.5 billion. Kohn-Parrott implemented innovative, evidence-based strategies that generated millions of dollars each year while increasing employee satisfaction and participation in award-winning prevention programs. She led national negotiations with the UAW on health care and other benefit programs in 2007, a collaboration that reduced costs for Chrysler and saved thousands of autoworker jobs.

Kohn-Parrott, a Certified Management Accountant and a Certified Internal Auditor, holds a master's in business administration (MBA) from University of Detroit Mercy and a bachelor's in business accounting from Eastern Michigan University. She worked at Chrysler for more than 25 years in a variety of leadership positions.

In addition, Kohn-Parrott is Treasurer and Executive Board Member of the Greater Detroit Area Health Council (GDAHC) and Co-Chair of the Board of Visitors of the Wayne State University College of Nursing. She has served as Co-Chair of the Health Focus Group of the Automotive Industry Action Group and as a member of the Health Committee of the Economic Alliance of Michigan, the Administrative Simplification Work Group sponsored by the Michigan State Medical Society and the Governor's Council of Economic Advisors Ad Hoc Committee on Health Care Costs.

Her work on health care has won awards from the National Business Group on Health, the Greater Detroit Area Health Council, the State of Michigan and the U.S. Health and Human Services Department.

DRAFT A

A bill to provide for consolidation of health benefits for public employees; to create a board to adopt a uniform public employee health benefits program; to provide for duties for certain state departments, agencies, boards, and officers; to require public employers who provide health benefits to employees to participate in the health benefits program; to provide for exceptions; to provide for optional participation by private entities; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 1. This act shall be known and may be cited as the
2 "Michigan health benefits program act".

3 Sec. 2. As used in this act:

4 (a) "Board" means the Michigan health benefits program board
5 created in section 3.



1 (b) "MI health benefits program" means the Michigan health
2 benefits program adopted by the board under this act.

3 (c) "Public employee" means an employee, officer, or elected
4 official of a public employer. Public employee includes an employee
5 retired from employment with a public employer as provided in
6 section 21.

7 (d) "Public employer" means this state; a city, village,
8 township, county, or other political subdivision of this state; any
9 intergovernmental, metropolitan, or local department, agency, or
10 authority, or other local political subdivision; a school district,
11 a public school academy, or an intermediate school district, as
12 those terms are defined in the revised school code, 1976 PA 451,
13 MCL 380.1 to 380.1852; a community college or junior college
14 described in section 7 of article VIII of the state constitution of
15 1963; or a public university described in section 4, 5, or 6 of
16 article VIII of the state constitution of 1963.

17 Sec. 3. (1) The Michigan health benefits program board is
18 created as an autonomous entity in the department of management and
19 budget and shall exercise its powers independent of the director of
20 the department of management and budget.

21 (2) The board shall consist of 13 regular members, as follows:

22 (a) The following members appointed by the governor:

23 (i) 4 members representing interests of state, municipal,
24 public education, and public safety employees.

25 (ii) 1 member representing interests of public employee
26 retirees.

27 (iii) 3 members representing interests of county, municipal, and



1 public education employers.

2 (b) 3 independent members with expertise in areas such as
3 employee benefit design, value-based insurance design, or health
4 care actuarial science, 1 of whom shall be appointed by the
5 governor, 1 by the senate majority leader, and 1 by the speaker of
6 the house.

7 (c) The following members serving by virtue of their position:

8 (i) The state employer or his or her designee.

9 (ii) The state budget director or his or her designee.

10 Sec. 4. (1) The members first appointed to the board shall be
11 appointed within 30 days after the effective date of this act.

12 (2) Appointed members of the board shall serve for terms of 4
13 years or until a successor is appointed, whichever is later, except
14 that of the members first appointed, 1 representative of labor, 1
15 representative of public employers, and 1 of the independent
16 experts shall serve 2-year terms and 1 representative of labor, 1
17 representative of public employers, the representative of public
18 employee retirees, and 1 of the independent members shall serve 3-
19 year terms.

20 (3) If a vacancy occurs on the board, an appointment for the
21 unexpired term of an appointed member shall be made in the same
22 manner as the original appointment.

23 (4) The governor may remove an appointed member of the board
24 for incompetence, dereliction of duty, malfeasance, misfeasance, or
25 nonfeasance in office, or any other good cause.

26 Sec. 5. (1) The first meeting of the board shall be called by
27 the state employer who shall serve as chairperson. After the first



1 meeting, the board shall meet at least monthly. The board may meet
2 more frequently, as needed, at the call of the chairperson or if
3 requested by a majority of the board's members.

4 (2) A majority of the members of the board constitute a quorum
5 for the transaction of business at a meeting of the board. A
6 majority of the members present and serving are required for
7 official action of the board.

8 Sec. 6. Members of the board shall serve without compensation
9 for their service on the board. However, members of the board may
10 be reimbursed for their actual and necessary expenses incurred in
11 the performance of their official duties as members of the board.

12 Sec. 7. The board shall have the following duties:

13 (a) Review recommendations of the office of state employer as
14 to health benefit plans and total premium cost for each plan to be
15 adopted as the MI health benefits program to be offered for public
16 employees.

17 (b) Adopt or reject the recommendations of the office of state
18 employer.

19 (c) Issue directions to the office of state employer as to
20 changes to be researched, developed, included, and resubmitted for
21 any rejected recommendation.

22 (d) Assess the financial stability of the benefit plans
23 proposed for adoption as the MI health benefits program.

24 (e) Assess the financial stability of the MI health benefits
25 program not less than annually after adoption and implementation.

26 (f) Determine whether the purchase of reinsurance for the MI
27 health benefits program is in the state's best interest.



1 (g) Include in its evaluation of the contract recommendations
2 of the office of state employer, the additional value of
3 contracting with Michigan-based businesses.

4 (h) Develop methods to extend the option to participate in the
5 MI health benefits program to the private sector.

6 Sec. 8. The board shall accept or reject the health benefit
7 plans recommended by the office of state employer using the
8 following criteria:

9 (a) Quality, efficiency, and effectiveness in improving the
10 health of public employees.

11 (b) Financial stability.

12 Sec. 9. The board shall consider the cost of health benefit
13 plans provided to public sector employees in similar states using
14 available data, such as the medical expenditure panel survey
15 published by the agency for health care research and quality, and
16 other sources of data when approving the total premium cost of each
17 plan and the expected average premium cost for all plans that are
18 offered.

19 Sec. 10. The office of state employer shall have the following
20 general powers, duties, and responsibilities:

21 (a) Administration of the MI health benefits program.

22 (b) Communicating with and educating public employees
23 concerning the MI health benefits program.

24 (c) Managing relationships with health care plans and
25 providers.

26 (d) Supporting and participating in public forums focused on
27 health care reform.



1 (e) Other duties granted by law.

2 Sec. 11. The office of state employer shall have the following
3 duties in developing MI health benefits program recommendations:

4 (a) Analyze current public employee health coverage plans in
5 this state to determine the types and levels of health coverage
6 provided.

7 (b) Review data on state health coverage plans in other
8 states.

9 (c) Develop a selection of plans of health benefits coverage
10 with different levels of coverage and benefits adapted to the
11 interests of various classes of public employees. Plans shall
12 comply with applicable federal standards and may include a variety
13 of structures and benefits, including, but not limited to, offering
14 benefits through preferred provider organizations, health
15 maintenance organizations, high-deductible plans combined with
16 health savings accounts, self-insurance, and plans that are
17 tailored to address groupings of geographic needs or categories of
18 employee risk or need.

19 (d) Negotiate with appropriate parties to develop plan
20 recommendations.

21 (e) Set standards and issue requests for proposals to develop
22 plan recommendations.

23 (f) Periodically review and update recommended plans as
24 necessary.

25 Sec. 12. The office of state employer shall consider all of
26 the following in developing health benefit plans to recommend to
27 the board:



1 (a) Maximizing cost containment while ensuring access to
2 quality health care.

3 (b) Wellness and prevention incentives, such as smoking
4 cessation, injury and accident prevention, reduction of alcohol
5 misuse, weight reduction, exercise, automobile and motorcycle
6 safety, blood cholesterol reduction, and nutrition education, that
7 focus on strategies to improve health and meet the needs of the
8 covered populations.

9 (c) Utilization review procedures.

10 (d) Evidence-based care and best practices.

11 (e) Use of clinical advocates to review diagnosis and care for
12 correct treatment.

13 (f) Coordination of benefits.

14 (g) Minimum standards for insuring entities.

15 (h) Minimum scope and content of plans offered to
16 participating employers.

17 (i) Incentives to engage in value-based health care
18 utilization.

19 (j) Methods of chronic care management that improve
20 coordination of care and identify employees best served through use
21 of a chronic care model that uses predictive modeling based on
22 claims or other health risk information.

23 (k) Cost considerations set forth in section 9.

24 (l) Any other factors the office of state employer considers
25 appropriate.

26 Sec. 13. The office of state employer shall have the following
27 powers in administering the MI health benefits program:



1 (a) Authority to negotiate and enter into contracts with
2 insurance carriers, health maintenance organizations, preferred
3 provider organizations, third party administrators, or any other
4 entity as necessary to implement the board-approved MI health
5 benefits program.

6 (b) Authority to contract externally for services related to
7 administration and operation of the MI health benefits program.

8 (c) Authority to hire an executive director and staff and to
9 incur expenses necessary to administer the program.

10 (d) Authority to include the additional value of contracting
11 with Michigan-based businesses in evaluating the best interests of
12 the state in the award of contracts.

13 Sec. 14. The board and the office of the state employer, using
14 evidence-based medical principles to develop common performance
15 measures, may include provisions for financial incentives in the MI
16 health benefits program that do the following:

17 (a) Reward improvements in health outcomes for individuals
18 with chronic diseases, increased utilization of appropriate
19 preventive health services, or reductions in medical errors.

20 (b) Increase the adoption of and use of information technology
21 that contributes to improved health outcomes, better coordination
22 of care, or decreased medical errors.

23 (c) Through purchasing, reimbursement, or pilot strategies,
24 promote and increase the adoption of health information technology
25 systems such as electronic medical records, electronic prescribing,
26 and integrated delivery systems, that do any of the following:

27 (i) Facilitate diagnosis or treatment.



- 1 (ii) Reduce unnecessary duplication of medical tests.
- 2 (iii) Promote efficient electronic physician order entry.
- 3 (iv) Increase access to health information for consumers and
- 4 their providers.
- 5 (v) Improve health outcomes.
- 6 (vi) Reward or encourage review of diagnosis and care by
- 7 clinical advocates to ensure appropriate treatment.
- 8 (vii) Reward employee participation in wellness or disease
- 9 management programs and regular preventive care.

10 Sec. 15. The office of state employer shall have the following
 11 continuing duties:

- 12 (a) Periodically conduct an internal review of plan efficiency
- 13 and effectiveness.
- 14 (b) Perform audits of any participating employer, as needed.
- 15 (c) Report annually to the board and make the report available
- 16 to the public on the internet.
- 17 (d) Maintain a website with information concerning meetings
- 18 and other information useful to the public concerning the
- 19 activities of the office of state employer in developing and
- 20 implementing the MI health benefits program.
- 21 (e) Employ other techniques to ensure that the program is
- 22 administered efficiently and cost-effectively, such as coordination
- 23 of benefits and dependent eligibility audits.

24 Sec. 16. The board shall make the MI health benefits program
 25 available to public employers. Except as provided in section 17, a
 26 public employer that offers health benefits to its employees shall
 27 offer benefits through participation in the MI health benefits



1 program. The MI health benefits program shall not restrict the
2 right of the public employer to select, subject to collective
3 bargaining, any of the following aspects of the MI health benefits
4 program:

5 (a) Which of the recommended plans the public employer will
6 offer.

7 (b) The share of the cost of the benefits that will be
8 allocated to the employer and the employee.

9 (c) Which of the employer's employees are eligible for MI
10 health benefits.

11 Sec. 17. A public employer may offer its employees a health
12 benefit plan that is not 1 of the recommended plans under this act
13 in any of the following circumstances:

14 (a) The health benefits are required under a contract in
15 effect on January 1, 2010. This exception expires with the
16 expiration of the contract and does not apply to a contract entered
17 into, revised, or renewed after January 1, 2010.

18 (b) If the public employer presents sufficient evidence to the
19 board that it can provide comparable benefits to its employees at a
20 lower cost, as determined under guidelines established by the board
21 under section 19. The public employer shall apply to the board for
22 approval to opt out at least 9 months before the expiration of the
23 current health benefits contract. The board shall apply the
24 guidelines and notify the public employer within 90 days as to the
25 approval or denial of the application.

26 Sec. 18. (1) The MI health benefits fund is created in the
27 state treasury and is held in trust to support the contractual



1 obligation for health benefits for the employees of the
2 participants in the MI health benefits program under this act.

3 (2) The state treasurer may receive money or other assets from
4 any source for deposit into the fund. The state treasurer shall
5 direct the investment of the fund. The state treasurer shall credit
6 to the fund interest and earnings from fund investments.

7 (3) Money collected for expenses of the MI health benefits
8 program shall be deposited in the fund.

9 (4) Money in the fund is continuously appropriated and may be
10 expended upon authorization of the office of the state employer
11 only for purposes of the MI health benefits program.

12 (5) Money in the fund at the close of the fiscal year shall
13 remain in the fund and shall not lapse to the general fund.

14 (6) The office of the state employer shall be the
15 administrator of the fund for auditing purposes.

16 Sec. 19. (1) The board shall establish standards to assess
17 whether a public employer who seeks to opt out of participation in
18 the MI health benefits program is able to offer benefits comparable
19 to those available under the MI health benefits program at a cost
20 that is at least 5% lower, so as to be eligible to opt out of
21 participation in the MI health benefits program. The standards
22 shall include factors such as the total premium, weighted averages
23 for multiple plan options, and out-of-pocket expenses, and
24 additional costs such as administrative fees in making the
25 comparison of benefits and costs and shall make the comparison over
26 a minimum of 3 years.

27 (2) The board shall require that a public employer provide an



1 actuarial study to support the request to opt out of the program.

2 (3) The board may require minimum participation periods and
3 minimum opt-out periods as necessary to the financial stability of
4 the MI health benefits program.

5 (4) The board may authorize exceptions to the minimum
6 participation or opt-out periods only in exigent circumstances.

7 Sec. 20. The costs of the MI health benefits program benefits
8 and administration shall be fully supported by assessments on the
9 participating employers and retirement systems, and those entities
10 shall be responsible for remitting any employee share of the costs.

11 Sec. 21. (1) Beginning January 1, 2010 and subject to section
12 17 and subsections (3) and (4), the board of a public employee or
13 officer retirement system shall offer only a health benefit plan
14 recommended under this act to public employees eligible for
15 retirement health care benefits under the following acts:

16 (a) The state employees retirement act, 1943 PA 240, MCL 38.1
17 to 38.68.

18 (b) The public school employees act of 1979, 1980 PA 300, MCL
19 38.1301 to 38.1408.

20 (c) The legislative retirement act, 1957 PA 261, MCL 38.1001
21 to 38.1080.

22 (d) The judges retirement act of 1992, 1992 PA 234, MCL
23 38.2101 to 38.2670.

24 (e) The state police retirement act of 1986, 1986 PA 182, MCL
25 38.1601 to 38.1648.

26 (f) The firefighters and police officers retirement act, 1937
27 PA 345, MCL 38.551 to 38.562.



1 (g) The municipal employees retirement act of 1984, 1984 PA
2 427, MCL 38.1501 to 38.1555.

3 (h) 1851 PA 156, MCL 46.1 to 46.32.

4 (i) The Michigan military act, 1967 PA 150, MCL 32.501 to
5 32.851.

6 (j) 1927 PA 339, MCL 38.701 to 38.706.

7 (2) Beginning January 1, 2010 and subject to section 17 and
8 subsections (3) and (4), the administrator of a public employee or
9 officer retirement system shall offer only a health benefit plan
10 recommended under this act to any other public employee or officer
11 who receives retirement health care benefits from a public
12 employer.

13 (3) If a collective bargaining agreement or other binding
14 agreement, such as an agreement specifying a vesting schedule, that
15 affects a health benefit plan is in effect on January 1, 2010, the
16 retirement health care benefits shall be administered in accordance
17 with the terms of the collective bargaining agreement or other
18 binding agreement until the agreement expires.

19 (4) This act does not modify terms relating to retiree health
20 benefits in contractual agreements under which a public employee
21 retired before the effective date of this act.

22 Enacting section 1. (1) The public employees health benefit
23 act, 2007 PA 106, MCL 124.71 to 124.85, is repealed.

24 (2) Sections 506a, 527a, 633, 1255, and 1311m of the revised
25 school code, 1976 PA 451, MCL 380.506a, 380.527a, 380.633,
26 380.1255, and 380.1311m, are repealed.



