Review and Analysis of Speaker Dillon's Proposal for A Mandatory State Government-Run Public Employee Health Insurance Plan

Prepared for
Citizens for Accountability in Reform

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Summary of Findings

The paper that follows is a review and analysis of Michigan House Speaker Dillon's proposal to change how health benefits are provided to all 500,000-plus public employees, retirees and their dependents at every level of government in Michigan, from cities, counties, townships, villages, special authorities, and local school districts, to the state, community colleges, and universities. Speaker Dillon issued a white paper in support of his proposal on July 16, with a subsequent revision on September 9. A bill creating the framework for governance of the plan, HB 5345, was introduced on September 10.[1] It is expected that additional legislation will be needed for full development of the proposal.

- The analysis that follows finds that the plan savings as claimed under the proposal are largely illusory, especially those claimed for administrative efficiencies and economies-of-scale.

- The proposal's idea of capturing additional savings by creating a "super pool" of an estimated 500,000 active and retired public employees is based on two critical errors of assumption: assuming that large pools do not already exist in the market (they do) and that the market is served by thousands of totally different insurance plans (it is not: the market is largely made up of slight modifications of common insurance programs).

- Actual administrative costs will far exceed those disclosed in the original white paper, likely in the range of $295 to $370 million based on comparisons to the commercial insurance market and the pool experience in other states.

- The desired underwriting model, whether self-funded or insured, is not clear from the white papers or legislation. In either case, costs that currently have not been accounted for in the

[1] A third version of the white paper was issued as this analysis was being finalized. The original release of the paper, labeled "Preliminary Draft," on July 16, 2009, was titled "Opportunities to Save Cost (sic) on Public Sector Health Care Benefits." A very slightly revised paper was released on July 27, 2009, still bearing the original title and preliminary draft identification, with the use of the singular "cost," but adding another title and subtitle: "The Dillon Prescription for Public Sector Healthcare Reform: How consolidating healthcare plans can save the State of Michigan $900 million a year." For ease of reference, this analysis will simply refer to this as the "original white paper."

proponents' estimated savings will be incurred: either an appropriation to set aside a startup reserve of $400 to $500 million or costs for re-insurance.

- "Standardization" of benefits is nothing more than a poor synonym for reduced benefits and/or increased employee cost sharing. It is not necessary to assert false cost savings from alleged administrative efficiencies and dubious economies-of-scale to have a discussion with employees about cutting benefits: that happens through negotiations today. A large and expensive new state bureaucracy is not needed.

- Benefit costs are already being addressed to a significant degree, and for public schools benefit costs actually declined in the 2007-2008 school year. These savings are occurring in the market today due to the real impact of market forces, and further savings are virtually certain without HB 5345.

- The proposed structure of the Office of the State Employer and its duties cannot sustain a true collective bargaining system as has been suggested. At best, HB 5345 suggests that employee groups would be limited to selecting from a small number of predetermined options. That is simply not collective bargaining.

- Claims of further savings cannot be estimated without knowing what the benefits offered by the proposed "super-pool" will be. Proponents of the idea say that benefit levels will not be reduced. The analysis finds that the only opportunity for obtaining savings in the plan as proposed is by reducing benefits and/or increasing employee costs, and while the sponsor has repeatedly stated that benefits will not be reduced, there can be no other purpose for benchmarking against average costs in the other 49 states without comparing the actual benefit package contents.

Other findings are noted below, and each is discussed in more detail in the analysis that follows.

Summary of the Proposal

On July 16, 2009, Michigan House Speaker Dillon released a draft white paper proposing major structural changes to the current system of public employee health benefits in Michigan, with all of its claimed "savings" coming in one form or another via creation of a single, mandatory, state government-run plan for all public employees in Michigan: state or local, university or local sheriff. The original white paper would more accurately be described as presenting some concepts for reform than a specific plan. The original white paper does suggest major policy changes impacting public employees at every level of government from the state to the smallest locality, local schools to universities, and presumably all government-operated or government-controlled quasi-public entities such as special authorities at any level.

HB 5345, introduced on September 10, 2009, outlines a slightly more detailed proposal that would create a 13-member board and charge it with actually drafting and overseeing the implementation of the insurance plans and their administration by the Office of the State Employer. Circulated earlier as a draft, HB 5345 is still short of detail on many issues, but one clear change is that it retreats from the original white paper suggestion of a double set of benchmarks for benefit "standardization" by eliminating the proposal to benchmark benefits and costs against private sector employers in Michigan (HB 5345 retains the concept of benchmarking against public sector employers nationally).

The original white paper and subsequent documents are also generally devoid of critical specifics about the current state of public employee benefits, about demographics of exactly which public employees would be included, about the proposed design of the new plans, about implementation, and about the proposed employee cost-sharing or projected start-up costs. If the plan is ultimately developed into more specific, implementable legislation with much more detail than in the draft bill or HB 5345, further analysis will be needed at that time to review and assess the accuracy of whatever savings claims are made at that time.

Much of the savings claimed from the general proposed structure as outlined by the proposal's supporters are overstated, have already occurred due to changing market conditions, or have additional offsetting costs that have been omitted.

The original white paper suggests that this single, mandatory, state government-operated health plan can be a major solution to the imbalance in the state budget (estimated in the paper at $1.3 billion) for fiscal year 2010, which began October 1, and press coverage to date has focused on the theoretical savings suggested in the concept paper of $700 to $900 million a year. The revised title page of the most current version of the white paper now claims $900 million in savings. The action plan and implementation schedule of the original white paper clearly intended this to be viewed as a FY 2010 budget solution.[2]

Analysis of the original white paper in its entirety, subsequent updates, and HB 5345, coupled with other research, knowledge, and experience related to state purchasing, public employee benefits, collective bargaining, state purchasing, and the state legislative and budget processes suggests that there are many major questions that remain to be answered about the calendar, the content of the proposal, and the process suggested.

Even over the longer term, there are serious questions about the potential for the level of administrative, efficiency, and economies-of-scale savings projected in the original white paper.

There are even questions about the theoretical level of the potential savings estimated from reducing employee and retiree benefits and increasing employee and retiree cost sharing, because some of these actions have already begun to be implemented at the state and local levels, thus reducing the potential for further gains from the status quo of the examples used in the original white paper—some of which date back to 2005.

It is also critically important to make the policy distinction between savings attainable by economies-of-scale or efficiencies of operation, and savings obtainable by reducing benefits and

[2] Original white paper draft, p. 2. The second White Paper released in mid-September suggests additional savings could be obtained by adding dental and vision insurance to the pool structure.

or increasing employee cost-sharing. The white paper itself and much of the subsequent discussion have tended to blur these together.

Analysis of the White Paper and HB 5345[3]

The analysis begins with some brief observations on the timing suggested in the original white paper, and then turns to an examination of the major categories of cost savings projected in the original white paper, including the issues of administrative efficiency, economies-of-scale via pooled purchasing power, and the actual sources of most of the savings claimed in the original white paper. It will then turn to a discussion of the original white paper's key components and their potential impact on the collective bargaining process. Finally, it will conclude with a brief review of a number of timing and process issues that would create barriers to a timely implementation of the proposal as presented, **even if** it were found desirable from a policy perspective.

The clear implication of the way the original white paper is structured suggests that it was intended to be considered in the context of solutions to the FY 2010 state budget crisis. In subsequent public comments, a more realistic timeline has been suggested.

The analysis clearly finds that the complexity of the changes suggested above make it nonviable for any near-term budget savings. The analysis additionally finds that the hypothesized administrative and economies-of-scale savings are simply not realistic. The only realistic savings related to the original white paper would come from reducing benefits and/or increasing costs to public employees and retirees, which could be accomplished without the creation of a large new office of state employees as proposed in the original white paper and HB 5345.

[3] The discussion of the original white paper will also include references to the HB 5345 (Draft "A"). Some references will also include the mid-September second white paper where appropriate.

Creating a "Super-Pool" of Insured Lives

The basic thrust of the concepts presented in the original white paper and HB 5345 is that significant administrative savings, efficiencies, and economies-of-scale can be achieved by creation of a single, mandatory plan to be run by state government with a "super pool" of an estimated 500,000 active and retired public employees whose buying power and size could achieve significant savings. In addition, the concept of "standardization" of benefits as proposed in the white paper would supposedly produce even greater savings.

In theory, this would become a mandatory single Michigan health plan for public employees and their dependents that could be able to achieve its savings through administrative efficiency, economies-of-scale, and the power of a large purchasing pool. In addition, HB 5345 contemplates the potential for private sector individuals and businesses to buy into this mandatory single-payer plan, in essence creating a state-level public plan option.

The savings theory for public employees is based upon two critical errors of assumption. The first error is the assumption that de facto pools of the necessary size do not already exist. The second error is the assumption that because there are a large number of individual bargaining unit contracts there are an equally large number of insurance plans and carriers, when the fact is most plans stem from common basic programs of insurance such as PPOs and HMOs.

It is important to understand that active state employees, at about 50,000, and retired state employees at about 50,000 as well, **plus their dependents**, already have very large pools, as would the retired school employees (167,265 **plus dependents**). All three of these groups effectively are already covered by one plan. The active school employees (250,918 **plus dependents**), are primarily covered by only two carriers.

Further, and more importantly, all of the above plans specifically proposed for further consolidation in the name of efficiency are already among the largest in the state and already have the benefit of the purchasing power of the Blue Cross Blue Shield network, with its total of 4.7 million enrolled members behind them in one form or another, either as the direct provider or as an underwriter.

It is difficult to conceive of any kind of additional assemblage of these plans (and many other local government plans that also would already have either direct Blues coverage or Blues backing) that would be able to obtain significant additional economies-of-scale and purchasing power.

This is a major, critical fallacy in the savings assumptions underlying this proposal.

For those who suggest that other large insurers might be able to do better than Blue Cross, which has 4.7 million covered lives, here are the other top health insurers operating in Michigan today, all of whom fall far short of the scope of the Blues.[4]

Table 1: Top 15 Accident and Health Insurance Writers

Regulated Entity	Michigan Direct Premiums Written (in Thousands)	Michigan Market Share	Rank
Blue Cross & Blue Shield of MI	$6,837,195	33.34%	1
Blue Care Network of MI	$2,139,115	10.42%	2
Health Alliance Plan of MI	$1,649,196	8.04%	3
Priority Health	$1,257,221	6.13%	4
Molina HealthCare of MI, Inc.	$649,110	3.16%	5
Great Lakes Health Plan, Inc.	$541,550	2.64%	6
Humana Ins. Co.	$491,658	2.40%	7
Delta Dental Plan of MI	$482,881	2.35%	8
Health Plan of Michigan, Inc.	$448,661	2.19%	9
Healthplus of MI	$417,709	2.04%	10
UnitedHealthcare Ins. Co.	$344,551	1.68%	11
Aetna Life Ins. Co.	$288,787	1.41%	12
McLaren Health Plan, Inc.	$205,853	1.00%	13
Midwest Health Plan, Inc.	$201,115	0.98%	14
Healthplus Partners, Inc.	$196,586	0.96%	15

Source: 2008 Office of Financial and Insurance Regulation Annual Report.

The second error of assumption is that the slight variations of individual group plans add significantly to the cost. Far more likely is that the added cost differential of having a $10 drug

[4] Crain's Detroit Business, August 10, 2009, p. 18.

co-pay in one plan versus a $20 drug co-pay in another is a very minor difference for administrative costs—especially in relationship to the savings for the group with the $20 co-pay. The **amount** of the benefit differential would be far more critical to the total cost of the plan than the fact of the differential.

About Those Savings Claims

Within the original white paper, the savings claimed from administrative efficiencies or economies-of-scale are not specifically identified, but simply asserted. Further, the amounts claimed for administrative efficiencies and economies-of-scale savings pale in comparison to the bulk of the savings, which per the proposal's own figures would come from **"standardization of benefits"** via proposed policy changes that would reduce costs by limiting benefits and increasing employee co-insurances, co-pays, deductibles, and the scope of benefits to the average of public employees in the other 49 states, and to the averages for private employees in Michigan. While HB 5345 changes this proposed double benchmarking to a comparison against only the other 49 states' public employee plans, it does not change the fact that the savings are really from reduced benefits and increased costs to employees, not administrative efficiencies and/or economies-of-scale.

HB 5345 also does not specify who will determine these averages and how those calculations will be done, or how frequently they would be updated. This critical cost factor is apparently left to the determination of the "board" or the OSE. Would these benchmarks of the average of 49 states be based simply on average premiums, or would they also be benchmarked to true comparisons of actual benefits provided, including co-payments and deductibles, and all other plan provisions? Since there is no official, legal publication of these figures, the methodology for this critical calculation would apparently be left to either the administrative determination of the Office of the State Employer or the new board proposed in HB 5345.

The analysis turns now to a more detailed review of each of the specific categories of claimed savings.

An Analysis of Specific Savings Claims[5]

The proposed mandatory single plan as introduced in HB 5345 would, according to the original white paper, include "all public sector employees, from the local school bus driver to the Governor and other elected officials."[6] All public employee retirees would also be affected according to the original white paper. HB 5345 confirms this broad scope of coverage.

As noted above, the proposal suggests the total potential savings might be in the range of $700 to $900 million. These savings claims were developed from the components summarized in Table 2.

Table 2: Summary of Savings Claims as Presented in the Original Dillon White Paper (in Millions)

Savings Component	Low Estimate in Millions	High Estimate in Millions
Administrative efficiencies		
Total savings	$80	$95
Estimated costs	($15)	($20)
Net time saved from administrative efficiencies	$65	$75
Economies-of-scale	$100	$200
"Standardized" benefits for all public employees[7]	$400	$600
Additional savings from better health practices	$0	$0
Total claimed savings[8]	$565	$875

Note that the itemized list for the low end of the potential savings range is well short of the total stated as $700 million in several portions of the original white paper. This analysis has not been able to account for this "lost" $135 million in the July 16 original white paper. It may be rounding, but if so, it's aggressive rounding, and far more so than the rounding from $875 to

[5] The revised white paper, the draft bill, HB 5345, and the recently released second white paper rely on the same savings estimates, with varying supporting rationale.
[6] Original white paper draft, p. 1. The second white paper seems to skip over the collective-bargaining savings, changing the story to argue savings from administering health benefits.
[7] These benefits would be "standardized" at a lower level than that in many current state and local contracts by bringing them to the average of the other 49 states, and employee costs would also be set at that 49-state average.
[8] Savings figures as cited on the summary page of the original white paper draft dated July 15, 2009.

$900 million for the high-end estimate outlined in the original white paper. The following section of this report will examine each of these categories of savings in more detail.

About the Administrative Efficiencies: Time Saved in Bargaining and Benefits Administration

The original white paper estimates net savings statewide at $65 to $75 million after added expenses of $15 to $20 million for new staffing in the Office of the State Employer (OSE). According to the original white paper, these savings would come from the time saved from collective bargaining and benefits administration that is spent "to individually negotiate and administer hundreds of unique health care plans."

These savings estimates are not supported by direct evidence, but they seem to be vaguely related to a portion of the analysis in the 2005 "Hay" Report, which suggested that administrative savings from a super pool might be obtained at least in part via self-insurance and administration of a self-funded plan.[9]

There are major differences between savings from a "self-funded plan" and savings from reduced collective bargaining. Moreover, nowhere else in the original white paper is the idea of self-funding versus purchase of insurance even suggested. While self-funding might be a valid approach in appropriate circumstances, arguing potential savings from self-insurance is very different from administrative efficiencies achieved via changes to collective bargaining.

HB 5345 does not directly address self-funding either, but does provide a bit more clarity here, suggesting that self-funding might be on the table. Note the following:

[9] "Report on the Feasibility and Cost-Effectiveness of a Consolidated State-wide Health Benefits System for Michigan Public School Employees," The Michigan Legislative Council, July 13, 2005. A number of the "savings" concepts and numbers in the original and subsequent white papers seem to derive indirectly from the Hay Report. Unfortunately they did not retain the caveats attached to some by the Hay Report itself, nor did they correct for critiques made at the time. Most importantly, much of the arguments made in the white papers about case management of benefits, disease management, and aggressive pharmacy benefits management including use of mail order and generics—already common at the time of the Hay Report—seem to be based upon the belief that these tasks are not already common to most coverages, and certainly those of the Blues and MESSA. Finally, much of the savings estimated by the Hay Report came from dramatic reduction of Fee-for-Service Plans (FFS). In the intervening years, the market has addressed that, and there are very few FFS plans still operating.

> Section 6(f) "Determine whether the purchase of reinsurance for the MI health benefits program is in the state's best interest."
>
> Section 18 (1) "The MI health benefits fund is created in the state treasury and is held in trust to support the contractual obligation for health benefits…" (In and of itself, some fund would need to be created simply to receive and disburse funds under any form of state administration.)
>
> Section 20 "The costs of the MI health benefits program benefits and administration shall be fully supported by assessments on the participating employers and retirement systems, and those entities shall be responsible for remitting any employee share of the costs."

Taken together these provisions begin to look like parts of an intended self-administered and self-funding plan, because if the administration of the plan were to be contracted out, the payments could more easily go directly to insurance company "X" rather than being run through the State Treasury. In addition, the Section 20 language seems to anticipate a system where all members could be assessed for any unanticipated operating costs or unanticipated costs of benefits, as well as all regular operating expenses.

About Administrative Costs

Even without the self-funding approach, and definitely with it, along with the other duties for the Office of the State Employer spelled out in the original white paper and HB 5345, this analysis questions the accuracy of the $15 to $20 million estimate for added costs to OSE.

This proposal looks to create a very large, complex organization that will effectively mimic the role of a large insurance company. The total premiums involved would likely range from a low estimate of $4 billion to a high of $5 billion (the combination of employer and employee payments) annually at full implementation. **To suggest that this could be managed for $15 to $20 million including other duties such as claims processing, negotiating benefits packages with thousands of government units, and the research and implementation of improved holistic quality medical practices, would suggest that all these duties could be carried out at an administrative cost of about 0.4% of premiums, which seems exceptionally low.**

Appendix A contains a complete copy of HB 5345 as introduced. For the long list of powers and

duties of the board see Sections 7, 8, and 9. For the powers and duties of the Office of the State Employer (OSE) see Sections 11, 12, 13, and 15. Section 14 addresses joint powers and duties.

In an effort to ballpark the appropriateness of that estimate, this analysis looked at some other measures of what the administrative costs might be. First, a rough financial analysis was performed on the public financial data of a large national for-profit health insurance company. That analysis produced an estimate of approximately 16.5% of premiums being utilized for "general and administrative expenses." Some portion of this would undoubtedly include advertising, which would not be necessary for the pool proposed here.

Assuming estimated advertising expenses equal half of the 16.5%, that leaves a rough figure of 8.25% for estimated administrative expenses. Making the multiplication of 8.25% times the range of $4 to $5 billon anticipated for potential premiums would provide a **ballpark estimate for administrative expenses of $330 million to $412.5 million** with a premium range of $4 to $5 billion.

Additional analysis was performed using reported data from the insurance pool operated by North Carolina. Their administrative expenses are approximately 7.0%.[10] **This would create a cost range for Michigan's larger proposed pool of $280 million to $350 million**. Additional information obtained about the expenses of a similar pool operated by Georgia indicated administrative expenses of approximately 8.1%.[11] This, of course, would produce a still higher potential cost estimate for the proposed Michigan plan, but indicates that 7% to 8% is a reasonable cost ballpark.

[10] State of North Carolina, Summary of Operations for the Period Ending June 20, 2009; additional calculations by Public Policy Associates, Incorporated.
[11] State of Georgia, Comprehensive Annual Financial Report for the Fiscal Year Ended June 20, 2009; additional calculations by Public Policy Associates, Incorporated.

Table 3: Comparison of Original White Paper Administrative Savings Assumptions versus PPA Estimate

	Original White Paper Low Estimate	PPA Low Estimate	Original White Paper High Estimate	PPA High Estimate
Original white paper gross administrative savings	($80)	-0-	($95)	-0-
Added costs for State Employer*	$15	$15	$20	$20
Net savings per original white paper	($65)	$15	($75)	$20
PPA estimate of cost for insurance administration**	NA	$280	NA	$350
PPA estimate of net cost[12]	NA	$295	NA	$370

*PPA uses original white paper estimate of costs to the Office of the State Employer to reflect potential collective bargaining and related duties proposed for the Office of the State Employer.
**This PPA estimate for the costs of administering the insurance program, processing claims, etc. is based upon the North Carolina experience.

The analysis thus concludes that the likely administrative costs far exceed those suggested by the proponents of the proposal, even allowing for the original white paper's claim of savings from "reduced" collective bargaining. Disallowing for those doubtful savings, as shown in Table 3, even using a low cost estimate of 7%, **there is a strong potential that the proposed change could actually cost the State of Michigan $295 to $370 million to administer, prior to any charge backs to local governments and schools and other pool participants than estimated in the original white paper.**

Further, the original white paper and subsequent documents do not seem to recognize that **IF** there are savings from reduced collective bargaining (to be discussed further below), the bulk of them would accrue to local governments, with the state at least initially assuming full costs of operations before any charge backs.

Additional Potential Costs

Note that aside from administrative costs, the ability to self-fund would require the creation of a large cash reserve, which is not a very realistic option for state government at this time or in the

[12] PPA's estimate assumes the $15 to $20 million might reflect added costs for the proposed increased OSE collective bargaining role, but not for the cost of operating a multi-billion dollar insurance program.

foreseeable fiscal future. As a ballpark, this analysis estimates that in order to fund an appropriate reserve for self-funding, something on the order of two months of potential claims might be needed**. The analysis estimates this amount to be approximately $200 to $250 million for each month, for a total of $400 to $500 million.**

This money would need to reside in a reserved account, unavailable for use for payment of other bills of state government, and might literally be impossible for Michigan to create without borrowing, given the fragile cash flow position of Michigan's state government funds. However, the State of Michigan already is borrowing as much as it is constitutionally allowed to borrow for cash flow purposes within a fiscal year. Assuming the state were able to borrow, or to set aside sufficient funds, the cost would be the net interest paid or interest foregone on the funds. **A ball park estimate of this over time might average 3% per year, or $12 to $15 million annually.** This cost would be in addition to basic costs of operation cited above.

Another option would be an "assessment" on plan members or employers, and that might be contemplated given Section 20 of HB 5345, which provides for an employer assessment if necessary. Such a reserve also could be minimized by the purchase of "reinsurance," and indeed, HB 5345 appears to at least contemplate that, because it allows the board to purchase reinsurance (see Section 7(f)). Much more information and detail is needed to review what self-funding does or does not imply for operating and administrative costs for this state-run plan.

Further, the State of North Carolina, which has been cited in other circumstances as an example of a state that has saved huge amounts from operating a self-funded super pool, **very recently had to appropriate $255 million of state funds to cover a deficit in the plan, with additional funds appropriated for future budget years.**[13] **In addition to those appropriations,** employee benefits were reduced and charges increased to bring the plan into balance, so the taxpayer and worker cost combined was substantially larger.

[13] See newsobserver.com 2-05-29, 4-15-09, 4-23-09. Also, Board of Trustees North Carolina Health Plan, May 19, 2008, "2009-10 Benefit Changes," www.shpnc.org.

The white paper also suggests that some portion of the administrative savings estimate would be due to "minimizing the costs associated with duplicate processes, staffs and insurance agents and brokers."[14] It is really unclear how this loss of private sector business would possibly benefit the state budget, but it is clear that in some cases the potential might exist that these local insurance agencies might pay lower taxes or go out of business, with unknown negative impacts on some of the affected local economies, and in the aggregate the state economy.

The white paper also describes other additional specific OSE duties: "responsibilities and functions needed to plan and administer…" including "researching best practices in health care design, negotiating benefit plans, administering benefits, communicating with and educating employees and retirees, managing relationships with health care plans and other providers, and participating in/supporting public forums focused on health care reform."[15] OSE would also be charged with negotiating plans according to the original white paper, and as already noted, with no discussion of the specifics behind its numbers, staffing-level needs are likely to be underestimated.

If the plan is to have OSE fully assume all of these functions, this analysis suggests that there is probably as much or more potential for increased costs to the system as a whole because the reality is that except in the largest units, the local officials and their staffs who already handle insurances and participate in the collective bargaining process also have other duties. This would also be true for time spent in helping local employees fill out forms, or assisting with paperwork for claims. In the real world switching these duties to the state would not save much if anything for local governments and schools beyond the opportunity cost of "found" time for other tasks, and it would be a completely new cost for the state budget.

Assuming that the bill's proponents are correct, and bargaining would formally occur at the state level rather than the local level, would that really be more efficient than the current system? In reality it would split bargaining of the key elements of compensation—**salary** would remain negotiated at the local level while **health benefits** would allegedly be bargained at the state level

[14] Original white paper, p. 11.
[15] Original white paper, p. 11. Also see Appendix A.

with a party that is not the employer—by selecting from a limited menu of plan choices. How, exactly would that work? The original white paper and subsequent supporting documents are silent on the answer. Experience suggests it would create a greater potential for increased compensation costs rather than reductions in relation to the current system.

If accurate, this potentially creates additional issues for the cost-savings estimate. HB 5345 and other public comments subsequent to the original white paper suggest that the real result would mean that collective bargaining on benefits would be constrained to a very limited menu of choices of plans available through the state pool.

If there is to be only one plan (which according to the basic premise of the original white paper is the core of the proposal, and the idea of one plan is also central to the arguments for administrative efficiencies and economies-of-scale savings), this analysis fails to see how allowing individual localities and bargaining groups to instead negotiate their own plans with the state employer can possibly save anything in time or money. The recent comment is, in fact, in direct conflict with the premise of the plan as suggested in the original white paper.

The real problem with this assumption of savings from reduced negotiation time is that it would not happen for three critical reasons.

First, much of the time spent on labor negotiations is spent by salaried employees, and while there is an "opportunity cost" of utilizing that time that would be freed up for other tasks if this proposed change saved any time, there would be little or no actual cash savings.

Second, a given number of those personnel presently involved in local negotiations would be local government employees, and if there were savings, they would certainly accrue to local budgets, more realistically as "found time" rather than cash, and certainly not to the state budget.

Third, and far more important in terms of negating the possibility of administrative savings via reduced negotiating time, is that these negotiations are nearly always over total compensation, including wages and benefits, with a trade-off on salary often being made for an improvement or

maintenance of benefits coverage or vice versa. The actual negotiation time is thus really determined by the difficulty of reaching a satisfactory compromise on the total compensation package.

For these reasons alone there are not likely to be any sizeable administrative savings from this proposal as it is presented in the original white paper and further outlined in HB 5345. Indeed, based upon comparisons to North Carolina, it appears that administrative costs to implement the proposal are significantly underestimated.

Further, even if there were administrative savings, as presented, the proposed structure involving the Office of the State Employer would mean that **all of the new costs would fall on OSE** and if there truly was significantly reduced negotiating time (which this analysis does not find) those savings would almost all accrue to local governments, school districts, and other units, not to the state budget.

Economies-of-Scale from the Creation of Super Pools

There is no detailed discussion of the assumptions made in the white paper regarding estimating these savings. There is no discussion of how big "big" really needs to be. There are some issues relevant to estimating the accuracy of the savings claimed here.

Research has turned up one recent study that suggests a group size of approximately 20,000 members is large enough to achieve much of the theoretical economies–of-scale.[16] Previous experience and other general research suggests that this number might be somewhat low (anecdotal evidence suggests that the optimum size might be 50,000), but the point is that there is probably an optimum group size that is larger than a few, a few dozen, a few hundred, or a few thousand. It is also appropriate to note that the pool size for insurance purposes would include dependents as well as the employees themselves. Table 4 summarizes this analysis' current estimates of group sizes.

[16] National Association of State Personnel Executives white paper, State Government Employee Healthcare Benefits, September 2006, p. 6.

Table 4: Estimated Potential Pool Size Impacted by Proposal

Group	Number	Estimated Dependents	Estimated Total Size	Coverage	Group Share of Total
State Employees					
Active Civil Service	**53,129**	**106,258**	**159,387**	**BCBS**	**10.19%**
Defined Benefit	28,568			BCBS	
Defined Contribution	24,561			BCBS	
Retired Civil Service	**54,287**	**81,431**	**135,718**	**BCBS**	**8.68%**
Defined Benefit	48,078			BCBS	
Defined Contribution	6,209			BCBS	
Active Legislators	**148**	**296**	**444**	Unknown	
Retired Legislators	Unknown	Unknown	Unknown	Unknown	
Active Judges	257	514	771	**BCBS**	**0.05%**
Retired Judges	540	810	1,350	**BCBS**	**0.09%**
Active State Police	1,660	3,320	4,980	**BCBS**	**0.32%**
Retired State Police	2,736	4,104	6,840	**BCBS**	**0.44%**
University [1]	NA	NA	NA		
Local Government					
K-12 Schools				Assume 60%	
Active K-12	278,790	557,580	836,370	MESSA/BCBS	**32.08%**
Retired K-12	**167,265**	**250,898**	**418,163**	**BCBS**	**26.74% Self-funded**
Community Colleges[2]		In K-12		BCBS	
Cities and Villages	Unknown	Unknown	Unknown	Unknown	
Townships	Unknown	Unknown	Unknown	Unknown	
Counties	Unknown	Unknown	Unknown	Unknown	
Special Purpose	Unknown	Unknown	Unknown	Unknown	
				Estimated share to BCBS/BC related:	
Estimated Total	**558,516**	**1,004,618**	**1,563,134**		**78.59%**

Sources: Comprehensive Annual Financial Reports for State Employees, Michigan Public School Employees, Judges, and State Police Retirement Systems for the Year Ended 2008.

[1] Some university employees are in the School Employees system; most are not.

[2] Community college active and retired employees are in the School Employees system.

There appears to be serious misunderstanding in the original white paper itself and subsequent comments about the size of the groups involved, and the difference between insurance carriers and specific group plans. According to the most recent Comprehensive Annual Financial

Reports for the School Employees Retirement System, it alone has 167,265 retired members (plus dependents who may be covered under their insurance), with 278,642 active non-retired members (plus their family members) on school payrolls around the state.[17]

The State Employees Retirement System has 48,078 retirees in the Defined Benefit (DB) plan and 6,209 in the Defined Contribution (DC) plan receiving health benefits. Active state employee members total 28,568 under the DB plan and another 24,561 under the DC plan.

The DC members and their dependents have already been impacted by graded premium changes that will produce major savings as they retire. The active employees and their dependents would now be covered under the active payroll and benefits programs. The retired members and their dependents would be included under the retiree insurance program with graded premiums for future retirees.

The total size of the MPSERS (school employees) system alone equals 445,907 members, and the state employees' system equals 107,416 for both active and retired, again, plus dependents for both systems. Calculated somewhat differently, the active and retired state employees, plus the retired school employees, all under the ultimate administrative control of the state already, total 274,681 (107,416 + 167,265), plus their covered dependents for insurance purposes mean an existing pool totaling somewhere near 500,000). This pool of covered lives is surely large enough to already have achieved much, if not all, of the theoretical potential of economies-of-scale, and despite the existence of several specific plans, nearly all of these members and dependents are ultimately covered by Blue Cross with its 4.7 million members.

[17] Michigan Public School Employees Retirement System, Comprehensive Annual Financial Report 2008, and the similar report for the Michigan School Employees Retirement System for 2008. The second white paper contains a similar looking table with much different estimates for state employees in particular, based on Census data. The Census data includes large numbers of part-time employees, and many of those would normally not be eligible for any benefits, especially health benefits. For state employees the second white paper also notes that the numbers include members of boards and commissions. Again, while a few (Liquor Control Commission) board members are really full-time employees, most are part-time and do not receive any compensation, since even most of the limited per diem payments for attending meetings have long been cut from the budget. Many of the large numbers of university employees included in the Census data would be part-time student workers—again, likely not receiving benefits.

As another indicator of the size of the pools that already exist, the systems administered by the State Office of Retirement Services, which include the plans noted above plus the State Police and Judges Retirement systems, is numerically the 15th largest public retirement system in the country, the 21st largest public or private system in the country, and the 39th largest system in the world.[18]

In the school employees group, the 278,642 active employees and their beneficiaries would be covered for health insurance by hundreds of differing bargaining groups in the hundreds of independent districts and public school academies around the state, but it is clear from the nature of the health insurance market that a relatively small number of large carriers share the majority of the market. BCBSM already serves either directly or indirectly, through sponsors such as MESSA and SET-SEG (the health plan of the Michigan Association of School Boards – MASB), a very large portion of the active school employee market.[19]

While coverage plans for individual districts or bargaining units may have some variance in levels of benefits covered and co-insurance, co-pay, and deductible requirements, the major basic insurance provisions all tend to be very commonly shared. It thus would seem to be one more reason that they have achieved much of the theoretical savings of mass purchasing power from large group size. The reader should not exaggerate the relatively minor cost differences created by small, local variations of benefits relative to the basic economies operated by the general insurance coverage provided under Blue Cross or Blue Cross-backed insurance. These do insert some added degree of administrative complexity, and ultimately cost, into the system, but the bulk of these costs would fall more directly on health care providers—as would the direct benefit of reducing them.[20]

[18] State Web site, accessed August 10, 2009, http://www.michigan.gov/ors.
[19] MESSA, or Michigan Education Special Services Association, is legally organized as a VEBA or Voluntary Employee Benefit Association, organized for the benefit of education employees in the state of Michigan. In addition to its own direct large size, MESSA contracts with BCBSM for reinsurance purposes and thus benefits from their preferred provider rates.
[20] The second white paper cites this as a possible justification for reducing administrative costs, but again, there will be minimal, if any savings here, because of the multiplicity of other plans existing in the real world that still must be administered, and the likely very long-term tail on any potential pay-off.

As noted above, this preliminary analysis of the insurance systems existing in Michigan today indicates that many of the very largest public employee systems should already be benefitting from near maximum levels of any theoretical economies-of-scale savings.

Standardized Benefits

As can be seen in Table 2 on Page 9 summarizing the white paper savings claims, the issue of "standardization of benefits" is really where the bulk of the savings are claimed to come from under the proposal: to require public employees to accept a combination of reduced health care benefits with increased employee cost sharing and limited coverage options is nothing more than a poor synonym for reduced benefits and/or increased employee cost sharing. .

Moreover, the policy goal of HB 5345 is aimed at a reduction of benefits and/or increased costs by setting the goal of equaling the average of premiums paid in the 49 other states versus recognizing that such an average would be composed of a wide range of plans and costs reflecting the traditions and history of each individual state. "**Standardization" of benefits is thus clearly intended to be a leveling down, not a leveling up. Make no mistake, "standardized benefits" as used by the proponents of the plan and HB 5345 is really a synonym for "reduced benefits."**

The justification for seeking to implement these changes is based upon some selected "comparisons" of public employee benefits in Michigan with public employee benefits in other states.

This discussion can be found on pages 13 through 15 of the original white paper, where there are repeated uses of examples of differences between Michigan public employees and private employees or public employees in other states that use examples of premiums in Michigan for the highest cost policies available, compared to averages for other states.

No consideration has been given to plan design differences such as deductibles, co-pays, coverages, waiting periods, coverage of pre-existing conditions, requirements for second opinions on selected services, or for pricing forces such as the difference in costs between rural

and urban areas, the wide range of risk variances among public professions such as the higher cost of covering police and fire fighters versus teachers, for example, and demographic differences between Michigan's public employees and the national averages cited in the original white paper.[21] No consideration has been given to different expectations of insurance coverages formed by decades of experience.

Yet another section of the original white paper finds that MESSA health insurance seems to cost even less than the state employee plans, that it is within the range of costs for private sector plans, and that "MESSA has controlled health care cost increases at levels below national averages."[22]

The original white paper specifically notes that MESSA leverages "its large size and scale to purchase health care services more efficiently…create larger pools to spread risk…offers health management tools…"[23]

The above descriptions from the original white paper itself suggest the more likely conclusion that the system in place today is not in need of dramatic change.

Further Analysis of the Standardized Benefit Savings Issue

Before leaving this analysis of the savings potential from what the white paper euphemistically terms "standardized" benefits, but what in reality would be reduced benefits, events occurring in real time in the real world suggest that additional "savings" from this venue may be illusory, or at best much harder to achieve. Specifically, state employees and retirees have already made major cost concessions, and analysis of school district expenditure data and anecdotal evidence suggests that benefit reductions also are already occurring there as well through the vehicle of local collective bargaining.

[21] This oversimplification of comparison of premium costs instead of plan benefits content is continued in the second white paper.
[22] Original white paper, pp. 6-7.
[23] Original white paper, p. 7.

First, consider some specifics related to state employee and retiree costs. The most recent state employees' contract included major changes related to health coverage. These changes have also been extended to state retirees. The original white paper itself acknowledges that this will save an estimated $100 million per year ($300 million over three years) via changes in premium sharing (from 5% to 10%), and changes in deductibles and copayments, as well as prescription drug coverage.[24]

This $100 million in 2010 and again each year forward would be an already achieved savings, under the current system, with the current insurance plans and collective bargaining system.

About the State Employee Pay Process

The original white paper also notes, moreover, that when this contract was negotiated, the resulting employee payments agreed to by state workers increased from greater than the average of other public employees in Michigan but less than private sector costs to greater than those of workers in the public and private sector. When the current state contracts were negotiated, they were in the context of historical data about private and other public contracts in Michigan, and that process resulted in an increase in state employee costs that exceeded the then-known Michigan private cost average.

It is important to understand the process of state employee pay and benefits setting used in Michigan. A key part of that process is research and surveys into what both private and other public employers pay their workers in direct compensation and benefits. The nature of that process means that it is always measuring against proven historical data, not estimates of what might or might not be happening with those other employers in the future. In typical times of rising pay, it means public employees would always lag behind. And in times of declining pay, it also means that they might not decline as fast.

In a report prepared in November 2008,[25] the House Fiscal Agency reported the following comparative data:

[24] Original white paper, p. 4.
[25] Civil Service Salary and Benefit Comparisons, Michigan House of Representatives, House Fiscal Agency, November 2008, p. 15.

Table 5: Employee Contributions to Cost of Health Insurances

Employee Group	Employee Family Coverage Contribution/Month
Median of other public employers surveyed*	$52.74
Average of other public employers surveyed	$62.01
State of Michigan employees 2006-07	$67.80
Median of private employers surveyed	$125.36
Average of private employers surveyed	$138.15
State of Michigan employees 2008-09	$142.37

*Survey responses from 128 private employers and 66 public employers. Survey conducted by O. William Rye & Co. LLC and Michigan Civil Service Commission.

At that point in time, the health insurance premium sharing for state employees was already slightly above the averages for other public employers in Michigan, but less than the private sector averages, and the new contract set future state employee costs slightly above the average for private sector employees based upon the best and most current actual data available at the time.

The original white paper proposes that Michigan public employee benefits be set in comparison to those of the private sector in Michigan (although this was dropped in HB 5345), and the public sector in the other 49 states. The nature of the public compensation process means that it is going to lag the private sector, especially if the intent is to benchmark against the private sector, if for no other reason than the simple fact that the private sector data will always need to be collected before it can be benchmarked. The same delay would be true for collecting data from other states.

The original white paper and HB 5345 are both silent on exactly how these benchmarks would be calculated. If the goal truly is to actually benchmark, those comparisons would need to be adjusted for all major policy details, not just employee share of premium, but also co-pays, deductibles, prescription drug coverages, including use of generics versus name brands, and

dozens of other details to ensure that the comparables are truly comparable. These will not be easy or simple rough averages.

The same House Fiscal Agency report also noted some other significant public-private comparisons. For example, 54.8% of the state civil service workforce has a college degree, twice the private sector percentage of only 26.9%. Michigan is one of only two states with a mandatory defined contribution retirement system for new hires, and since it made that move in March 1997, it has saved $143 million in pension costs. Michigan's defined benefit plan for pre-1997 hires uses the second lowest multiplier (1.5%) compared to other states.[26]

This different mix of workers is not an unknown phenomenon. Most labor researchers are well aware of it and caution against direct comparisons of public/private compensation because the workers have such dramatically different skill sets, education levels, and tasks.

The evidence suggests that at the state level, and at the local school level in the discussion that follows, the marketplace already does a pretty good job of keeping public employee compensation and benefits as a totality in approximate conformity with the private sector.

This analysis takes an approach different from the original white paper's attempt to analyze different premium charges for different policies, and analyzes recent trends in K-12 expenditures as a whole. A review of data at an aggregated level for all school districts (and public school academies, also known as charter schools) suggests that a large degree of savings from "standardization" is already occurring there as well, under collective bargaining and with local control.

Figure 1 is based upon data for Instructional Services reported by all Michigan school districts and charter schools over the last several years. It disaggregates the data for total fringe benefits based upon known actual rates for retirement and social security contributions. While the remainder of the costs analyzed would have included more than pure health insurance per se (for

[26] House Fiscal Agency, Civil Service Salary and Benefit Comparisons, November 2008, Lansing, p. 15.

example, dental and vision coverages, and disability and life insurances, which normally do not vary much from year to year, the amounts involved there are relatively small, and should not materially distort the comparisons in the chart).

Figure 1 shows the annual percentage changes in the total expenditures for salaries, total fringe benefits, and the analysis' estimated proxy for insurances alone. It suggests that rather dramatic changes have occurred in the last few years. Annual changes in salaries have hovered consistently around the 2.0% mark, but benefits overall, and especially health benefits, which would be the major variable in this category, began to show dramatically slower growth rates in 2006. This would seem to indicate that these costs are being addressed to a considerable degree in the existing collective bargaining system.

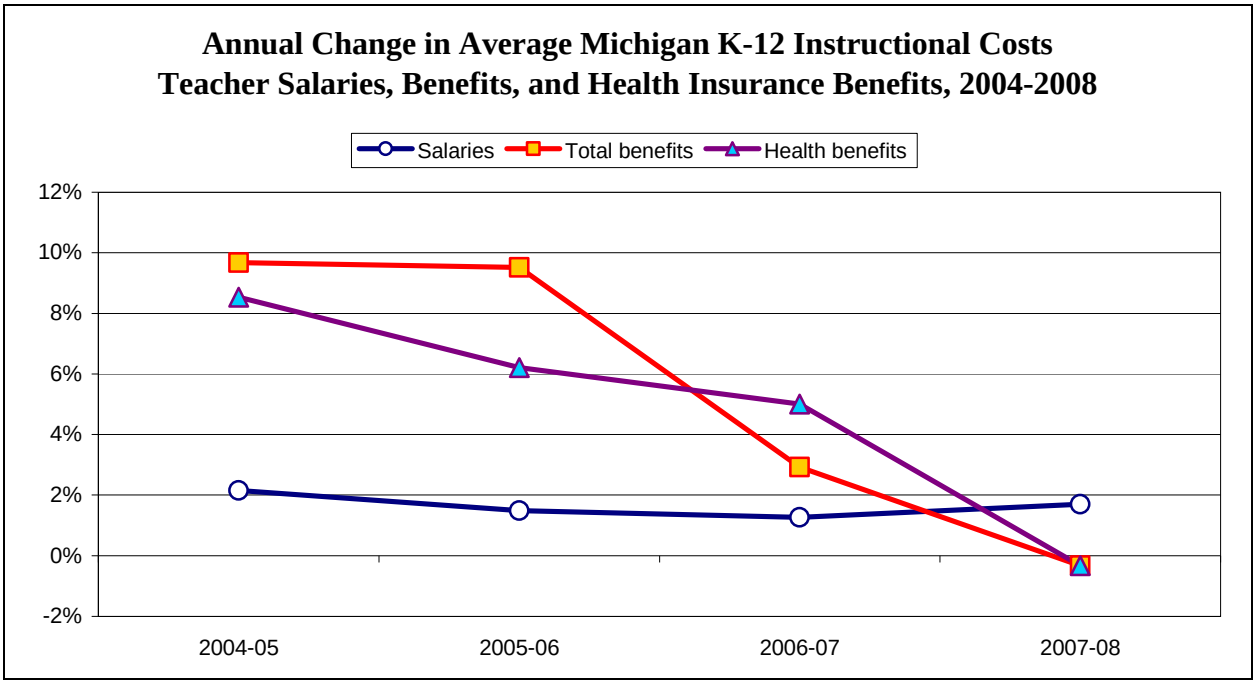

Figure 1
Source: Michigan Department of Education, Bulletin 1011, 2003-2004 through 2007-2008; additional calculations by Public Policy Associates, Incorporated.

In an attempt to parse this data a bit further, the analysis also calculated the annual percentage change in a proxy for health benefits, as a share of total instructional costs, as presented in Figure 2. Here there is an actual decline in costs in 2008. The data presented here are only indicative of potential trends, rather than confirmative, but it may be the most comprehensive

current data available about changing directions in public employee health care costs and it certainly merits consideration in the debates on this issue. This would likely result from a combination of reduced benefits and employee cost sharing changes—the exact goal contemplated by the original white paper.

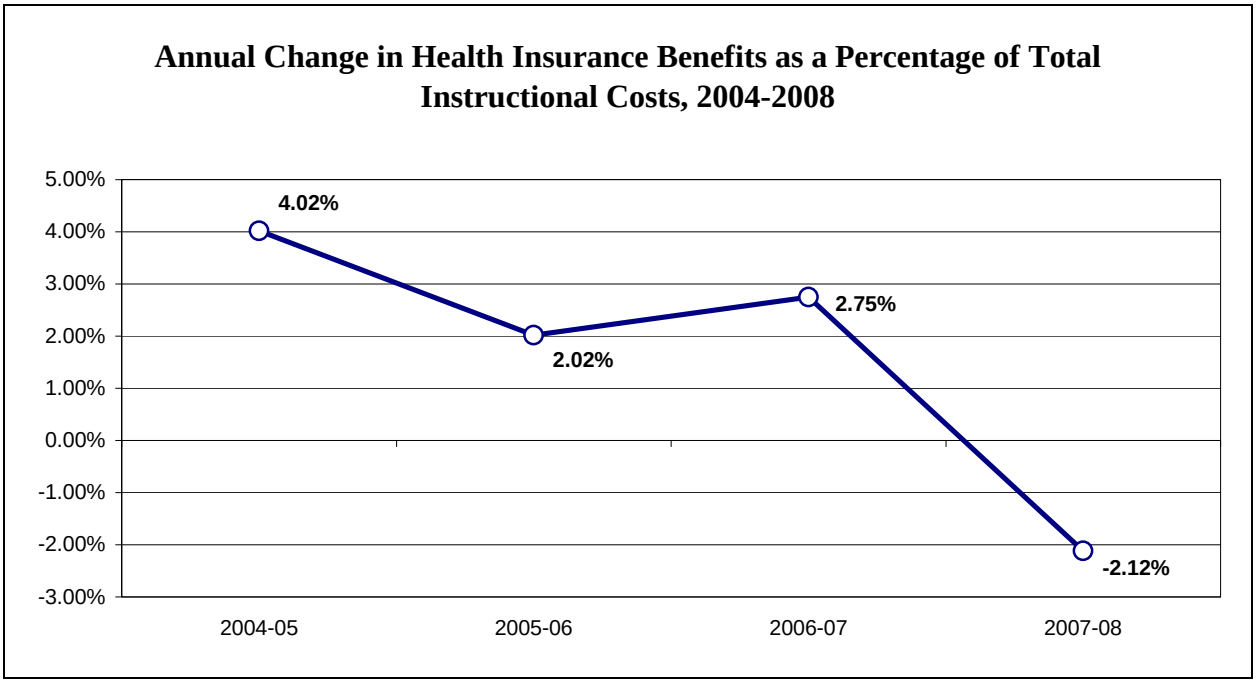

Figure 2
Source: Michigan Department of Education, Bulletin 1011, 2003-2004 through 2007-2008; additional calculations by Public Policy Associates, Incorporated.

Finally note Figure 3, which compares health insurance premium changes for all United States employers as reported by the Kaiser Family Foundation, and PPA's calculated health insurance component of actual Michigan instructional costs.

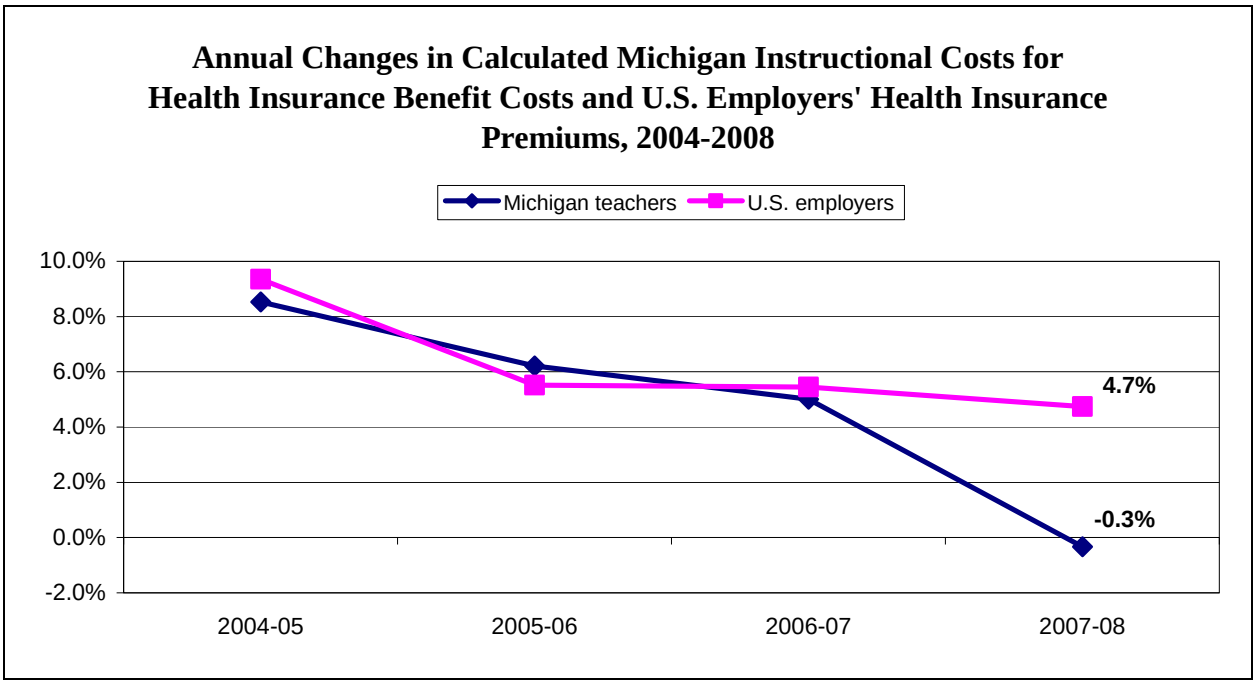

Figure 3
Source: Michigan Department of Education, Bulletin 1011, 2003-2004 through 2007-2008 and Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; additional calculations by Public Policy Associates, Incorporated.

The trends displayed in Figures 1, 2, and 3 suggest that K-12 employees in the aggregate in Michigan have both slowed growth in direct salaries, and not only slowed, but reduced total costs for health benefits.

The declining trend also shows up in the national data, but at a slower pace. One big contributor, in Michigan, and in the nation, is a very dramatic change in the health care/health insurance market overall, marked by a systemwide shift from traditional fee-for-service coverage to Preferred Provider Organizations (PPO), Health Maintenance Organizations (HMO's), and other new service delivery and payment mechanisms.

Given the current economic crisis facing Michigan, and its widespread impacts across governmental units all over the state, the near-term outlook is that some further degree of savings is virtually certain **without a the proposed large expansion of state government**, since employers with constrained revenues will be faced with the choice of reducing employees or reducing employee costs (be it fringes or direct salaries), with or without this proposed change.

About Potential Savings from "Holistic Health Approaches and Best Practices Improvements"

The original white paper assumes no savings from these suggestions, but public comments by the Speaker have suggested that they may be a source of huge savings. The second white paper contains an extensive discussion of the potential savings here, but still at a theoretical level.

They may be achievable, over long periods of time, but many of them will require fundamental changes in how all Americans—not just public employees—relate to medical care and personal responsibility. Indeed, the original white paper itself notes that "studies show that it often takes seventeen years for best practices to be fully adopted by the medical community."[27] This is because doctors, nurses, hospitals, and other health professionals do things the way they were trained to do them—as do most other professionals—and knowledge of new practices, and more importantly, understanding of their value relative to previous practices takes time to work its way into the general knowledge base of the medical community and even longer until it is widely understood and accepted by the general public.

All major health insurers already invest considerable efforts in health education and in offering supportive services to their member clients. This is the kind of service that should continue and should be expanded, but it is unrealistic to even suggest that there might be short-term payoffs from this. Offering such services, moreover, is far different from requiring them. The original white paper was somewhat ambiguous about them, but HB 5345 seems to confirm that this is the ultimate intent (Sections 12(b), 14, and 14(a)).

Other Issues of Note

Extending One Mandatory Plan to All Public Employees in Michigan

While the issues discussed above apply to the state-controlled plans (active state employees, retired state employees, including active and retired state police, and presumably active and retired legislators and legislative staff, as well as judges), there are substantial additional issues associated with extending this one-plan concept as outlined in the original white paper to state

[27] Original white paper, p. 1.

universities, community colleges, local and intermediate school districts, charter schools, counties, cities, villages, townships, charter townships, and a host of special-purpose and intergovernmental combinations of service districts.

The State Employee Pay Process

There are definite constitutional issues that would need to be resolved about the proposal, HB 5345, and the constitutional role of the Legislature in the state employee pay process. Others have noted this concern, and further discussion seems unnecessary.[28]

Michigan's Public Universities

There also are some constitutional issues associated with "requiring" Michigan's public universities to participate in a plan like this. Consider the following:

Article VIII, Section 4 of the Michigan Constitution of 1963 requires that "The Legislature shall appropriate moneys to maintain …" and then specifically names ten of Michigan's 15 universities, although two more, University of Michigan (U of M) Dearborn, and U of M Flint are arguably covered by the U of M Ann Arbor mention. Three of the schools, U of M, Michigan State University (MSU), and Wayne State University (WSU) are further governed by independently elected Boards (Article VIII, Section 5). Board members at the other schools are appointed by the Governor. Section 5 further buttresses the independence of the University of Michigan, Michigan State University and Wayne State University.

This constitutional legacy has generally been interpreted to mean that the schools have considerable discretion over their own funding, once it is granted, with only the requirement that an accounting be provided. While this analysis does not claim the status of a constitutional legal brief, the above language generally has been interpreted to mean that the state and the Legislature cannot force these schools to do very much. However, the analysis concludes, based upon past experience with other issues of potential legislative mandate, that the state could not require these schools to join a single statewide plan.

[28] Memo from Carol J. Cukier, Legal Counsel, Legislative Service Bureau to the Honorable Pam Byrnes, Chair, House Committee on Health Care Reform, September 16, 2009.

The larger issue with the universities in terms of potential savings from reduced benefits is also impacted by another practical one: many of them do not even offer retiree health benefits from which to obtain savings. If all were forced to offer health benefits to retirees, for a number of them it would be an increase in costs, not a savings. As far as this analysis can tell, outside of the legacy costs associated with the group known to some as the MPSERS 7, whose employees used to belong to the Public School Employees Retirement System, but new hires no longer do, only MSU, U of M, and Western even offer health benefits to retirees.[29]

This combination of constitutional autonomy and already partially realized savings plus lack of retiree coverage on the part of a number of schools would mean that the pool for potential savings from one plan is likely significantly smaller than anticipated—yet another reason to doubt the savings estimate claims put forth by the proponents of the proposal.

Savings from Grouping All Local Governments and the Opt-In and Opt-Out Provisions

As noted above, it is believed that other groups of local governments may have formed purchasing cooperatives or groups to one extent or another. Further research should be completed on this issue. Some local units of government themselves may have pools large enough to have already achieved significant savings. Given the shortness of time, the analysis has not attempted to fully research this issue, but to the extent they exist and have already reached some degree of economies-of- scale, the maximum additional savings available from further mandated cooperation would be further reduced.

This is additionally harder to analyze because the actual grouping contemplated by the original white paper and in HB 5345 is not clear. In some subsequent reports, Speaker Dillon has been quoted as saying that perhaps not all would be forced to join, and the white paper notes that those whose costs are less than the single plan (which since by the description in the original white paper would be set at the average of costs for public plans in the other 49 states, one would expect that some significant number of smaller units with many part-time officials and

[29] Ibid.

employees might be below these averages) would not be required to join. HB 5345 provides for a limited opt-out option. This would seem to create two critical problems.

First, the overall group would be smaller still. Since the costs and savings estimates of the original white paper are based upon averages, this would suggest that up to half of the potential participants could opt out unless the single plan would develop an insurance package that cost employers less than the average. Failing this step, a large number of units would almost certainly opt out and reduce the size of the super pool, and according to the proponent's theory, its purchasing power.

Second, as the analysis understands the math of the savings estimates in the white paper, the economies-of-scale savings and standardization-of-benefits savings are based upon participation by all. Thus, the savings are likely overstated for yet another reason.

Opting Out

The provisions in HB 5345 allowing an opt-out option for those whose costs are less (whether from their own efficiency of purchasing, the good fortune of being located in an extremely low medical cost area, having a younger-than-average or healthier-than-average group, or providing fewer actual health benefits) seems to violate the original white paper's basic concept of a single plan and certainly violates principles of insurance. The principle of adverse selection would thus suggest that the super-pool could end up being composed primarily of higher-cost individuals and groups, with the end result of significantly higher costs.

Opting In

Recent comments, and HB 5345 (Sec 7 (h)), suggest that ultimately this mandatory public, plan might be made available to small businesses and individuals who would "buy-in." In addition to the potential impact on individual insurance agents, brokers, or companies, this could potentially have a negative economic impact on a number of business, trade, and professional associations, which both provide services to their members and help support their basic operations by selling health and other insurances to members and member businesses.

Governance Structure

While the original white paper is silent on the issue, HB 5345 (Section 3 (2)) creates a board to manage the plan, with a mix of specified appointments by the Governor, the Senate Majority Leader, and the Speaker of the House. This appointment structure raises a question regarding separation of powers that also seems to violate known constitutional precedents.

Issues of Potential Litigation at the Local Level

Creation of a "State Mandate"

Requiring local units of government to participate in one single state plan might arguably inspire one or more units or their associations to litigate based upon the argument that such state action could effectively create a state "mandate" under provisions of Article IX, Section 29 of the state Constitution, especially if the implementing legislation required the local unit to purchase only the state-selected plan.

Savings from Local Units in General

There could theoretically be savings from increasing the purchasing pools for smaller general purpose local units of government. The degree of those savings would be impossible to estimate, and would vary according to the amount of voluntary pooling that might already be occurring, the amount of ad hoc pooling benefits that are already being obtained by purchasing, directly or indirectly, benefits that allow access to Blue Cross Blue Shield's preferred provider network, and other issues. There is, however, no way to accurately estimate this from available data and especially without knowing what the benefit provisions of the super-pool plans would look like. **If there is major Blue Cross penetration in this market as well, as is likely, any savings would likely be minimal.**

The analysis finds no way, however, that any of these local savings—which this analysis believes are minimal at best outside of benefit cuts or increases in employee payments—can benefit the state budget unless offsetting cuts are made in existing state payments to locals such as via unrestricted revenue sharing, and in that event there would be no incentive whatsoever for local units to cooperate in supporting this plan.

An Additional Timing Issue: the National Health Insurance Reform Debate

This analysis also notes that regardless of anyone's position on national health insurance reform, it seems premature to embark on a major change in the structure and delivery mechanism of health insurance benefits for an estimated 500,000 public employees and retirees in Michigan, plus their dependents, given the current debate over national health insurance reform and its uncertain outcome and content.

An Additional Issue of Accruing Savings to Help the GFGP Budget

The original white paper generally discusses the state budget deficit and potential savings from the proposed conceptual reforms in terms of "savings" by implying a state budget benefit from savings that even if realized, would clearly accrue to local governments. It also clearly ignores the probable non-applicability or availability of savings at the state level in the state budget that would NOT accrue to the General Fund-General Purpose budget where the greatest portion of both the current year and FY 2010 deficit issues and the structural deficit as well are focused.

What this means in practice relative to the original white paper is that any savings in state personnel costs will be allocated by fund source across the state payroll. As a working rule of thumb, in recent years this fund split has grown to something like 60% GFGP and 40% state and federal restricted, due largely to the growing number of Michigan Department of Corrections employees on the state payroll over the last decade. As Corrections costs are reduced due to budget constraints, this balance will shift again towards a larger share supported by restricted funds, especially with the short-term impacts of federal stimulus funds. Reducing costs for programs supported by federal funds would not benefit the state budget at all and could ultimately mean that the dollars leave the Michigan economy and go back to Washington, D.C.

This would produce the following hypothetical break out of the potential for allocation savings in the various fund sources if the benefits or salary component of the payroll were:

GFGP Fund	60%
Other state restricted funds	10%
Federal funds	30%[30]

[30] This is suggested as a rough rule of thumb for exemplar purposes only. The actual shares would change almost daily as positions were vacated or filled.

Issues of Impacts of the Proposal on the Collective Bargaining Process

The original white paper itself suggests that one of the goals of the reforms contemplated is to "sustain collective bargaining rights."[31]

This analysis finds that if the proposals contained in the original white paper and HB 5345 are implemented to the extent suggested, the very opposite would occur. Allowing selection from a limited number of options offered by a single plan might allow "choice" to a limited extent, but it would be a far distance from the traditional understanding of full collective bargaining.

Summary and Conclusions

Overall this analysis finds structural, logical, and mathematical inconsistencies in the original white paper and follow-up documents, including HB 5345. It is seriously flawed in its internal logic and arbitrarily dismisses or ignores serious issues that would need to be addressed in implementation.

The analysis finds that of the employee groups in question, most are already covered by very large health insurance plans, which already possess the bargaining and purchasing power the paper suggests as desirable goals for reform. The likelihood of substantial additional savings from administrative efficiency or economies-of-scale is unrealistic.

More realistic is the likelihood of substantial additional net costs if the Office of the State Employer is to administer a pool as proposed and detailed in HB 5345, and more still if OSE negotiates benefit plans on behalf of local governments with thousands of individual local bargaining units as proposed in the original white paper.

[31] Original white paper, p. 2, "Goals."

The analysis further finds it likely that the Office of the State Employer also would incur substantial increased costs if it were to be required to negotiate reimbursement rates with individual hospitals and health professionals around the state, again as suggested in the original white paper.

Even if real, a large portion of any theoretical savings would accrue to local governments, not the state budget as implied in the original white paper, and as noted, those savings would be substantially smaller than suggested in the original white paper or even nonexistent.

Any real potential for savings would come from benefit reductions and increased employee contributions towards the costs of health insurance. This is a legitimate policy position for proponents to put forth, but it is not legitimate to imply that it can come from economies-of-scale, nor is it legitimate to imply that "standardization" does not mean reduced benefits and/or increased employee costs when the clear intent is to benchmark employer costs and employee contributions to the average premiums of the other 49 states, ignoring the wide-range distribution of costs and cost sharing that exists across the country, and the wide variation of the benefits provided within the plans themselves. It is also not legitimate to ignore or minimize the fact that tens of thousands of Michigan public employees are accepting benefit reductions and cost increases today in the present system.

"Averaging" in this context is not a careful policy choice—it is the very antithesis of both careful and policy.

Appendix A: House Bill 5345

HOUSE BILL No. 5345

September 10, 2009, Introduced by Rep. Dillon and referred to the Committee on Public Employee Health Care Reform.

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 powers and duties for certain state and local government departments, agencies, boards, and officers; to require public employers that provide health benefits to employees to participate in the health benefits program; to require uniform health benefits for retirees of public employers under certain conditions; to provide for exceptions; to provide for optional participation by private entities; to allocate costs to participating public and private sector employers; to make an appropriation; to create a restricted fund; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

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

Sec. 2. As used in this act:

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

(b) "Fund" means the MI health benefits fund created in section 18.

(c) "MI health benefits program" or "program" means the Michigan health benefits program adopted by the board under this act.

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

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

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

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

(a) The following members appointed by the governor:

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

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

(*iii*) 3 members representing interests of county, municipal, and public education employers.

(b) The following independent members with expertise in areas such as employee benefit design, value-based insurance design, or health care actuarial science:

(*i*) 1 member appointed by the governor.

(*ii*) 1 member appointed by, and serving at the pleasure of, the senate majority leader.

(*iii*) 1 member appointed by, and serving at the pleasure of, the speaker of the house of representatives.

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

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

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

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

(2) Appointed members of the board shall serve for terms of 4 years or until a successor is appointed, whichever is later, except that of the members first appointed, 1 member appointed under section 3(2)(a)(*i*), 1 member appointed under section 3(2)(a)(*iii*), and 1 member appointed under section 3(2)(b)(*iii*) shall serve 2-year terms and 1 member appointed under section 3(2)(a)(*i*), 1 member appointed under section 3(2)(a)(*ii*), 1 member appointed under section 3(2)(a)(*iii*), and 1 member appointed under section 3(2)(b)(*ii*) shall serve 3-year terms.

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

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

Sec. 5. (1) The first meeting of the board shall be called by the state employer within 30 days after the members are appointed.

The state employer shall serve as chairperson. After the first meeting, the board shall meet at least monthly. The board may meet more frequently, at the call of the chairperson or if requested by a majority of the board's members.

(2) A majority of the members of the board constitute a quorum for the transaction of business at a meeting of the board. A majority of the members serving are required for official action of the board.

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

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

(a) Review recommendations of the office of state employer as to health benefit plans and total premium cost for each plan to be adopted as part of the MI health benefits program to be offered for public employees or other beneficiaries.

(b) Adopt or reject the recommendations of the office of state employer based on the criteria listed in sections 8 and 12.

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

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

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

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

(g) Include in its evaluation of the recommendations of the office of state employer, the additional value of contracting with Michigan-based businesses to implement the program.

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

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

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

(b) Financial stability.

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

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

(a) Administration of the MI health benefits program.

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

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

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

(e) Other duties granted by law.

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

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

(b) Review data on public employee health benefit plans in other states.

(c) Develop an array of health benefit plan options with different levels of health care coverage and health benefits adapted to the interests of various classes of public employees.

The plans and plan options shall comply with applicable federal standards and may include a variety of structures and benefits, including, but not limited to, offering benefits through preferred provider organizations, health maintenance organizations, high-deductible plan options combined with health savings accounts, self-insurance, and plan options that are tailored to address groupings of geographic needs or categories of employee risk or need.

(d) Negotiate with appropriate parties to develop health benefit plan recommendations.

(e) Set standards and issue requests for proposals to develop health benefit plan recommendations.

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

Sec. 12. The office of state employer shall consider in developing, and health benefit plans recommended to the board shall include, all of the following:

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

(b) Wellness, chronic disease management, and prevention incentives, such as smoking cessation, injury and accident prevention, reduction of alcohol misuse or abuse, weight management, exercise, automobile and motorcycle safety, blood cholesterol management, nutrition education, and other methods that focus on strategies to improve health and meet the needs of the covered populations.

(c) Utilization review procedures.

(d) Evidence-based care and best practices.

(e) Use of clinical advocates to review diagnosis and care and to promote correct treatment.

(f) Coordination of benefits.

(g) Minimum standards for insuring entities.

(h) Minimum scope and content of health benefit plans offered to program participants.

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

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

(k) Cost considerations set forth in section 9.

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

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

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

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

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

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

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

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

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

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

(*i*) Facilitate diagnosis or treatment.

(*ii*) Reduce unnecessary duplication of medical tests.

(*iii*) Promote efficient electronic physician order entry.

(*iv*) Increase access to health information for patients and their health care providers.

(*v*) Improve health outcomes.

(*vi*) Reward or encourage review of diagnosis and care by clinical advocates to ensure appropriate treatment.

(*vii*) Reward employee participation in wellness or disease management programs and regular preventive care.

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

(a) Periodically conduct an internal review of each health benefit plan and entire program efficiency and effectiveness.

(b) Perform audits of any participating public employer, as needed.

(c) Report annually to the board regarding its activities under this act and make the report available to the public on the internet.

(d) Maintain a website with information concerning meetings and other information useful to the public concerning the activities of the office of state employer in developing and implementing the MI health benefits program.

(e) Employ other techniques to ensure that the program is administered efficiently and cost-effectively, such as coordination of benefits and dependent eligibility audits.

Sec. 16. The board shall make the MI health benefits program available to public employers. Except as provided in section 17, a public employer that offers a health benefits plan or health care coverage to its employees shall offer benefits through participation in the MI health benefits program. The MI health benefits program shall not restrict the right of the public employer to select, subject to collective bargaining, any of the following aspects of the MI health benefits program:

(a) Which of the health benefit plans in the program that the public employer will offer.

(b) The share of the cost of the health benefit plan that will be allocated to the employer or the employee.

(c) Which of the employer's employees are eligible to receive health benefits under the program.

Sec. 17. A public employer may offer its employees a health benefit plan that is not part of the program in any of the following circumstances:

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

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

Sec. 18. (1) The MI health benefits fund is created in the state treasury and is held in trust to support the contractual obligation for health benefits for the employees of the employers participating in the MI health benefits program.

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

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

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

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

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

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

(2) The board shall require that a public employer provide an actuarial study to support the request to opt out of the program.

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

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

Sec. 20. The costs of offering health benefit plans and administering the MI health benefits program shall be fully supported by allocating program costs and assessing the participating public employers and private sector participants, and those entities shall be responsible for remitting any employee share of the costs.

Sec. 21. (1) Beginning January 1, 2010 and subject to this section and section 17, the board of a public employee or officer retirement system shall offer only a health benefit plan that is part of the MI health benefits program to public employees eligible for retirement health benefits under the following acts:

(a) The state employees' retirement act, 1943 PA 240, MCL 38.1 to 38.69.

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

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

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

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

(f) The fire fighters and police officers retirement act, 1937 PA 345, MCL 38.551 to 38.562.

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

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

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

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

(2) Beginning January 1, 2010 and subject to this section and section 17, the administrator of a public employee or officer retirement system shall offer only a health benefit plan that is part of the MI health benefits program to any other public employee or officer who receives retirement health benefits as a result of service with a public employer.

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

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

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

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