Health Care Recommendations
University Committee on Faculty Affairs
December 2009
Preface

It is important to understand these recommendations in their historical context. In 2006, UCFA became concerned about the quality of the health care our constituency was receiving AND the ever rising cost (rising an average of 8 percent for the last five years becoming one of every 15 dollars in the MSU budget). This led UCFA to form a task force of faculty to study these issues and bring forth recommendations. Deliberations included public presentations by Roger Feldman, Professor of Economics and Health Policy Management at the University of Minnesota and Paul Ginsburg, President of the Center for Health Systems Change in Washington D.C. The task force report was approved by UCFA in February of 2008 and subsequently reviewed and approved by Faculty Council.

Based on this report, and subsequent discussions involving the administration and the MSU Labor Coalition, the UCFA supported changes, this fall, in the institution’s prescription drug policy. The following additional recommendations are based upon the task force report, continued review of health care issues, and the recent UCFA faculty survey to better identify useful options. In all cases, UCFA is strongly committed to maintain choice for our constituency in health care benefits. In sum, they maintain and in the future should improve the quality of health care while providing a 10 percent reduction in current health care costs and the mechanism to flatten the future escalation in health care costs to approximately 5 percent per year. Both the initial task force report (MSU Faculty: Health Care Concerns, Policies, and Future Options) and the results of the faculty survey are posted at the UCFA web site:

http://opbweb.msu.edu/ucfa

Health Care Recommendations

In recognition of the immediacy of the current economic circumstances, UCFA recommends adoption as of July 1, 2010 of the Blue Care Network as the base faculty health care plan. This would replace the current PHP plan. This product combines the benefits of a community; physicians-based HMO with Blue Cross’ national availability when traveling. Savings are generated through plan designs incorporating deductibles and co-pays with a defined, tighter provider network allowing for more opportunities to leverage better service, discounts and economies of scale. At this time 63 percent of PHP physicians participate in the Blue Care Network.

Secondly, UCFA recommends that the existing Community Blue option be maintained. The university contribution, however, will be based on the Blue Care Network amount with the individual faculty member contributing the difference. At this time, the increased faculty contribution -- for those who are currently enrolled in Community Blue -- is estimated at approximately an additional $65 per month for two-person coverage and could be reduced by about half of that amount if an annual deductible (not to exceed $100/$200) and an increase in office co-pays (not to exceed $5) was incorporated for all participants.

Thirdly, UCFA recommends that effective July 1, 2011 an employer-provided clinic be established to serve as the predominate base health care option and to serve as the vehicle -- with ongoing faculty consultation-- to maintain and improve plan quality and effectiveness while constraining future University spending to the 5 percent level. The additional time is necessary to better refine the model for particular MSU needs. Over a period of time, it is anticipated that Blue Care Network will no longer be required. The Community Blue option should be continued as an alternative coverage with University support based on the cost of the employer provided clinic.
Fourthly, UCFA recommends the establishment of an annual “Report Card” for the faculty health care plan. The annual “Report Card” will document the plan’s quality, access, equity and cost savings against established benchmarks. This “Report Card” will be developed by the administration in cooperation with UCFA and shared annually first in consultation with UCFA and subsequently by UCFA with the appropriate academic governance organization.

Given the complexity of the healthcare crisis at MSU and in the United States, the four steps recommended here are likely only the beginning. Going into the future, careful monitoring of the effects of all changes on patient care, satisfaction, outcome, and cost will be necessary. UCFA is committed to diligence in this arena. In the near term, several specific approaches will be explored and recommended if appropriate. First, centers of excellence are likely to be beneficial to the MSU community. This would involve selecting high performance providers and providing incentives (to consumers and providers) for the most effective and efficient outcomes for particular medical procedures. Second, medical or case management techniques have been found effective in coordinating medical care across multiple providers for chronic conditions. Third, use of medical information technology holds the promise of improving the efficiency and quality of medical services in our region. It is likely that MSU will initiate such developments in our area for the benefit of MSU employees. Fourth, the advantages of moving MSU to a smoke-free campus seem obvious. In the near future, UCFA hopes to help stimulate campus wide discussion of a move to a smoke-free campus. Finally, UCFA is committed to improving the information available to our faculty about health care choices and their effectiveness. It is our observation that we, like most of us in this country, have been relatively passive consumers of our health care choices. Further, the information available to us about quality, effectiveness, and efficiency has been lacking or of low quality. As an institution and as individuals, we will have to become much more proactive in this area.

It is understood that the calculations underlying these changes are best estimates available at this time and that the university will make available to UCFA, on an ongoing basis, actual costs incurred over the course of the year.
Frequently Asked Questions

1. Is Blue Care Network (BCN) an HMO (health maintenance organization)?
   a. Yes. HMO’s are typically structured in two forms, one as a staff model (a central location from which physicians practice) or by contracting with community physicians and providers. In both instances, savings are generated through a defined, tighter provider network allowing for greater opportunity to leverage deeper discounts and economies of scale. The current BCN model is community physician based. For example, many of MSU’s Health Team physicians are part of the BCN provider network.

2. How extensive is the provider network?
   a. Most doctors and hospitals including Sparrow and Ingham, across the state participate with BCN. BCN contracts with more than 110 hospitals and more than 3,300 primary care physicians as well as 9,000 specialists throughout Michigan. You can visit the following Web link to search for participating doctors and hospitals: http://www.mibcn.com/provsearch/search?plan=COMM&desc=Blue%20Care%20Network
   b. Approximately 63 percent of PHP participating physicians are part of BCN.

3. Will I have coverage if I travel?
   a. Yes, emergency care is covered anywhere in the world and you’ll have access to hospitals and doctors who participate with Blue Cross Blue Shield plans across the country. This is the same arrangement that exists for those enrolled in Community Blue.

4. Does BCN focus on preventative care?
   a. Preventative care is the foundation of BCN’s coverage; they believe it is easier to stay healthy than it is to get healthy. BCN also helps manage acute and chronic medical conditions to avoid costly complications.

5. What is the difference between an HMO and a PPO?
   a. One example of the differences between and HMO and a PPO is that under an HMO, your primary care physician is much more involved in management of your care, including referrals to specialists.

6. If my son or daughter attends college in another state, will they still have coverage if I choose BCN?
   a. Yes, however, they will need to seek services with a provider that is part of a Blue Cross Blue Shield plan.

7. Has MSU considered other options besides BCN?
   a. Yes, other vendors and provider networks have been considered and upon final analysis, BCN provides the best short-term solution.

8. When would the change to BCN be effective?

9. Will I have an option to enroll or continue my enrollment in Community Blue?
   a. Yes, however, there will be a premium difference consistent with the current structure between PHP and Community Blue. In other words, if you wish to enroll or remain enrolled in Community Blue, there will be a premium deducted on a pre-tax basis from your paycheck.
10. What will the premium difference be if I want to enroll in Community Blue?
   a. This is currently being evaluated and will depend on the final BCN plan design and whether there are any changes made to the Community Blue plan design. It is estimated to be about an additional $65 for two-person coverage for those presently enrolled in Community Blue. This could be reduced by approximately half with the incorporation of an annual deductible (not to exceed $100/$200) and an increase in office co-pays (not to exceed $5).

11. How is the 10 percent savings achieved by contracting with BCN?
   a. Approximately one-half of the savings is derived from the defined, tighter provider network and associated provider discounts and the other half is derived from plan design changes, e.g. implementing co-pays and deductibles.

12. What other issues are under consideration?
   a. Due to changes in accounting standards a few years ago, employers are required to include post-retirement health care as a liability. While this is not part of the recommendation from UCFA, elimination of post-retirement health care for new hires is likely to be implemented by the MSU administration. While planning is not complete at this time, it is possible that the university will partially offset this loss for new employees by an adjustment to its retirement contribution. Post-retirement health care for present employees will not change.