TO: The Steering Committee of Academic Governance

FROM: UCFA Task Force on Health Care
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RE: Future Faculty Health Care Benefits

DATE: April 30, 2012

We would like to begin by expressing our appreciation for your support of faculty efforts to reform the health care benefits offered by Michigan State University. We are writing to enlist your assistance in moving in a more innovative and positive direction. We listened with considerable sadness to the HR presentation to the Faculty Senate on April 11, 2012 of the plans for the health care benefits package for 2012-2013. Because of action by UCFA six years ago, a faculty group, supported by the administration, took an in depth look at the health care benefits at MSU. This activity was driven by our amazement at the long term and severe rise in costs in our health care AND our belief that MSU was uniquely positioned to take a leadership role in health care reform. The situation at that time (and today) seemed unsustainable and a genuine threat to our institution. Clearly, MSU is not unique. All employers who offer health benefits see continuously rising costs, issues with employee access to care, and outcomes that are less than desired. We approached the health care benefits situation with the multiple aims of containing costs, enhancing access, and increasing quality. In fact, the best advice we could garner was that unless we addressed all three (access, quality, and cost), little would change in the medium or long run. We initially issued a report in February 2008 that has had several iterations since then. We feel it important to express our frustration with the current approach which seems, in the main, to be characterized by maintenance of the traditional approach along with serious cost shifting to individual consumers. We understand that the situation is complex, the diffusion of responsibility for health care benefits makes change difficult, and the resources available to plan and execute innovation are limited. We have three primary concerns.

1. We are not yet convinced that the approach of two “options” with the Blues does much to contain costs, enhance access, or increase quality. While cost growth has certainly been slower in the more tightly controlled BCN model, based on data provided by HR it is likely that this cost containment is largely due to migration of the younger and healthier among us to the BCN. As the spread between BCN and Community Blue premiums widens, more of the older and less healthy among us will migrate to BCN, and BCN premiums will begin to rise rapidly (unless costs are further shifted to us through higher copays, deductibles or reduced access). In short, 40 years of such approaches have indicated that the health system is very adept at adjusting to recover lost revenue without fundamentally changing the way it behaves. In addition, to the degree that it is true that the BCN plan versus the Community Blue plan is really a self selection effect, then we, as an institution, have drifted away from an “insurance philosophy” towards a “those that need pay” philosophy. For example, the stated 11% increase in the cost of Community Blue to those “in need” is really a doubling of the co-insurance payments required of employees. Those in Community Blue are now paying nearly 30% (according to HR) of their health care. It is well known that older and riskier individuals consume more care. It does not appear that this implication has either been acknowledged or addressed.

2. Of greater concern was hearing that the implementation of key “system changes” the faculty task force recommended are again being pushed off for over a year. We might be less concerned about these developments if we had not experienced delays for several years running. The best advice we received from the national experts we consulted indicated that unless we changed the game by altering the incentive structure of our plans and focusing on availability and outcomes, little is likely to change. It is important to emphasize that this is not our opinion, but the best advice of the scientific community inside and outside MSU. We heard during the Faculty Senate meeting on April 11th that implementing centers of excellence,
engaging in quality enhancing/cost containing procedural carve outs, soliciting additional benefits vendors, and implementing an innovative MSU based primary care provider would all be delayed at least another year. For example, the innovative MSU based primary care provider is viewed as a wedge into the system to address issues of quality, access, and cost containment. This approach is now widespread among employers, a fact that was not true when we first proposed it five years ago. Those with experience with this model, indicate that it is a potent intervention that creates a true alternative. Why we have not embraced and implemented these innovations is not clear.

Overall, it appears that the things that have the best hope of actually making a difference (albeit more complex and difficult to implement) are again being postponed in favor of the status quo and further cost shifting. Cost shifting is easy to implement in the short run, but does little to address the key issues. But there are successes. A stellar example of the approach we have advocated is embodied in the generic prescription drug program. By all indicators, this has resulted in comparable outcomes and substantial cost savings. The best evidence is that the prescription drug plan cost (which covers all insured lives not just those that self select into the lower cost plan) has remained flat. Quite amazing in an environment when those in Community Blue are increasing their medical care expenditures by 11%. Sadly, it’s the only one of our recommendations that has been implemented. While we understand only too well the uncertainties created by the changing environment of health care in the country, increasing quality and access while containing cost will be valuable no matter what happens.

3. We strongly urge that MSU take a proactive approach to health care rather than continuing to react more passively to major forces in the environment (like the Blues). We are struck by the parallels to the Energy Transition Plan. Clearly a complex issue, energy use has challenged us in terms of cost, access, and outcomes. Faced with this situation, MSU moved thoughtfully but aggressively to influence its future and put in place short term and long term actions and delineate outcome benchmarks for course adjustment. Health care is a substantially larger portion of the University budget AND we cannot imagine a more important outcome than the health of our community. The “crisis” so acute with coal has been around so long in health care that we may have been numbed by it. We continue the current path at our collective peril. When we designed our recommendations for the health care benefits future for MSU it was based on the assumption that the unique hybrid of science, education, and engagement should guide our approach. We will have to be bold if this is to work. Risk taking is part of innovation. Failure will be part of the approach, but the status quo is an overwhelming failure. But we do not seem to be strangers to any of this. It is part and parcel of science and innovation. The key question is whether our University with our size, two medical schools, and a faculty committed to innovation in this area will be satisfied to “ride it out” or will seize the opportunity to lead.

In light of this situation, we believe it is essential that a viable vehicle be put in place to provide urgency to the implementation of the recommendations of the health care task force AND to provide regular proactive input from faculty to the process of designing health care benefits. We suggest that a standing committee be appointed by the Steering Committee to continue to press for implementation of the suggested approaches AND to interface with HR deliberations about future planning for health care benefits. This group would necessarily need representation from HR and the key university decision-makers with regard to benefits. Labor coalition representation would also be welcomed. Due to the complexity of this issue and the vast amount of information required in this area, we recommend that members of this standing committee serve for terms that are relatively longer than is typically the case throughout academic governance. We continue to be committed to participating in these all-important discussions and are confident in the future of MSU in its leadership in quality programs for the health care of employees.