Michigan State University Faculty:
Health Care Concerns, Policies, and Future Options

A Preliminary Report of the Health Care Options Task Force

University Committee on Faculty Affairs: Budget Subcommittee
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# Table of Contents

**EXECUTIVE SUMMARY AND RECOMMENDATIONS** ....................................................... 4

**INSTITUTIONAL INITIATIVES** ........................................................................................................... 5

**ADMINISTRATION OF INSURANCE BENEFITS** .................................................................................. 5

**POLICY INITIATIVES** ..................................................................................................................... 5

**PROCESSES FOR COMMUNICATION, IMPLEMENTATION, AND MONITORING** ..................... 8

**HEALTH CARE: A MAJOR ISSUE FOR MSU** ............................................................................. 9

**MSU AS A LEADER: AN ALTERNATIVE PERSPECTIVE** ...................................................... 11

**BACKGROUND** ......................................................................................................................... 13

**HEALTH CARE OPTIONS TASK FORCE (HCOTF)** ................................................................ 14

**HEALTH CARE BENEFITS AT MSU** ......................................................................................... 15

**MSU’S COMMITMENT TO HEALTH CARE** ............................................................................... 16

**EXAMINATION OF POLICIES AND OPTIONS AVAILABLE AT MSU** ............................................ 16

**NATIONAL EXPERTISE** ............................................................................................................ 17

**GENERAL PATTERN OF FINDINGS** ........................................................................................... 18

**HEALTH PROMOTION OPTIONS** .............................................................................................. 21

**ENVIRONMENTAL MANAGEMENT** ............................................................................................ 21

**WELLNESS ACTIVITIES AND PROGRAMS** ............................................................................... 21

  - Health Promotion at MSU .............................................................................................................. 22
  - Fitness and exercise programs....................................................................................................... 22
  - Obesity intervention/prevention and nutritional wellness programs ............................. 23
  - Potential Additional Program: .................................................................................................... 24
  - Online health risk assessment: .................................................................................................... 24
  - Health assessment coaching: ......................................................................................................... 24
  - Health risk assessments ............................................................................................................... 24
  - Effects of Health Promotion Programs: .................................................................................... 25

**IMPROVED CONSUMER INFORMATION** ................................................................................. 26

**PROVIDER OPTIONS** .................................................................................................................. 28

**CARE COORDINATION** .................................................................................................................. 28

**EVIDENCE-BASED MEDICINE** ..................................................................................................... 32

**INCREASING CARE ACCESS** ......................................................................................................... 34
Executive Summary and Recommendations

Among many challenges facing MSU, one of the largest is the rising cost of its employee health benefits program. Like other public universities, MSU struggles to secure financial resources and control costs. Despite the University’s best efforts to control ever-increasing health care costs, the problem remains a critical threat to the fiscal health of the institution and its ability to sustain its core missions. This report outlines a series of options which will lead to MSU taking a leadership role in developing alternative health benefit options to control cost while maintaining or improving health. The task force made every attempt to open “the Pandora’s box” of health care. In other words, the assumptions of the status quo were critically examined and new alternatives were considered. It is important to point out that the report is focused at the level of principles rather than at the level of designing specific health care benefits. It is anticipated that these principles would serve as guidance for future health care programming by Human Resources (HR) in collaboration with the University Committee on Faculty Affairs (UCFA).

The UCFA assembled a task force to evaluate options for reducing health care costs and improving or maintaining health. The task force considered a wide variety of alternatives. The alternatives which were within the MSU sphere of direct influence were examined as well as external practices (e.g. some specific federal policies) likely to affect the MSU situation. This report describes the current situation and documents the task force findings and recommendations. In the interest of brevity, only those alternatives and recommendations that survived serious scrutiny are described. Most importantly, the task force argues that MSU must provide leadership in promoting excellence and innovation in health care arena. Unless MSU takes a proactive approach to health care services, the status quo is likely to continue.

The recommendations fall into four categories: (1) institutional initiatives in the area of health care services and financing; (2) specific changes in current health care benefits administration; (3) specific policy initiatives; and (4) processes relevant to communication, implementation, and monitoring of any adopted changes related to health care benefits or wider health care policies.
**Institutional Initiatives**

It is recommended that MSU expand its commitment to a program of leadership in health services research that is congruent with its land-grant mission. MSU needs to increase support for multidisciplinary academic and research collaborations to enhance our capacity in this arena. This work is vital to MSU and will serve as a model for national and international audiences. Creating environments that encourage multidisciplinary external research funding is critical. Further, MSU should support increased collaboration between Human Resources Benefits Program and UCFA by encouraging faculty members with relevant expertise to contribute to research efforts that focus on health improvement and health care savings. New academic structures such as multidisciplinary programs, graduate training programs, and/or research initiatives would assist in this regard.

**Administration of Insurance Benefits**

Like larger employers, MSU is self-insured, which means that the institution bears the financial risk associated with its employees’ benefits. Also, like other employers, it relies on third parties to contract with providers and administer its benefits. Most of the options that would change incentives for employees and providers require the cooperation of its third-party administrators. Currently, MSU offers plans administered by Blue Cross Blue Shield of Michigan and Physicians Health Plan, and contracts with Caremark as its Pharmaceutical Benefits Manager (PBM). The task force supports a continued commitment to self-insurance. Contracts with plan administrators should be strengthened, wherever possible, to assure full university access to data on both costs and health outcomes (this would be a major change). Improved access to these critical data would better enable MSU to evaluate the performance of medical providers and to analyze future options. MSU should also insist on transparency regarding the basis (i.e. invoices and payments) for billing from plan administrators, including its PBM. The task force also believes that competition for MSU’s business can motivate better performance from plan administrators. The task force recommends a continued commitment to engage new bidders.

**Policy Initiatives**

The Health Care Options Task Force recommends ongoing research and implementation efforts for improving the effectiveness and efficiency of the health care
system. The underlying principles to all of the following recommendations are that our health care benefits programs should provide incentives for care that is effective, closely coordinated, and contains cost. They should also provide disincentives for care that is of unknown effectiveness, provided in isolation, and costly. Care should emphasize outcomes, tighter provider networks that collaborate and share information, and cost efficiency. Each of these recommendations should be implemented within the context of monitoring and research that examines the dual criteria of outcomes and cost. Specific recommendations are for strategies that:

- Identify best practice models to achieve optimal health outcomes, including:
  - Identifying centers of excellence for: (1.) statistically common, high-tech, and high-cost procedures (e.g. knee and hip replacement, organ transplant, some cardiovascular surgery, and cataract surgery) and (2.) statistically unusual, high-tech, and high-cost procedures (e.g. organ transplant). Consumers should receive incentives to use centers of excellence; providers should receive incentives for documented improvements in outcomes and cost containment (evidence of cost utility analysis).
  - Focusing on a benefit structure guided by the best scientific evidence, where such evidence exists, about preventive care and approaches to treating common problems. The evidence needs to be specific for variations in age and gender. Examples of such common problems include back pain (e.g. coverage for unnecessary or ineffective imaging and surgical procedures) and childhood ear infection (e.g. coverage for surgery only when it meets well-documented criteria).
  - Immediately pursuing strong care/case/patient management for consumers with certain chronic diseases (e.g. diabetes and congestive heart failure). Management should focus on enhancing proven best practice, eliminating irrelevant procedures, facilitating patient adherence, and measurement of short and long term outcomes. It may
be more feasible to pilot a program with only one or two diseases, with careful evaluative procedures in place.

- Continuing ongoing efforts that encourage the use of generic drugs, when available. Consideration should be given to a policy that requires employees to pay the full marginal cost of brand name prescriptions when medically equivalent generics exist. Further, policies should also be explored that further discourage the use of high priced drugs in instances where there is no scientifically credible evidence of significant benefit compared to the generic equivalent (e.g. Nexium vs. Prilosec OTC). Re-evaluating coverage for lifestyle drugs should also be considered.

- Encourage MSU to continue pursuing innovative cost-sharing arrangements for faculty and reimbursement arrangements for providers. This may well lead to “capitation like” systems.

- Encourage MSU to take a stronger proactive role in investigating, testing, and evaluating alternative programs that will have positive effects on health status and promote cost containment. Three examples of such initiatives would consider:
  - Provide MSU employees with the ability to purchase optional riders for procedures considered as experimental and/or ones with less than evidence based support.
  - Environmental changes to support and align with benefit option changes – e.g. a smoke-free campus; structuring of parking options to encourage walking for able-bodied persons; food labeling in on-campus facilities; and options for broader use of campus exercise facilities.
  - Differential incentives for employees who engage in healthy behavior patterns (e.g. smoking cessation, weight control, exercise).
Processes for Communication, Implementation, and Monitoring

Implementation of these recommendations should engage institution-wide efforts, incorporating input from academic and nonacademic employee groups of University governance. Substantial support for HR will be needed in the process. The task force recommends that a working group be formed within the current academic year to coordinate and collaborate in efforts related to the implementation and monitoring of specific health care issues. It is recommended that this group operate as part of the UCFA Budget Subcommittee and consist of representatives from UCFA and University faculty who can contribute expertise in health care systems and HR benefits and collaborate with HR and University administration on issues of health care on a continuing basis.
Health Care: A Major Issue for MSU

Over recent decades, enormous growth in health care spending has contributed to a significant improvement in the longevity and quality of life for people in the United States. The knowledge base regarding health and disease is expanding at a highly accelerated pace along with technology associated with health care delivery (Cutler, 2004). On the other hand, international comparisons of health care spending rank the United States as the highest spending nation but indicate that it lags behind in factors such as life expectancy and infant mortality, as well as other quality measures. For example, the United States spends nearly two-thirds more per capita on health than Canada, which also ranks among the highest spending countries. In a 2000 study, the World Health Organization ranked overall health system performance in the United States as 37th best in the world.

National estimates put the average annual rate of growth in health care costs at approximately 7% through 2016. As a result, the proportion of GDP allocated to health care costs is projected to increase from 16% in 2006 to over 19% in 2016. The rising costs of Medicare and Medicaid pose serious threats to federal and state governments. The employer-based insurance system seems to be eroding, particularly with regard to post-retirement benefits. As costs continue to rise, the number of uninsured people in the United States continues to rise. These numbers underscore the long-term challenges faced by the federal government and by employers as they support programs that provide health care.

The employee health care benefits program at MSU operates within a national health care environment. Like other public universities, MSU struggles to secure financial resources to operate its programs. One of the biggest challenges that MSU faces is the rising cost of its employee health benefits program. Over the past ten years, the costs associated with the MSU health care programs have risen 8.8% on an average annual basis, and 9.7% over the last twenty five years. If health care costs had risen by the annual inflationary adjustment of 3%, or could have been constrained to even 7% annually, MSU would have between thirty and fifty million additional general fund dollars for high priority needs (refer to Figure 1). Currently, health care expenditures represent approximately 7 cents of every dollar in the MSU budget. This is compared with 5 cents of every dollar ten years ago and less than 3 cents of every dollar twenty five years ago (refer to Figure 2). Despite the University’s best
efforts to control ever-increasing health care costs, the problem remains critical to the overall “health” of the institution and its ability to sustain its core missions. Extrapolations of national calculations, in absence of change, indicate that the trend of health care growth as a portion of the budget will continue indefinitely. The more we spend on health care, the less we have for core operations and developing programs.

The UCFA Health Care Options Task Force discussed these and other issues pertaining to the current and future impact of rising health care costs felt by the MSU family. In this report, the Task Force does not speculate on the future of the national health care debate; instead, it focuses on options within the MSU sphere of direct influence. Even within a broad context, the task force argues that MSU can occupy a leadership role in promoting excellence and innovation in health care.

Figure 1: Growth in MSU Health Care Expenditures
The health care crisis facing MSU and all employers was critical to initiating task force deliberations. Within this context, the task force focuses on changes within the current scope of MSU health care programs that would constrain costs while maintaining or improving the quality of services. Based on this approach, all stakeholders are expected to contribute to a solution, including insurers and health care providers.

Ultimately, as in other industries, the economic environment will likely dictate changes in the scope of employer funded health care coverage. Such changes, however, represent trade-offs within faculty total compensation arrangements and are different than efforts to constrain current health care expenditures and optimize benefits discussed here.

**MSU as a Leader: An Alternative Perspective**

Unraveling the problem of health care costs is complex. It requires a consideration of the consumers of health care services, health care providers and insurance providers in order to provide a solution that is acceptable to all audiences. By some ways of thinking, it is so complex that followers of expediency might suggest avoiding the problem and leaving it in the hands of others. As the task force considered these, and many other issues, the most common situation encountered in our deliberations is best described as a standoff where the status quo prevails. This can be summarized as follows:
Common Employer’s Response to the Crisis in Health Care:

Over time, employees will grow accustomed to less health care coverage as a result of increasing concerns of affordability.

Common Employee’s Response to the Crisis in Health Care:

The employer should devote more resources to growing health care costs because faculty members deserve reasonable, affordable coverage.

Common Health Care Provider’s Response to the Crisis in Health Care:

Given the current fiscal situation, more resources must be provided in order to sustain health care as it is currently delivered. This view is particularly true of the subspecialties and higher paid specialties paid per procedure.

Common Insurer’s Response to the Crisis in Health Care:

Costs are growing, but insurers are doing all they can to provide what employers and employees want.

Another perspective is available and, when compared to those above, seems more congruent with the University’s commitment to excellence and its tradition of leadership as a land-grant institution: MSU is a unique environment comprising a large number of highly educated people; these persons represent diverse disciplines and can contribute to the solution of this crisis.

As the University continues to struggle with health care issues, it is imperative that the faculty maintain an active role in the discussion for a number of reasons. First, faculty members have self-interest and share an institutional interest in the management of this enormous and valued resource. Second, all other MSU employee groups have an active voice in the process through collective bargaining procedures. Third, and most important, there are a number of professionals among MSU faculty who possess unique expertise in the areas of health care systems and health care planning. It is recommended that these professionals be included in the dialogue concerning health care options. Moreover, it is recommended that the University develop and support the role of the faculty in the decision-making process regarding the benefits programs that are available to its employees and retirees. The task
force is convinced that a collaborative approach of this kind will yield the strongest opportunities for success.

**Background**

The University Committee of Faculty Affairs (UCFA) is a standing committee within the MSU Academic Governance System. Its charge is to address the issues that reflect policies and procedures directly affecting the University’s regular faculty, excluding discussion of retention, promotion, and tenure issues. The UCFA has two subcommittees: Personnel and Budget. The Personnel Subcommittee focuses on policies and procedures that affect regular faculty, and the Budget Subcommittee focuses on the University budget, especially with regard to faculty salary and benefits issues.

During UCFA Budget Subcommittee deliberations in 2006, it became apparent that the MSU community (including faculty) faces a crisis in health care funding related to quality issues, access, and escalating costs. Health care expenditure now represents a substantial portion of MSU’s budget and is projected to increase (refer to Figure 1 and Figure 2, pages 10-11). While efforts made by MSU Human Resources to control rising costs have met with some success, the full scientific and intellectual resources of MSU have not been applied to this issue. Thus, the UCFA Budget Subcommittee felt it imperative to become more actively involved in order to fulfill its charge.

In addition to focusing on MSU health care related programs, the Subcommittee discussed national cost trends and the implications of federal health care decisions on budget programs in Michigan. As an institution of higher education, MSU relies on state appropriations to support its provisions for health care benefits within its family. After many discussions, it became apparent that health care benefit costs at MSU will continue to increase along with national trends. As part of the 2006–2007 faculty salary recommendations, the UCFA requested support to establish a task force that would address the health care options available to MSU. The mission of the task force was two fold: 1) to investigate health benefit plans and 2) to address the bigger picture related to the delivery of high-quality, fiscally responsible health care for the MSU family. In essence the task force would look at the “Pandora’s box” of health care, open it, and examine ways for MSU to improve the quality of its program and also to maintain its fiscal responsibilities. The Health
Care Options Task Force was assembled, and the Office of the Provost agreed to support its operations.

**Health Care Options Task Force (HCOTF)**

The HCOTF membership included three persons from the 2006–2007 UCFA Budget Subcommittee and members of the MSU faculty with expertise in areas appropriate to the charges given the task force. The task force, in order to conduct a comprehensive examination had the ability to consult with local and national experts in the health care field. HCOTF began its investigations in September 2006. The goal was to evaluate various policies and options available to the MSU community that would improve personal health and quality of care offered by the benefits programs. In addition, the task force considered alternative policies and options that would reduce the fiscal growth of health care benefits. While the focus of the task force discussions was centered on the implication for regular faculty, the deliberations quickly revealed that nearly all of the issues faced (and options considered) were applicable to the entire MSU community. There was no intention to be parochial in our deliberations; however, since the task force was established by UCFA, we felt a need to focus on faculty concerns.

The HCOTF was co-chaired by William Davidson, Department of Psychology, and John Powell, Department of Kinesiology. The task force also included the following MSU faculty members: Jonathan Bohlmann, Department of Marketing and Supply Chain Management; Dele Davies, Department of Pediatrics and Human Development; James Dulebohn, School of Labor and Industrial Relations; John Goddeeris, Department of Economics; Teresa Wehrwein, College of Nursing; and Lynne Zelenski, Department of Accounting and Information Systems. In addition to the above faculty, the Task Force brought into the discussion additional expertise from Dave Byelich, Office of Planning and Budgets; Pam Beemer, Chris Hanna, and Renee Rivard, Office of Human Resources; and Beth Alexander, the University Physician. The Task Force met seven times during the fall semester in 2006 and at least weekly during the spring semester in 2007. In addition, task force members spent numerous hours reviewing written materials provided by members, staff, and consultants.
Health Care Benefits at MSU

To place the current package of MSU health care benefits and programs in context, it is necessary to understand the history of health care benefits at MSU. Around 1940, Michigan State University has made health insurance available to its employees. During the early years, the University permitted several health plan vendors to market services on campus and to deduct from employee paychecks the premiums to cover the cost of health care insurance. Effective February 1, 1945, the University entered into an exclusive group arrangement underwritten by the American Hospital Medical Benefit Company (American). For several years, American provided the only group health insurance coverage available to employees through the University. In the late 1940s, Blue Cross Blue Shield was authorized to insure employees, and the University deducted the premium from employee paychecks for this new vendor. The two carriers, American and Blue Cross Blue Shield, coexisted on campus, and all employees were permitted to choose between the two providers.

In the late 1960s, the University began contributing to health insurance costs. The initial contribution was $8.00 per month, which paid the total cost of the lowest cost option available from American and provided coverage for the employee only. The $8.00 contribution constituted approximately one-third of the cost of the American family coverage. Contribution levels have changed over the years, and, currently, the University contributes 86% of costs for the lowest cost health care plan available to faculty. Prescription drug coverage was added to the health plan coverage in the 1970s.

MSU currently offers comprehensive health care and prescription drug coverage. Two health plan options are available to faculty, staff, and retirees: one option is administered by Blue Cross Blue Shield of Michigan, and the other option is a local health maintenance organization (HMO) offered through Physicians Health Plan of Mid-Michigan. Current retirees receive full benefits (employee and spouse) without cost sharing; employees hired by MSU after July 1, 2005, receive post-employment benefits for themselves only. Prescription drug coverage is administered through Caremark. A detailed description of the health and prescription drug plans can be found on the Office of Human Resources Web site at http://hr.msu.edu/HRsite/Benefits/FacStaff/HealthCare/.
**MSU’s Commitment to Health Care**

MSU has the potential to become a leader in managing health care benefits programs. Its position as one of the largest employers in Michigan, especially in the mid-Michigan area, provides it with leverage to be an important player in the health care discussion. Currently, MSU provides health care benefits to over 28,000 persons, rendering it a strong force in the community as employer-based health care benefits programs come under review. The issues involved in health care benefits align well with MSU’s land-grant mission. Clearly, research and innovation are needed, and any solutions and discoveries are likely to have widespread applied impact. Health care options, policy, economics, and service systems research and innovation should be at the center of the land-grant mission. At present, MSU would benefit from a more programmatic research focus in this area, and expansion should be seriously considered. A good deal more will be said in this regard in later segments of this document.

**Examination of Policies and Options Available at MSU**

Initially, the task force reviewed the current benefits programs offered by MSU to employees, spouses, dependents and retirees. It examined the utilization and cost parameters over recent years and considered current trends in health care at both national and local levels. The task force studied institutional data from a number of other comparable institutions of higher education. Most notably, it examined data comparing our faculty benefits to those of other Big Ten institutions. The comparison is summarized in Table 1. Overall, MSU closely aligns with other Big Ten institutions. Employee contributions for single premium shares are somewhat higher, while contributions for family coverage tend to be lower. Other comparisons show MSU to be comparable with the exception of retiree benefits, which are more generous at MSU. It should be noted that the coverage of retiree health benefits is a major contributor to MSU’s standing near the middle of the Big Ten in total faculty compensation. If this benefit was discontinued or reduced, MSU would likely fall to near the bottom of the Big Ten in total compensation.
Table 1: Big Ten Health Plan Comparison Data

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<th>B</th>
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Source: 2006 AAUDE Benefits Survey

¹ Based on most comparable available plan design compared to MSU lowest cost plan
² Offers a catastrophic plan at reduced premium sharing
³ Offers a tiered premium sharing arrangement based on salary levels
⁴ Inpatient deductible $150; outpatient $250
⁵ Eligibility for retiree health care coverage and contribution levels vary widely

**National Expertise**

In addition to its own internal deliberations, the Task force sought counsel from two national experts in the area of health care systems. These individuals were invited to the MSU campus to meet with the Task force and to present at a symposium on health care, open to the MSU community. The first consultant, Dr. Roger Feldman, is Blue Cross Professor of Health and Insurance and Professor of Economics at the University of Minnesota. Dr. Feldman’s research examines the organization, finance, and delivery of health care, focusing on health insurance. His lecture and the accompanying PowerPoint presentation can be found on the UCFA Web site: [http://opbweb.msu.edu/ucfa/](http://opbweb.msu.edu/ucfa/). The second consultant, Dr. Paul Ginsburg, is President of the Center for Studying Health System Change. His center is
funded by the Robert Wood Johnson Foundation and affiliated with Mathematic Policy Research, Inc. Dr. Ginsburg studies health care environments in a number of U.S. cities; Lansing serves as one of his survey areas. His presentation is also available on the UCFA Web site: [http://opbweb.msu.edu/ucfa/](http://opbweb.msu.edu/ucfa/).

Throughout continuing discussions, the task force examined a wide range of policies and options. Some appeared to be promising and some never gained traction as a choice for the MSU community. In each case, the task force addressed a series of specific questions about each option, including the following:

- What are the likely effects on the health of the consumers?
- What are the effects on the short-term and long-term costs associated with these policies and options?
- What are the effects on costs, accessibility, and/or efficiency of the health care delivery systems?
- What are the effects on the interests of both employees (cost and health) and the employer (cost and productivity)?
- What types of paradigm shifts among consumers, providers, and insurers are necessary to implement the recommendation?

**General Pattern of Findings**

The findings presented here focus on the options that MSU should consider in planning its future health care benefits programs. These were derived from the literature examined, task force deliberations, and input from consultants. For purposes of organization and discussion, these options are divided into four perspectives: (1.) health promotion options, (2.) provider options, (3.) insurer/administrator options, and (4.) employer (MSU) options. It should be noted that these four perspectives interact and to be viable, many options must include the consumers, the employer, the providers, and the insurers in the discussion to examine the quality of care, appropriateness of care, and the costs of care. Some of these intricacies will be pointed out below. Each of these options represents a promising direction in future health care benefits that has the potential to enhance consumer
health, improve quality of health care, and manage costs. The task force deliberations can be summarized with the grid presented in Table 2. This grid lists the health care benefit option in the first column. The next three columns rate the likely impact of the option on MSU’s health care benefits. The goal of this approach was to identify those options most likely to improve health and health care, as well as cost containment. The task force demanded that an option have credible evidence of positive effect to be considered for a positive rating. Ratings for each option for each criterion are either positive (will likely improve the situation), neutral, or negative (will likely make the situation worse). The cost criteria were considered for both the short and long term. Each option was rated on the following:

**Quality/Effectiveness of Health Care** – To what extent is there credible evidence that the option will improve health care outcomes and to what extent is there credible evidence that the option will enhance the health status of MSU faculty and employees?

**Cost Containment** – To what extent is there credible evidence that the option will reduce cost in the long and/or short term?

**Implementation** – To what extent is there credible evidence that the option can be put in place for MSU?

A summary rating was assigned to each option in the final column of Table 2. This rating registers the task force’s overall recommendation relative to each option. This column provides a rating of the level of support (little, some, strong) for each option. The report discusses the nature of each option, the short- and long-term benefits for the option, the costs and resources necessary to implement the option, and its relative potential for success in the MSU environment. The report is intended to evaluate possible future options and recommendations and not to assess past or current activities or general approaches. Clearly, the topic of health care is complex and dynamic. Hence, while the task force is confident of its deliberations as of fall, 2007, it is very likely that things will change in the future. Most important, it must be realized that proactive examination of health care options must become a focus of faculty involvement in the budget review process at MSU.
Table 2: Summary of Task Force Options

<table>
<thead>
<tr>
<th>OPTION</th>
<th>Quality/Effectiveness of Health Care</th>
<th>Cost Containment</th>
<th>Implementation Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST = Applicable in short term</td>
<td>LT = Applicable in long term</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HEALTH PROMOTION OPTIONS**

- Environmental Management (p. 21) | ↑ | ↑ | ↑ | ↑ | Strong
- Wellness Activities and Programs (p. 21) | ↑ | ↑ | ↑ | ↑ | Some
- Improved Consumer Information (p. 26) | ↔ | ↓ | ↑ | ↑ | Little

**PROVIDER OPTIONS**

- Care Coordination (p. 28) | ↔ | ↓ | ↔ | ↔ | Some
- Evidence-based Medicine (p. 32) | ↑ | ↓ | ↑ | ↔ | Strong
- Increasing Care Access (p. 34) | ↔ | ↓ | ↓ | ↑ | Some

**INSURER/ADMINISTRATOR OPTIONS**

- High-Performance Providers (p. 35) | ↑ | ↑ | ↑ | ↔ | Strong
- High-deductible Health Care Plans (p. 37) | ↔ | ↑ | ↔ | ↓ | Little
- Variable Cost Sharing – Pharmacy (p. 38) | ↔ | ↑ | ↑ | ↑ | Strong
- Variable Cost Sharing - Value-based Benefits Design (p. 40) | ↔ | ↔ | ↔ | ↔ | Some
- Variable Cost Sharing – High-Performance Networks and Centers of Excellence (p. 41) | ↔ | ↔ | ↔ | ↔ | Some

**EMPLOYER (MSU) OPTIONS**

- Self-insurance vs. Standard Insurance** (p. 42) | ↔ | ↑ | ↑ | ↑ | Strong
- Encouraging Multiple Bidders (p. 43) | ↔ | ↑ | ↑ | ↑ | Strong
- Developing Innovative Delivery Systems (p. 44) | ↔ | ↔ | ↔ | ↑ | Strong
- Developing Innovative Payment Systems (p. 45) | ↔ | ↓ | ↑ | ↔ | Strong
- Developing Community-wide Information Systems (p. 45) | ↔ | ↔ | ↔ | ↔ | Some
- Group Purchasing (p. 46) | ↔ | ↔ | ↔ | ↑ | Some
- Centers of Excellence (p. 47) | ↑ | ↔ | ↑ | ↑ | Strong

**Key:**
- ↓ = Likely negative effect
- ↔ = Effect undeterminable
- ↑ = Likely improvement

**Note:** **Refers to the difference between traditional insurance, where the University pays premiums and the insurance company takes the risk (labeled Standard Insurance), and Self-insurance, where the University pays actual costs of health care (labeled Self-insurance) through a third-party manager (often an insurance company)**
Health Promotion Options

Environmental Management

The work environment influences the health and safety of its workers. Occupational health and safety regulations required by government agencies (e.g. the Occupational Safety and Health Administration, the Michigan Occupational Safety and Health Administration, and others) are fundamental in the discussion of workplace health and safety. Many safety training and preventive occupational health services are mandated by federal and state statutes, and MSU currently has comprehensive programs in all of these arenas, with excellent compliance, except for a few “delinquent” departments or colleges. Programs that consider ergonomics and job aids contribute to decreasing injuries on the job.

A healthy work environment includes both campus environment and safety programs that promote healthy lifestyles and are not mandated by outside agencies. For example, the food choices offered by University Food Services could limit availability of high-fat, high-sodium options for students and faculty. Or, environmental changes that support physical activity for its employees could include design features such as paths for safe walking and bike use, among others. Smoking has been identified as a major health risk. Currently, MSU prohibits smoking in University buildings to decrease the risks associated with passive or “second-hand” smoke. The next environmental step in reduction of tobacco use would be to move to a smoke-free campus. While such a decision offers a beneficial change for many people in the campus community, this type of policy comes in conflict with personal values related to individual freedom of choice (e.g. the freedom to smoke on campus vis-à-vis the proven benefits to both smokers and nonsmokers of creating an environment free of tobacco.) The cost and productivity benefits of a smoke-free campus, in addition to the health benefits, are substantial. Studies concerning the cost utility of a smoke- and tobacco-free environment are well documented and while the long term effectiveness is variable, the general consensus indicates that smoking cessation programs are effective.

Wellness Activities and Programs

While most people know that tobacco use, unhealthy eating patterns, lack of fitness, and excessive alcohol use jeopardize health, those with one or more of these health habits
have much more difficulty in knowing how to change these longstanding patterns. At present, MSU, through its Health4U programs, has fairly robust and growing programs in all of these areas. In addition, it offers stress reduction programs that give employees tools to help them change. Where evidence is available relative to efficacy and the probability of lowering costs, these programs could be reinforced by benefits programs that support these changes. This could be in the form of allowing smoking cessation drugs on the formulary or through incentives and disincentives for certain known adverse health behaviors (e.g. changes in the deductibles and/or co-pays for those engaged in health improvement strategies or through campus environmental changes like a smoke-free campus). Some employers have provided physical activities facilities and programs that provide incentives for those employees that engage in routine exercise programs; MSU has recently added facilities for physical activity that are available of use by MSU employees. Programs that utilize these facilities should be examined and implemented, when appropriate.

**Health Promotion at MSU:** MSU has a recently “renovated” health promotion unit that continues to improve and expand its efforts in areas that make a difference. The current programs in Health4U are aimed at five areas known to influence health status and costs to the employer/employee. These programs include a focus on (1.) smoking/tobacco cessation; (2.) fitness and exercise; (3.) obesity intervention/prevention and nutritional wellness; (4.) consumer education as users of health care services; and (5.) emotional health promotion/stress reduction. These programs are outlined below and continue to expand.

**Smoking/tobacco cessation programs:** At present, this program offers support groups, individual coaching, online coaching, and information for employees and their spouses attempting to become tobacco free. In addition to assisting on an individual level, Health4U is in the midst of planning a transition to a smoke-free campus (environmental change) as well as a Chantix pilot program, involving the new drug that has had much more success in assisting persons in becoming tobacco free.

**Fitness and exercise programs:** Health4U promotes fitness and exercise programs by way of providing walking and movement programs, coaching for those determined to be more physically active, and connections to University and area resources with goals to help people become physically fit. There is an online program (MSU Moves) to assist people in
tracking their individual progress. What might expand these efforts are environmental policy shifts. Such shifts could include limiting driving on central campus or a campaign to promote walking among able-bodied persons. Further, there could be incentives for increased use of on-campus exercise facilities or potential employer sponsored “donated work time” to encourage flexibility programs, walking, etc., for those who have fixed work schedules. Since fitness and exercise are the cornerstones of successful weight management programs, continuing to expand this effort is important in the work to reduce obesity rates.

**Obesity intervention/prevention and nutritional wellness programs:** Health4U has a comprehensive nutrition program, based on principles of healthy eating and increased exercise rather than severe restrictive eating. These programs include classes on healthy nutrition, lunchtime sessions on cooking at the University Club, recipes online, and individual coaching. Environmental-option expansion for food labeling, healthy choices in vending machines, and improved options in on-campus food services are yet to be initiated.

**Consumer education as users of health care services:** Healthy E-mail, started in 2001, serves as the cornerstone of consumer education regarding evidence-based “best practice” recommendations for approaching common problems. The Health4U E-mail service delivers a lay-language summary of graded literature review on a common problem once a week to both providers and consumers wishing to receive it. Feedback from both providers and consumers has been excellent, and the numbers receiving this service continue to grow. Additionally, in this area, Health4U offers employee coaching on appropriate access and use of the health care system. Finally, within the next few months, Health4U will be purchasing and adding an MSU-tailored online information base (Healthwise) for consumers to query the best approaches to most health care problems. Potentially, these efforts could be improved by some incentives that reinforce the use of evidence-based information available to employees and their families.

**Emotional health promotion/stress reduction programs:** The Employee Assistance Program offers group classes that address more effective responses to stress. These are free of charge to University staff through Ed-Assist in Human Resources, but the classes have a nominal cost for faculty. One way to make this program more accessible is to find a way, through Academic Human Resources, to fund several groups each year for
faculty and academic staff. This would involve nominal resources and address a growing cost problem, related to absenteeism, health care costs, and productivity costs, that is a national trend related to depression and stress and its impact on job performance (National Institute for Occupational Safety and Health, 2007). Additionally, the Employee Assistance Program offers free consultation on an individual basis for assessment and referral for all employees facing personal stress that may impact their work.

**Potential Additional Program:** Risk assessment provides a systematic method for obtaining data that assesses possible health risks based on individual factors (i.e. lifestyle, familial health history, etc.). By completing periodic assessments, the health care consumer is likely to minimize health risks as he/she would identify areas for annual follow-up. Early recognition of alterations in health status may prevent more serious outcomes of certain diseases. Risk assessment may include:

**Online health risk assessment:** Many risk assessment programs are available online, delivering automated risk analyses intended to be shared with the health care provider who might tailor a personalized plan around identified risks.

**Health assessment coaching:** Often, once a risk assessment is completed, the results are sent to an individual, “an assessment coach,” who then discusses the results with the health care consumer. This person could be a representative of the health benefits program or the individual’s personal physician.

**Health risk assessments:** Frequently, the problems with risk assessments completed through a health promotion program are that they remain unconnected to the health care delivery system. This often produces duplicate services and increases the costs. Many independent risk assessment programs are not evidence-based and routinely perform or recommend screening biometric testing that is not recommended universally, thus fractionating health care systems and adding to costs. If a routine risk assessment program is to be considered, integration with primary care providers and avoiding tests not recommended by the U.S. Preventive Health Services Task force for the population is critical. Otherwise, we simply add another layer of costs to the health care delivery system, as well as duplicating some screening tests.
Effects of Health Promotion Programs: There is reliable data indicating that effectively delivered and focused health promotion programs do make differences in both health outcomes and cost differences in some areas. The areas where the data is most compelling are in tobacco cessation and nutrition/fitness/obesity interventions. For example: on a national scale the direct medical expenses and lost productivity resulting from premature death cost $157 billion each year or about $3,391 per adult smoker per year ($1,760 in lost productivity and $1,623 in excess medical expenditures). To determine how much a business could benefit by helping employees quit smoking, the following formula (Center for Prevention and Health Services, 2003; Centers for Disease Control and Prevention, 2002) can be used: (Number of employees) *.20 (proportion of Michigan State employees who smoke) * $3,391 (estimated cost generated by each smoker). For MSU, this equals $7,121,100 per year.

Furthermore, the immediately recoverable costs related to productivity are even higher than health care costs of tobacco use. Studies incorporating the effect of both absenteeism and presenteeism show that smokers cost employers approximately $4,400 per year in terms of lost productivity. (Bunn et. al., 2006; Centers for Disease Control and Prevention, 2007) For MSU this loss in productivity equals $9,240,000 per year, assuming a 20% smoking rate. If we were to successfully help only a percentage of workers to stop smoking, for example, the immediate savings in the short run would be considerable. Some of these examples are outlined in Table 3.

The estimated health care costs related to obesity (persons with a Body Mass Index (BMI) over 30) are about 6% of the total national health care expenditure (National Center for Health Statistics, 2007). At MSU, savings in helping people to reduce their weight to below a BMI of 30 are estimated to be $6,660,000.
Wellness programs have the ability to capitalize on faculty expertise and generally lend themselves to collaboration with interested faculty as far as program design and evaluation. But, wellness programming tends only to affect the individuals who are motivated or who have acute needs. The individuals for whom these programs are designed may choose not to participate. A well-designed wellness program can provide motivated consumers with evidence-based information regarding health risks. The program encourages consumers to make healthy lifestyle choices and to seek treatment for potential conditions. And, with health reimbursement arrangements, the largest limitation of risk assessment involves underutilization by those who need assessment most. In addition, this redundancy or conflict with recommendations from primary care providers may pose a risk to the consumer. Risk assessment is frequently integrated into the annual physical exam by many providers; thus, this could potentially produce duplicate services, both of which have costs. These approaches are feasible for MSU and are congruent with our approach. As a result, the task force sees some support for increasing these approaches, provided that there is evidence that screening measures are appropriately matched by age and gender and that these assessments are coordinated with primary care providers.

**Improved Consumer Information**

With the advent of the Internet, information of all types has become more readily available. Health care information is no exception. Many health care experts have argued that
accessible high-quality information on health care treatment options, outcomes, and cost would lead to improved health care decision making on the part of consumers. Particularly when health care treatment procedures can be anticipated (rather than occurring in inpatient settings following acute health emergencies), consumers could make informed decisions about procedures (e.g. knee replacement surgeries). These decisions could take into account possible treatment alternatives, alternative treatment locations (e.g. Sparrow Hospital vs Mayo Clinic), the outcomes of alternative treatments and locations (satisfaction, health, and complications), their relative costs (treatments and locations), and long-term efficacy. There seems to be good evidence that when consumers have such information available, they can make better informed decisions that often enhance their wellbeing and decrease costs.

At MSU, there is an ongoing project directed at consumers called Healthy E-mail, which is designed to give consumers evidence-based and graded information about best approaches to common health care problems, including preventive health care. In addition, there will soon be available a commercially produced but evidence-based information system that employees can use to query about personal health questions. What is lacking in the best commercially available systems is sound information on effectiveness and cost. According to both of our external consultants, there is wide variability in the effectiveness of alternative approaches to the same health condition. An additional issue related to quality/effectiveness is provider locations (e.g. hospitals); these have widely varying rates of complications (e.g. infections) and costs. Cost does not seem to be a predictor of quality or complications. Hence, it seems very beneficial to enhance the quality of health care option information available to our consumer groups. It could be argued that MSU faculty members are likely to be more interested than the average person in availing themselves of such information. New resources would be required to make health information systems available to MSU as well as expenditures for ongoing maintenance.

While better consumer information is potentially quite valuable for improving health and promoting more efficient resource use, the question is what more can MSU do now that would make an important difference? While the Task force believes that MSU should keep informed of emerging opportunities to provide better information, it concluded that this is not a high-priority area for immediate action.
Provider Options

Care Coordination

Care Coordination is defined as “Facilitating the right care, in the right amounts, in the right settings, by the right provider, with evidence of quality, while preserving continuity of care, if possible.” Care coordination includes a broad spectrum of increasingly intensive services to facilitate the care of individuals experiencing chronic or post-traumatic conditions. While specific definitions for the types of care-coordination services vary from provider to provider, they are typically described as *stratified systems of interventions for individuals with specific conditions that are varied in intensity, based upon the needs of the client.* Population-level stratification of individuals across the spectrum of a disease or condition is frequently used to determine which individuals require the levels of care-coordination services. For most clients with chronic and other moderately complex conditions, the personal health care provider is prepared to deliver the care and support necessary for the client to achieve treatment goals and perform self-care activities to maintain a stable healthy condition. Many providers utilize the Wagner’s chronic disease model as a framework to guide their practice. This includes self-management supports and decision supports and makes use of clinical information system and process redesign to support patients in achieving positive health outcomes. When providers consistently use evidence-based protocols and well-designed care processes, the majority of individuals can be assisted to achieve their health goals within their “medical home.”

Within any population, between 10% and 30% of individuals with more complex chronic and post-traumatic conditions require additional supports to achieve successful health outcomes. Disease management and case management programs may improve outcomes for these individuals. Disease management programs focus on groups of individuals with similar conditions and provide them with supports. Frequently, these are educational materials, reminders of required screening and check-ups that assist the individual to successfully participate in care and achieve their health goals (Short et. al., 2003). For example, disease management may designate a group of all diabetics and provide them with self-learning modules on diabetes and its treatment.
Case management services, by contrast, are more intense and include individualized interventions for persons with very complex conditions or psychosocial factors that make it more difficult for them to successfully navigate the health care system to access and use necessary services (Short et. al., 2003). Case managers are generally nurses, social workers, or other health professionals with specialized skills in assisting individuals to access appropriate health care services, complete complicated diagnostic and treatment regimens in the community, and negotiate care delivery from multiple specialists and health care agencies. For example, among people with heart disease, those with multiple hospital admissions for congestive heart failure would be identified for case management. These persons would generally be assigned a case manager who would monitor them on a regular basis, using daily phone or internet contacts to track the progress of the patient’s response to treatment. Any individual with measures falling outside of protocol guidelines could be identified immediately. Moreover, the provider could be notified, and treatment plans could be modified accordingly.

The strength of this option is that information and/or service is targeted to the populations with the highest potential for immediate benefit. Evidence supports positive outcomes for intensive case management approaches applied to certain conditions, such as heart failure and diabetes in the first year of service. Long-term cost effectiveness, however, has not been clearly documented. There is inconsistent evidence regarding the effectiveness of the broader disease management programs.

Many insurance carriers, including those available to the MSU faculty, have programs available that are defined as disease management and case management. They are not usually as intensive as the case management programs described in the literature as being most successful (Norris et. al., 2002; Sisk et. al., 2006; Stafford and Berra., 2007). Disease management programs offered by insurance providers are not always directly aligned with the individual’s health care provider, and this lack of coordination may result in confusion when slight differences exist in interpretation of evidence-based guidelines. Also, this lack of coordination makes it much more likely that services will be duplicated; this results in a higher cost to the employer.
Identification of patients who will benefit can sometimes be a limitation. MSU has a well-defined population and access to claims data to assist in identifying individuals with specific conditions who are inappropriately utilizing disproportionate services or experiencing many potentially preventable hospital admissions. Some conflict may be seen with insurance carriers that have parts or all of this service available, thus altering these general contracts for specific populations may be difficult. Insurers have been resistant to individualizing services for small populations, such as those that would be in the high-risk group and thus eligible for case management services within the MSU community. If the insurer agreed to change, it is expected that an administrative cost would be incurred for this specialized service. One option is to provide employer-paid case management services as a benefit outside the general health plan and to not include these same services within the contracted health benefit plan. This option, of course, will be unpopular for those who argue for individual choice in provider. These services can be provided directly by the employer or through a vendor of case management services contracted by the employer. Such services can be used to assist employees meeting criteria for having conditions likely to be helped by case management or care coordination, as defined by the University.

As stated earlier, the process of care coordination is generally a population-based initiative. This simply means that a condition is identified, and specific management protocols are implemented for individuals who meet critical inclusion parameters. For example, a specific protocol for diabetes may include management routines for diet, exercise, and medication. If protocols are followed, the patient maintains a better health and biometric profile, reducing the need for emergency services that may be required when the diabetic has uncontrolled disease. This approach may improve health outcomes, save costs, and contribute to decreased absenteeism and improved work productivity. This approach only offers a hope of being successful if conditions are carefully selected and known to be helped by care coordination and case management, if those delivering these services are held accountable to cost and quality measures, and if such efforts are carefully evaluated. Otherwise, disease management, case management, and care coordination become yet another cost center for the health care delivery system.

Though disease management is promising, strong evidence of the positive effects on health care costs is scanty, at best. In the short term, there is likely to be an increase in costs
with a promise of long-term cost reduction. Successful care coordination services require effective communication between the individual, the individual’s physician(s), his/her other health care providers, and the case manager or disease management service provider. There seems to be very good support for MSU to continue investigating care-coordination programs for health conditions common in the MSU community. MSU currently has disease management and case management programs that are part of the services provided by our health plan vendors. Human Resources is currently evaluating options to carve out the disease management programs and place them with one vendor.

Determining which diseases to initially target as part of care coordination should be based on the following:

- Common prevalence of the condition so that there is likely impact on health status and costs and so that evaluation can have statistical significance.

- Significant data that point to variability in quality of care for selected conditions, and good evidence that there is a preferred approach to care that benefits outcomes.

- Good evidence that care coordination/disease management benefits quality and cost for the conditions selected.

- A consistent evaluation program that monitors the efficacy and cost utility of the care-coordination/disease management program for both quality measures and long-term evidence of cost reduction within two to three years of the program’s initiation.

- Insistence on connection with primary and specialty care providers in disease management programs (to avoid duplication of costs) as well as care continuity.

- Policy design that supports incentives for patients to use successful care coordination programs.

The following represent a few examples of conditions that might meet these criteria:

- Congestive heart failure
• Type 1 (insulin dependent) diabetes
• Chronic obstructive pulmonary disease (COPD)
• Post-hospitalization severe injury care

Successful care coordination programs are dependent on the development of appropriate level of external supports for the patient–provider team in achieving health care goals. There must be an incentive for both patients and providers to participate as these programs require the commitment of time from both parties. The utility of care coordination programs for MSU is subject to selection of chronic and post-traumatic conditions for which evidence is available that care coordination improves outcomes and controls costs.

**Evidence-based Medicine**

Evidence-based medicine (EBM) is the “conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett et. al., 1996). The general goal of plans utilizing EBM is to cover treatments and therapies that have evidence of working, as well as possibly restricting coverage for tests and treatments that have no scientific evidence of effectiveness or improved patient care. For example, nearly 300,000 patients in the United States have surgery each year to relieve sciatica (pain in the lower back and leg due to irritation of the sciatic nerve). A two-year study of 2000 sciatica patients showed no difference in patient outcomes with back surgery, compared to simply waiting (Weinstein, et. al., 2006). Certain tests are also done routinely with no demonstrable benefits. Screening electrocardiograms (EKGs) are often performed on asymptomatic patients, for example, with no improvement in care. Hospitals can also overtreat patients. A recent study of California hospitals evidenced “Medicare over-care” documenting that California hospitals have three times the cost of others to care for patients with similar chronic illnesses and no quality gains in patient outcomes to show for it (Wennberg et. al., 2005). The study estimates that if Los Angeles area hospitals alone could achieve the cost efficiencies of Sacramento hospitals, Medicare expenditures for chronically ill patients would be reduced by $1.7 billion over five years. Given a typical medical payment system that pays for and even rewards redundant tests and over-utilized therapies, EBM plans may help improve the efficiency and effectiveness of patient care.
There are several general principles and considerations in building an effective medical plan based on EBM. Perhaps most critical to this process is compiling and understanding evidence of what works. Some studies can suffer from conflict of interest problems. Consequently, evidence-based sources of information should be transparent and explicit in their scientific processes and derive from validated results. In general, a limited set of tests and procedures may have sufficient evidence to incorporate into an evidence-based plan. For example, Prometheus, Inc. (http://www.prometheuspayment.org/), recently announced a pilot project for evidence-based coverage that includes five clinical areas: lung and colon cancer care; chronic care for diabetes, depression, hypertension, and hyperlipidemia; interventional cardiology; joint replacements; and preventive care.

According to Joanne Wojcik (2006), “These conditions were selected because they are among those for which the various medical societies have agreed on treatment guidelines and protocols.” Some of the best evidence available is done by organizations that do not have a proprietary interest in “selling procedures, medicines, or testing.” Good sources of such information that is comprehensive and rigorous are: (1.) the U.S. Preventive Health Services task force for preventive screening, (2) the Canadian Task Force, primarily for necessary preventive screening, and (3) the Cochrane database. These would be the best places to start for structuring a benefits program around the best evidence. Collecting and monitoring quality-of-care measures, of course, is critically important for effectiveness of evidence-based programs. The National Guideline Clearinghouse™ (http://www.guideline.gov/) and the U.S. Preventive Services Task Force (http://www.ahrq.gov/clinic/uspstfix.htm) review the effectiveness of health care services and clinical practice. A key recommendation provided by Dr. Roger Feldman in building an evidence-based plan that may limit coverage for ineffective services involves starting with a small number of procedures that have no scientific evidence of effectiveness (e.g. toenail fungus medications for persons other than diabetics and those with certain peripheral vascular disease in the legs).

Even in cases where clear evidence exists, evidence-based programs may meet with a lack of enthusiasm from providers, insurers, and consumers. Data are needed on providers to ascertain “compliance” with evidence-based guidelines, and providers may be reluctant to have their “failings” measured and revealed. For example, administering preventive antibiotics one hour before certain kinds of surgery may be effective in reducing surgical
infections. According to “Hospital Compare” data (United States Department of Health and Human Services, 2007), Ingham Regional gave surgical patients timely preventive antibiotics 92% of the time, but this occurs only 67% of the time at Sparrow. Providers need to cooperate in data provision.

Designing an evidence-based plan requires careful coordination and planning with insurers. While being self-insured can help with information requirements and the flexibility to incorporate evidence-based guidelines, not all insurers will necessarily welcome or become efficient and effective at administering such a program. Consumers often bristle at limitations to coverage. For example, an evidence-based plan could provide 100% coverage for evaluation and management of sciatica-related pain but require cost sharing on the part of the consumer for surgical intervention. If this is viewed as a restriction imposed by a health plan, consumer backlash is possible. However, if evidence-based coverage decisions are made by physicians and communicated/publicized to patients and health plan members, consumer acceptance may be enhanced.

Implementation of an evidence-based plan would require careful study and cooperation among the provider–insurer–consumer triad and would likely be offered as one choice among more traditional health plan(s). Two caveats are worth noting: (1.) an evidence-based plan may attract healthier or more compliant enrollees such that risk adjustments among all plans offered may be necessary and (2.) evidence-based plans may receive little traction unless and until Medicare and Medicaid implement such programs.

The task force sees strong support for evidence-based plans to improve quality and contain costs, although specific projections are difficult. Success of an evidence-based plan would require close cooperation with providers, MSU health plans, and consumers. It also may involve starting with a segment of coverage, such as preventive health care screening.

**Increasing Care Access**

One option that may lead to improved care would be the introduction of a “convenience clinic” in order to provide the MSU family with more efficient access to health care services. Today, healthcare practitioners are specializing in very finite elements of the health care delivery system. With this specificity comes the task of providing consumers with sound initial contact health care, for example through trauma centers, emergency rooms, and
physician’s offices, as well as continuing access to the medical needs of the individual’s specific condition. In general, when the patient arrives at the local health care in-take point (ER, etc.), he/she will receive the appropriate attention for the medical need. In addition, following the initial care, the patient may be referred to any number of specialties and subspecialties in order to complete the management of the diagnosis.

Arguably, the best type of facility for consumers to access for routine health issues is one that is staffed and operated by health care providers. To accommodate the need for a facility of this nature, one that maintains on-hour and off-hour staff, a substantial financial commitment is required. There are clinics like this available in a number of areas and are labeled as “urgent care,” “redi-care,” or “doc-in-the-box.” In general, these facilities provide health provider supervision and general radiology access. Because of the center’s policy for 24-hour access, overhead is high, and thus, the patient is, in effect, accessing an emergency room that is privately operated in their area. Once the initial visit is completed, the patient will most likely be referred to a full-service ER or at least to the physician of choice. Access to this type of facility is easier yet has little effect on the cost of the care that was provided. Other than the cost of service, the patient that frequents this type of facility may not see the same medical provider over multiple visits.

The idea of providing a facility that allows patients easy access and, at the same time, offers high-quality health care services seems to be difficult to grasp. If such a program was to enjoy any degree of success, the providers would have to be on-board with the services, and the patients would have to adjust their behavior away from using the ER as their personal physician. One could argue that having this type of easy access to health care would be ideal. However, the cost of these facilities may be prohibitive, especially if the patient population is not educated about the advantages and quality of care provided by these convenience clinics.

**Insurer/Administrator Options**

**High-performance Providers**

The incentives in the current health care system are aligned to finance health care services rather than to produce health. These incentives reward the use of procedures and technology to treat the medical consequences of disease rather than to prevent it. Misaligned
incentives encourage the over utilization of resources with little regard for the health benefit produced. One increasingly popular method used to address misaligned incentives is pay-for-performance (P4P) programs. P4P programs offer financial rewards to clinicians who meet certain standards related to quality and cost effectiveness. Existing P4P initiatives are sponsored by government purchasers, such as Medicare and Medicaid, as well as private employers, coalitions of employers, and health plans. Blue Cross Blue Shield of Michigan has a pilot P4P program that appears promising.

P4P programs can improve both medical care and quality of life by giving health care providers a financial incentive to seek measurable improvements in the health of their patients. However, P4P does not come without challenges. One such challenge involves P4P sustaining its effect on the quality of health care, including its administrative complexity and its ability to work in non-managed care settings, such as preferred provider organizations where a large portion of people get their health care. In addition to the overall goal of improved quality of health care, P4P programs also have the potential to:

- Decrease the incidence of unnecessary tests and procedures.
- Increase the numbers of patients who receive preventive care.
- Provide incentives to physicians to monitor patient care more aggressively, particularly for those who are chronically ill.
- Help health care providers embrace information technology and electronic medical records at a faster pace.

Along with the improvement goals associated with P4P programs are a number of challenges that implementation may face. Among them are:

- Gaining the support of the health care community.
- Determining the appropriate financial incentive structure.
- Finding ways to engage health care providers in sustained quality-improvement activities.
- Supporting funding for improvement of information technology and other infrastructure necessary to support quality improvement.
• Evaluating the return on investment.

Pay-for-Performance is an area of interest to the task force. The task force would like to learn more about the results of Blue Cross Blue Shield of Michigan’s Pay for Performance program. These results will provide insight for next steps in the exploration of this concept.

**High-deductible Health Care Plans**

“Consumer-directed health care” is gaining attention from employer–sponsors of health care and policy analysts (Buntin, 2006). Usually, this type of care involves an insurance plan with a large deductible, at least $1,000 for a single individual or $2,000 for a family. Proponents believe that individuals who are directly responsible for more of their health care spending will use health care more wisely and will put pressure on providers to keep prices reasonable. Other things equal, a high-deductible insurance plan should have a lower premium than a more conventional plan because a larger share of expenses is paid out-of-pocket rather than through insurance. If the high deductible leads to lower total health care spending, the premium would be lower for that reason as well. A lower premium provides an opportunity for the employer to take some funds (that would have gone toward the premium) and deposit them in an account that the employee can use to cover some out-of-pocket spending. Federal tax law makes it possible for such funds, if unused, to be put in an account that rolls over without being counted as employee income. Hence, this provides a tax advantage. Accumulated funds can be applied to future health care liabilities. There are two possible ways of setting up such an account: (1.) health reimbursement accounts, which do not belong to the employee if they leave the university and (2.) health savings accounts, belonging to the employee should they leave.

A high-deductible plan could be attractive if the change in incentives created by the high deductible leads to much more efficient use of health care, that is, if it leads to a large reduction in health care spending with no reduction in quality of care or worsening of health outcomes. In that case, premiums would go down sufficiently, and contributions to a reimbursement or savings account could cover much of the deductible liability without harming the employer. All employees, or at least a large majority, would then be better off under the high-deductible plan.
If, at the other extreme, the high-deductible plan leaves spending essentially unchanged, it will benefit some employees at the expense of others. It will reduce the degree to which health care costs are spread broadly among faculty and favor the healthy (who will spend little and accumulate funds in their accounts) at the expense of the sick (who will spend their accounts and be responsible for the remaining deductible).

Whether a high-deductible plan would generally work well for MSU faculty rests on whether it would lead to significantly more efficient use of health care. There is too little evidence to know definitively. The potential depends in part on whether consumers can be given easy-to-use tools with information about quality and price for different providers and courses of treatment for particular conditions. In addition, one concern about the potential for this strategy to significantly affect health care use is that health expenditures in any year are significantly concentrated among a small share of users (those, for example, undergoing major surgeries or with lengthy hospital stays). Key decisions for these individuals would not be influenced by the deductible or other cost sharing because such individuals would exceed their out-of-pocket limits. Consultants Roger Feldman and Paul Ginsburg, leading researchers on health care, were not optimistic about the potential for long-term savings based on their work.

Simply adding the high-deductible plan to the menu of choices might seem a good alternative, but it creates other issues. Adding another choice adds to the complexity of administering our health benefits programs. In addition, if it turns out that the high-deductible plan is chosen mainly by relatively healthy enrollees, it will drive up the average cost in the other plans, increasing the burden of premiums for those who select them (unless specific actions are taken to counteract this phenomenon). In light of these considerations, the Task force does not see the introduction of a high-deductible health plan as a promising option for the faculty health benefits program at this time.

**Variable Cost Sharing**

Although the Task force does not favor the adoption of a high-deductible plan at this time, it does see a number of ways in which consumer cost sharing could be redesigned to promote our objectives and align with other initiatives under consideration. With few exceptions, cost sharing as currently practiced in our faculty health plans – while providing
some deterrent to overuse of services – does not encourage the use of high-quality, cost-effective providers. For example, in the Community Blue plan, faculty members are responsible for the same $15.00 co-payment for a wide variety of types of physician visits, regardless of the physician they see or the reason for the visit. Cost sharing is higher for seeing out-of-network doctors, but Community Blue networks are quite broad.

Much greater variation in cost sharing could be considered in an effort to create desired incentives and spread burdens more equitably. However, greater variation also increases administrative complexity, which has its own costs. Creating the right incentives also requires good information concerning which providers truly provide high-quality care in a cost-effective way. Any attempts to introduce variation are likely to draw fire from both providers who are disadvantaged thereby and from enrollees who find that they are paying more than they have been.

Variable cost sharing – pharmacy. The use of variable cost sharing is currently most advanced for the prescription drug benefit. The current drug benefit is four-tiered. The first tier, lowest co-payment, is $10.00 for generics based on a 30-day supply. Co-payments are generally more favorable for 90-day supplies through the Caremark Mail Service. For brand name drugs, the pharmaceutical benefit manager, Caremark, maintains a list (or “formulary”) of preferred drugs. Preferred brand name drugs have a $20.00 co-pay and non-preferred a $40.00 co-pay. Bio-tech drugs are the fourth tier, with a $50.00 co-pay.

Consultant Roger Feldman recommended taking this approach and going a step further. In cases where a generic equivalent is available, enrollees could be asked to pay the full difference in cost if they select a brand name drug. Such a policy would strengthen the incentive to adopt generics when they are available. It would preserve some coverage for brand name drugs when generics are an option but would place the full extra cost on an enrollee making this choice. The Task force believes that this recommendation is appropriate and fair.

In some areas of treatment, generics may exist along with brand name drugs that have no exact generic equivalent. For example, Nexium – prescribed for treatment of acid reflux and for preventing ulcers is a drug still under patent protection with close generic or over-the-counter substitutes. A generic may work well for some enrollees, while others respond
much better to the brand name drug. A possible response is to create a protocol under which a generic (or lower costing brand name drug) is tried first, but if it proves ineffective, the patient is moved to the more expensive drug. Cost sharing might be set quite high (i.e., the full difference in cost between the high- and low-cost treatment) for those who do not follow the protocol and set lower for those who do. This is an idea well worth exploring, but it should be done in a way that maintains or improves quality, and the benefits in lower treatment costs need to be compared with the extra administrative costs required.

**Variable cost sharing – value-based benefits design.** Another application of variable cost-sharing has been labeled “value-based” by its proponents (Charnew et al., 2007). As currently conceived, this idea aims primarily at improving quality of care and reducing burdens on the chronically ill by lowering cost sharing for services believed to be of particularly high value. In its most sophisticated versions, it targets patients with particular conditions and reduces cost sharing for certain services only for those patients. For example, in July 2006, the University of Michigan implemented a program targeting enrollees with diabetes, reducing cost sharing for certain highly beneficial services, including several drugs that affect blood sugar, blood pressure, cholesterol, and depression (Charnew et al., 2007). Reduced cost sharing in such circumstances may have the potential to reduce costs over the long term by preventing costly complications, but evidence of cost-offsets is not yet available.

In concept, a value-based approach to consumer cost sharing is highly consistent with and complementary to a greater emphasis on evidence-based medicine. Cost sharing is reduced for the services evidence shows to be highly beneficial and, by the same token, could be increased for those for which evidence shows a lack of strong benefit. This simple idea would encounter numerous challenges in implementation. For example, certain services (some screening tests) or classes of drugs (beta blockers and statins) may be highly cost effective in some circumstances and of little or no benefit in others. Differentiating these to apply differential cost sharing is not easy, and the evidence base is frequently ambiguous. Enrollee backlash is possible when different co-pays are applied to the same service or drug for different patients. Information on a patient’s medical condition necessary to apply the principles of value-based design is not always available in an insurer’s administrative
database. This is an example of a potential benefit from improved use of information technology and shared access to electronic medical records.

**Variable costs sharing – high-performance networks and centers of excellence.**

Another potential use of variable cost sharing is to create incentives for enrollees to choose providers delivering high-quality care in a cost-effective manner. Consultant Paul Ginsburg spoke about “high-performance networks” as one of the more promising options for MSU to consider. He has recently written about the idea for the Center for Studying Health System Change (Draper et. al., 2007). A few health plans have begun to put this idea into practice, usually at the urging of large employers. Health plans gather data on groups of specialty physicians regarding both cost and quality of care. Cost and quality data usually center on episodes of care. Interestingly, costs apply to all medical costs associated with the episode, including hospital care and pharmacy, not only the reimbursements to the medical group.

Groups that perform well on both cost and quality are designated as “high performing.” Incentives to be high performing might include bonus “pay-for-performance” payments to the group. But importantly, enrollees could also be given incentives in the form of differential cost sharing to use the high-performing networks. If the designation and the cost sharing influence consumer choices, physician groups would have a stronger incentive to seek the designation, including working with the hospitals in which they practice in order to become more cost effective. Money might be saved first by directing more enrollees to better physicians. The larger long-run potential rests in creating incentives for improvement for all physicians in the market as well as the other providers they work with to provide episodes of care.

As Ginsburg discussed with the task force, high-performance networks of doctors are relatively new, and evidence related to their effectiveness is very limited. Clearly necessary for the concept to succeed is the ability to compile credible data on cost and quality (which must weigh differences in patient mix across groups), from which to rate groups of doctors. As with other forms of variable cost sharing, enrollee acceptance of higher cost sharing when their doctors are not designated as high performing can be an issue, as can provider backlash.

A closely related idea is the use of variable cost sharing to encourage enrollees to use “centers of excellence,” which are discussed in more detail elsewhere in this report. We
interpret centers of excellence to be provider groups that have been identified as high quality (and, it is hoped, also low cost) for managing certain types of cases or performing certain procedures (e.g. bariatric surgery and coronary bypass surgery). MSU might consider contracting exclusively with one or more centers of excellence for a particular procedure, but this could be viewed as an improper interference with consumer choice, particularly if the center is not convenient for some enrollees. A less drastic alternative would utilize variable cost sharing to strengthen the incentives to use the center.

The task force sees a great deal of potential in using consumer cost sharing in more complex ways than is currently practiced in order to align with other initiatives and, ultimately, to enhance quality and control cost. The general idea is to make individuals more responsible for bearing the costs of their actions that contribute to cost but do not enhance quality and to create incentives for them to make better choices. The challenges come in the process of identifying, based on current evidence, what constitutes good choices in particular situations and in creating an appropriate and administratively feasible incentive structure. A relatively simple step that we support is to make enrollees responsible for the full additional cost of brand name drugs when generic equivalents are available. Evidence about the best ways to carry out the other ideas in this section and the potential for cost savings and quality improvements is rather limited, but we believe that these ideas, nevertheless, merit serious consideration.

**Employer (MSU) Options**

**Self-insurance vs. Standard Insurance**

There are two primary financial arrangements available to employers when paying for health and prescription drug coverage: fully insured and self-funded. Under a fully insured arrangement, an employer pays a fixed premium, and the insurer bears the risk and absorbs the cost should claims and administration fees exceed the set premium. Conversely, if claims and administration fees are lower than the set premium, the insurer stands to gain financially. MSU has a fully insured arrangement with Physicians Health Plan (PHP).

Self-funding generally requires a pool of insured lives that is large enough to balance the financial risks associated with large catastrophic claims. The self-funded approach offers
greater access to claims cost data, potentially lower fees (the administrator need not be compensated for taking on risk), more flexibility in plan design options, and greater overall control of the program.

With approximately 28,000 faculty, staff, and retirees covered under the health plan, MSU has an adequate pool of covered lives to support utilizing a self-funded arrangement. MSU is currently self-funded under Blue Cross, PHP and Caremark. Self-insurance has no effects on health, though it appears to have very positive effects on cost containment and information availability. Given that it is very feasible (i.e. we already do it), the task force gives strong support to the concept of self-funding, provided that full advantage is taken of the greater access to data and greater control over plan design.

**Encouraging Multiple Bidders**

Historically, MSU’s ability to create new health care benefit options or, more specifically, to create incentives for consumers and providers has been limited by insurers and plan administrators. In short, MSU has been a “captive to the Blues” for some time. This would appear to be a function of the Blues’ dominance in the Michigan market, its breadth of service network, and its special status under state statute/regulation.

MSU’s situation is not unique, especially within the State of Michigan. Even very large employers rarely administer those aspects of their employee health benefits that involve interactions with healthcare providers. When large employers self-fund (self-insure), typically, they still contract with insurers for administrative services. In this role, an insurer is often referred to as a third-party administrator, or TPA. TPAs are responsible, for example, for contracting with doctors and hospitals, determining which providers are in the network, and negotiating payment rates. The exact structure of a benefit plan, even if self-insured, is thus determined in negotiation between the employer and the administrator. If MSU wants to incorporate performance incentives into its payments to doctors in a way that would make life more difficult for Blue Cross, Blue Cross may refuse, or it may agree only in return for a larger administrative fee. Many of the innovative directions for improving health benefits that might be explored can be approached only in cooperation with the plan administrator.

As in any market situation, the health benefit purchaser (e.g. MSU) is in a stronger position to demand good performance from third party administrators (TPA) or health
insurers when there is more competition for that business. Unfortunately, health insurance options in the mid-Michigan area have been limited over the years. The mid-Michigan market, as well as the entire Michigan market, has been dominated by Blue Cross Blue Shield of Michigan, with a handful of regional HMOs offering some alternatives. The addition of another regional HMO may also have a limited ability to fully meet the needs of employers like MSU, who serve employees and retirees across the state, nation, and globe.

This situation has created a serious lack of competition that presents challenges to employers (like MSU), limiting their ability to: (1.) negotiate the most cost-effective financial arrangements, (2.) pursue creative and alternative plan designs, or (3.) pursue innovative strategies to provide incentives for consumers and providers. Recently, there have been efforts by two national health insurers (Aetna and United Health) to enter the Michigan market and potentially provide viable competition to Blue Cross. The Office of Human Resources is actively gathering information about these evolving options.

The task force sees attracting other national health insurer into the mid-Michigan market as critical in successfully pursuing many of the options and opportunities discussed in this report. The leverage gained by having additional competition in the marketplace would improve the willingness of all health insurance players to negotiate more favorable terms, conditions, and provisions. This option will be among our highest priority recommendations.

**Developing Innovative Delivery Systems**

For MSU to address the problems and options outlined in this document and to become a leader in this field, an institutional commitment will have to be made that develops innovative delivery systems focused on excellence in health care. A collaborative approach employed by the University scientific community, human health colleges, and administration will be necessary to develop innovative delivery systems focused on excellence and cost containment. Without innovation from within, change to the status quo is likely to be only minimal. The characteristics of effective health care delivery systems, which were described above, need to be amalgamated in order to be effective.

As one example, a new model might involve MSU group practice agreeing to take responsibility for a broad set of services for a group of enrollees and to be paid on capitation basis (per member per month) rather than fee-for-service. While it is not realistic to think that
such a model could quickly replace one of our current plan options, it might be offered as an additional option on an experimental basis. Design of the model, the terms on which it would be offered to MSU faculty, and a plan for rigorous scientific evaluation would all need to be developed by a multidisciplinary team.

**Developing Innovative Payment Systems**

This study has demonstrated that the current reimbursement system provides financial incentives to providers to perform procedures, for both diagnosis and treatment, often with no regard for avoiding duplication and little or no positive incentive for optimal quality. Within our current health care options, alternative methods of payment that will provide incentives for quality care, improved outcomes, and cost containment need to be explored. MSU should take a leadership role in developing innovative payment systems. This is not a simple undertaking or one that MSU, large as it is, could accomplish alone. Careful planning and experimentation will be needed, as well as cooperation from insurers and possibly other major purchasers in our area.

**Developing Community-wide Information Systems**

MSU is engaged in a project that promotes the community-wide use of information technology to improve coordination of care and reduce duplicative services. This project is called a Regional Health Information Organization (RHIO). RHIO is a technological organization that connects health information in a community. It allows health care providers access to timely, accurate information about most or all aspects of patient care. Such information can reduce medical errors, save money by reducing unneeded and duplicate procedures, and improve patient health by improving diagnosis and treatment. Currently, this project is being championed by the Capital Area Health Alliance (CAHA). The CAHA is a coalition of organizations (including MSU), businesses, health care professionals, and volunteers (from Clinton, Eaton, and Ingham Counties), working together to empower the community to achieve better health.

The task force sees some support for concepts used by RHIO. These approaches seek to provide community-wide information so that historical, diagnostic, and treatment data can be shared across providers. The goal is to decrease duplication and errors, make second
opinions more efficiently available, and enhance outcomes. Given the current incentive systems for insurers/administrators and providers, it is not clear if this option can be implemented. In order to provide adequate incentives for health outcomes and care quality, MSU will likely have to serve a leading role.

**Group Purchasing**

Group purchasing is a way to increase leverage when contracting with health care insurers. It involves organizations joining together to create a larger pool of coverage that, in turn, becomes more attractive to insurers. It also encourages insurers to be more accommodating. Group purchasing can be challenging. Participating organizations generally must agree on a standard set of benefits so that all participating members buy the same product. Moreover, the organizations must pledge to abide by the joint negotiating process and not bargain with providers on their own behalf. MSU currently participates in two purchasing coalitions: the Michigan Universities Coalition on Health Inc. (MUCH) and the AFL-CIO Employer Purchasing Coalition (AEPC).

MUCH is a coalition of twelve public universities in Michigan with a mission to improve the value of health care benefit plans and services through better quality and lower costs for Michigan universities and their faculty, staff, retirees, and dependents. MSU’s Office of Human Resources leads this coalition. Human Resources estimate that membership in MUCH will save MSU over $500,000 in Blue Cross administration fees over the term of the current contract. While this is by no means a trivial number, it represents less than one-half of one percent of total projected MSU expenditures administered by Blue Cross. In addition, any such estimate of savings relies on assumptions about what would have happened had MSU not participated in MUCH.

As a member of AEPC, MSU contracts with Caremark to administer the prescription drug program. Partnership with this coalition may help MSU gain significant pricing advantages compared to what could be achieved alone. Human Resources recently participated in an RFP bidding process along with the other coalition members. The Task force sees some support for continued involvement with group purchasing coalitions in cases where there are net gains to MSU. However, the Task force believes that group purchasing coalitions need to be evaluated carefully to assure that participation does not unduly limit our
ability to create competitive pressures by negotiating with new bidders, to design our own health benefit plan, or to create improved incentives for providers. In order for MSU to pursue a leadership role in this area, it may limit or increase involvement in group purchasing options.

**Centers of Excellence**

Centers of excellence are generally hospitals or other providers with quality of care identified as high for particular tests, procedures, or services. Typically, these centers operate at lower costs due to higher volumes, shorter stays, and better outcome rates. Interest in centers of excellence is generally high given the prospect of high quality and lower costs. The proliferation of centers of excellence may be aided in the future by the trend of hospitals and physicians becoming increasingly specialized.

An example is bariatric surgery, an operation such as gastric bypass, designed to help promote weight loss and treat obesity. Considerable cost and quality differences exist among hospitals that offer bariatric surgery. To improve patient care and potentially reduce costs, Medicare has begun covering bariatric surgery in certain instances only when performed in a facility meeting evidence-based standards. This illustrates the close tie between centers of excellence and quality/cost information related to evidence-based programs. In general, the potential benefits of identifying centers of excellence and encouraging their use among health plan members are most promising for expensive services with large variation in quality among providers.

Identifying centers of excellence requires the following: (1.) deciding how quality and/or cost measures are to be emphasized and determining the relevant criteria, (2.) assessing access to a center of excellence by health plan members, and (3.) determining changes to the health plan to contract with proposed centers and structure any cost or other incentives.

The National Quality Forum has a series of standards for hospital performance that are applicable to a number of procedures and services. Other data sources for hospital quality include Hospital Compare (cited earlier) and the Leapfrog Group – an organization of major employers and other public and private health care purchasers whose mission includes “promoting high-value health care through incentives and rewards.”
The potential exists that centers of excellence could improve quality and costs for certain services utilized by MSU members. For example, MSU spends nearly $2 million on MRIs annually. Encouraging use of an MRI center of excellence could lower costs and redundancy in MRI services without sacrificing quality.

The task force sees considerable potential in improving quality and costs with careful identification of centers of excellence. These receive high marks on all criteria considered by the Task Force and, hence, receive strong support. Detailed analyses of provider cost/quality data are required to determine high-impact applicability to MSU. Further, implementation of centers of excellence as a health care option will have to be carefully monitored to insure that quality of care and cost savings are realized.
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