Recommendations to Reduce the Economic Burden of Providing Employer-Sponsored Health Care Benefits

Governor's Council of Economic Advisors
December 2005

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Foreword

An outcome of Governor Jennifer M. Granholm's 2003 Summit, Manufacturing Matters in Michigan, was consensus on the urgent need to develop practical steps for federal and state actions to address the skyrocketing costs of employer-sponsored health benefits for employees and retirees. Michigan's manufacturing leaders called for collaborative efforts that would engage all stakeholders to seek solutions to manage the rapid rate of increase in health care costs, which negatively impacts their competitiveness by increasing production costs and diverting funds from research, development, and hiring. Leaders also noted the competitive disadvantage resulting from Michigan's comparatively unhealthy and costly workforce.

An appointed Task Force on Manufacturing & Health Care representing Michigan's large and small manufacturers and organized labor convened to formulate recommendations for state and federal actions that would produce substantive, sustainable improvements in the cost and quality of health care, thereby improving the position of Michigan manufacturers and other employers who wish to continue to provide health care benefits to workers and retirees.

Chaired by Michigan Department of Community Health Director Janet Olszewski, the Task Force worked with the Michigan Economic Development Corporation (MEDC), the Michigan Department of Community Health (MDCH), and the Office of the Governor in this effort. The Task Force presented its recommendations to the Governor's Council of Economic Advisors (CEA) in late spring 2005.

The CEA asked that an Ad Hoc Committee comprised of the Task Force, selected CEA members, and state government further consider the recommendations and augment them where appropriate. Under the chairmanship of Ford Motor Company's Chief Economist, Ellen Hughes-Cromwick, the Ad Hoc Committee's refined recommendations were accepted by the CEA in November 2005, to be forwarded to Governor Granholm.

Technical assistance and consultation were provided throughout both efforts by the Lansing-based consulting firm of Health Management Associates, Inc.

Overview

Rapidly growing health care costs are a well-documented concern to every segment of our country. Government, employers, and employees all have an enormous stake in controlling costs and in producing better outcomes for our health care dollar. Employers who provide health care benefits for their employees see profits and research/development funds disappearing under the growing cost of these benefits. Michigan manufacturers find themselves increasingly disadvantaged in the global marketplace. In 2003, total health care spending in the U.S. comprised more than 15 percent of the Gross Domestic Product (GDP). Under current programs and policies, nearly 19 percent of the GDP will be spent on health care goods and services by 2014.[1] This is an unsustainable trend.

On the way to identifying strategies to alter this trend, Michigan manufacturers and state government examined their combined expenses for health care, as employers and purchasers. They found:

- The total expense for all health care goods and services by all payers in the U.S. in 2004 was $1.8 trillion.[1] Depending on the estimate used, Michigan's total expense in 2004 for health care goods and services by all payers fell within a range of $57 billion to $63 billion.[2]

- The State of Michigan currently provides direct health care benefits to more than 15 percent of the state's population. This includes state employees and retirees, adult inmates, Medicaid beneficiaries, and others.[3]

- Total government outlays from all sources (including federal) spent on direct health care purchases in Michigan in 2004 exceeded $10 billion, accounting for more than 25 percent of the state's total budget and more than one third of its General Fund.[3]

- The Big Three Automakers spent $10 billion in employee/retiree health care in 2004, half of which was spent in Michigan.[4]

- The combined health care expenditures by the Big Three and the State of Michigan in 2004 exceeded $15 billion, accounting for 24 to 26 percent of Michigan's total expense for health care goods and services.

This information clearly illustrates that collaborative initiatives between the state and employers in addressing health care costs have the potential to significantly impact large portions of the Michigan health care market.

Assumptions That Underlie the Recommendations

The cost of health care will continue to outpace inflation for at least another decade and will continue to divert an increasing proportion of employer resources. While the upward cost trend has slowed, the anticipated continued trend will erode the budgets and capacities of all employers.

The current levels of quality, effectiveness, and efficiency of health care services are unacceptable. Recommended services for prevention, screening, and treatment of disease are provided less than half the time. Nonrecommended and potentially harmful care is provided more than 10 percent of the time. Physicians, patients, payers, and educators all bear responsibility and must all be involved in a concerted effort to reduce unnecessary care and assure that recommended care is delivered.

The health care system information technology infrastructure is insufficiently uniform and substantially underdeveloped. The national, state, and local health care information technology infrastructure must serve a wide range of diverse purposes ranging from the storage and transmission of individual electronic medical records, comparison of provider quality, and safety and efficiency to the assessment of relative effectiveness of medical procedures and prescription drugs. The entire information technology infrastructure is substantially underdeveloped. This significantly hampers evaluation of the effectiveness and cost efficiency of care, impedes value-based purchasing of care, and adds billions of dollars in administrative expenses to all parties.

Advancing the capacities and efficiencies of the health care system requires national leadership in developing standards, and state action in the application of those standards. Significant progress on these complex issues will require active participation from all parties and bipartisan commitment from the government.

Categories of Recommendations and Their Potential Effect on Employer Premiums

This report addresses nine aspects of the health care system in which substantial change can occur to the benefit of purchasers/employers and consumers. The categories are listed in Figure 1. Recommendations for substantive action at the state level are identified for each category. In addition, most categories also include recommendations for action at the federal level, which serve to provide leadership and national infrastructure necessary for real change within the state.

Figure 1

Categories of Recommendation

- **Health Information Technology**
- **Health Status**
- **Best Practice and Clinical Efficacy**
- **Prescription Drugs**
- **Medical Errors**
- **Employer-Sponsored Coverage**
- **The Uninsured**
- **Mandated Benefits**

EACH CATEGORY OF RECOMMENDATION carries the potential to impact the premiums paid by employers for employee health benefits. Figure 2 is provided to depict elements of cost within employer-sponsored health insurance premiums that would be affected by the recommendations. The figure should not be construed to predict that changes in the health care system would eliminate these premium elements; rather, it illustrates that each category of recommendation directly affects a quantifiable portion of employer health care expense.

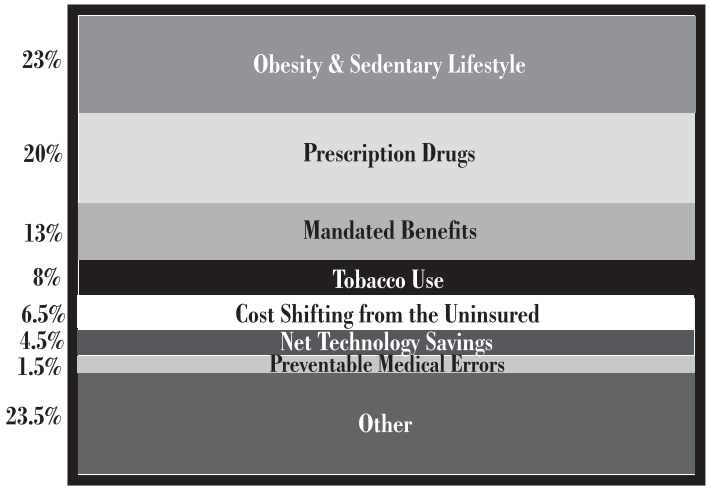
Data used in Figure 2 include the following:

- The Centers for Disease Control and Prevention estimates that 23 percent of employer premiums in members aged 40 or older can be attributed to the cost of obesity and sedentary lifestyle.[5]
- The cost to Michigan employers for prescription drugs is heavily dependent on the age of employees and on retiree coverage. The range of Michigan premiums attributable to prescription drugs is 12 to 35 percent, with an average of about 20 percent.[6]
- Estimates place at least 8 percent of the cost of care attributable to the effects of tobacco use.[7]
- Estimates of the impact of federal and state-mandated benefits on Michigan health care premiums in the range of 12 to 14 percent.[8]
- Hospitals and physicians directly shift the cost of services for the uninsured to other payers. Families USA estimates that in 2005 the direct impact of this cost shifting on employers in Michigan is 6.5 percent of premium cost.[9]
- The net savings of comprehensive national health information technology is expected to compound over 15 years. Early reductions in health care costs will be nearly offset by investment expense. At full implementation in 15 years, reduction in health care cost is estimated to exceed $77 billion a year. The average annual reduction in health care cost over 15 years is predicted to average 4.5 percent of the cost of private insurance.[10]
- The cost of medical errors in terms of lives and dollars is vast and well-documented. The Institute of Medicine percent of total personal table to preventable medical

Each of the categories above can be impacted by the recommendations in this report. In addition, the remainin 24 percent of premiums will be indirectly but significantly impacted by reductions in unnecessary care and more efficient clinical outcomes directly elated to the increased use of evidence-based practice and reimbursement based on the use of evidence-based care.

Figure 2

Directional Estimates:
Impact of Recommendations on Employer Premiums



Health Management Associates

Recommendations to Reduce the Economic Burden of Providing Employer-Sponsored Health Care Benefits

Underlying Principles of Recommendations for Health Care Reform

The Council of Economic Advisors asserts that the following principles must guide reform of the health care system in order to provide the best clinical outcomes at the most appropriate cost and achieve meaningful, sustained containment of the cost of health care/insurance, thereby closing the competitive gap for Michigan-based companies.

Evidence-Based Medical Practice in prevention, wellness, and treatment of disease through:

- Health service reimbursement methodologies that encourage evidence-based practice where possible.
- Public and private health care benefit programs that encourage evidence-based practice where possible.
- Uniform, standardized information on health service performance and outcomes, widely available to purchasers and consumers.

Creation and Realignment of Health Care Incentives. Realign health care incentives among providers, purchasers, and consumers to reduce cost shifting, encourage evidence-based care, reduce unnecessary services, and increase consumer responsibility for lifestyle and health status. At the same time, strengthen the insurance risk pool to increase affordability and access.

Transparency in the cost and value of health care interventions. Purchasers and consumers need information on the product, unit price, and volume of services being purchased, rationale for the purchase, and what outcomes or results are expected and attained. Transparency also allows comparison of aggregate performance by provider, enabling informed decisions about where to go and how to treat.

Coverage for and Access to Basic Medical Care for every citizen within the contexts of the employer-based system and expanded public sector options, which is essential to the elimination of cost-shifting and for a healthy population and workforce. Basic medical care must address wellness, prevention, and treatment.

Recommendation 1: Advance Health Information Technology

Includes Electronic Health Records, E-Prescribing, and Infrastructure

Ranking of This Category of Recommendation

Priority: Very High
Financial Impact/ ROI: Very High
Time Required for ROI: Intermediate, 3-5 Years and Beyond

This category of recommendation, while not the most significant in immediate financial return, is an essential underpinning to most of the other recommendations. A robust, effective health information technology infrastructure will enable the advances called for in the use of evidence-based practice, transparency in purchasing of health care services, efficacious service delivery, medical errors, benefit design, and elimination of unnecessary care. Health care lags significantly behind other industries in developing and deploying interoperable technologies. Building the necessary capacity will require substantial developmental costs, but is an investment in future health care efficiency and cost containment.

The Office of the National Coordinator for Health Information Technology estimates that widespread adoption of interoperable health information technology (HIT) can significantly reduce health care costs by saving time and reducing duplication and waste. The office estimates that a fully integrated, national HIT system would eliminate 20 percent of costs from the delivery of health care services.[12] More conservative estimates attach development costs of $400 billion over five years, with savings of $78 billion per year, thereby offsetting the development costs in just over five years and producing an annual net decrease in private health insurance costs of 4.5 percent per year over 15 years.[10]

Recommendations for State Action

1. Further develop cooperative efforts between Michigan Departments of Community Health and Information Technology to assess and advance HIT in Michigan and to maximize collaboration among all public and private parties. Collaborative efforts should include:
    a. Establish Michigan presence in the national HIT leadership, creating and sustaining an understanding of the urgency of this effort to business.
    b. Convene public and private sector stakeholders to track HIT developments and disseminate emerging best practices across the state.
    c. Seek funds and partnerships to develop a Health Information Network to advance the use of information and communication technologies that enhance effectiveness and quality of health care services.
    d. Identify creative access to capital to fund HIT infrastructure.
    e. Implement HIT in government health programs.
    f. Collaborate with private sector to tie HIT capacities to provider performance reporting.
2. In partnership with insurance carriers, providers, and business, implement strategies that result in a 25 percent increase within two years in the number of health records of Michigan residents that are stored in interoperable electronic health information systems.
3. In partnership with providers and business, implement strategies within two years, that result in a 25 percent increase in the number of physician offices using electronic health records.

Recommendation 1: Advance Health Information Technology

Includes Electronic Health Records, E-Prescribing, and Infrastructure

Recommendations for Federal Action

1. The federal government must set standards and definitions for all components of HIT, to be used by all private and public sector interests. It must continue to develop Regional Health Information Organizations (RHIOs), develop a Nationwide Health Information Network (NHIN), and drive adoption of Electronic Health Records (EHRs) and E-prescribing.
2. The federal government should reduce intended development time of EHRs from 10 years to five years.
3. The federal government should implement EHRs in all government health programs.
4. The federal government should foster conversion to EHRs in the private sector by:
   a. Offering low-rate loans for EHR adoption.
   b. Funding state and regional EHR and E-prescribing initiatives.

Recommendation 2:
Improve the Health Status of Michigan's Workforce

Ranking of This Category of Recommendation

Priority: High
Financial Impact/ ROI: High
Time Required for ROI: Intermediate/Long Term; 3 Years and Beyond

The Centers for Disease Control estimates that 23 percent of an insurance plan's costs are attributable to obesity and low mobility among plan members.[5] The percentage is undoubtedly higher in Michigan, with our excessive rates of obesity and sedentary behavior. The lost productivity associated with an overweight, unhealthy workforce imposes a significant additional burden on business. In addition, many estimates attribute at least eight percent of all health care costs to the use of tobacco.[7] The Council of Economic Advisors calls on MDCH and the legislature to work with business to improve the health status of Michigan residents. In addition to the workplace provisions of the Surgeon General's Prescription for a Healthier Michigan, the Council makes the following recommendations:

Recommendations for State Action

1. Michigan should require HMOs, insurers, and BCBSM to incorporate wellness and personal responsibility options into the benefit design of all health insurance policies and to discount the premiums for the optional components in a range sizable enough to drive meaningful changes in the insurance market.
2. MDCH should provide certification of worksite wellness programs, enabling employers to identify effective, evidence-based programs.
3. MDCH should evaluate the Greater Detroit Area Health Council's Regional Business Group on Health's initiative to help business understand its options and limitations with respect to workforce health status, and partner with business to disseminate effective emerging tools.

Recommendation 3: Support "Best Practice" and Efficacy in Medical Care and Pharmaceuticals

Ranking of This Category of Recommendation

Priority: Very High
Financial Impact/ ROI: Very High
Time Required for ROI: Short to Intermediate, 1-5 Years

Only about 55 percent of people with chronic disease receive the recommended care for their conditions, and less than half are considered medically well-managed. In addition, more than 10 percent of persons with chronic disease receive care that is medically ineffective and potentially harmful.[13] The use of recommended preventive services, such as cancer screenings and immunizations, is also far from efficacious. Further, large majorities of physicians, hospital administrators, and nurses all believe that extra tests, referrals, and procedures ordered by physicians because of liability concerns contribute significantly to health care costs.[14]

The combined purchasing power of the state (as both payer and employer) and the Big Three auto manufacturers for health care services in Michigan exceeded $15 billion in 2004. A partnership among these parties has the potential to significantly move provider behavior.

Recommendations for State Action

1. In partnership with the Michigan Office of the State Employer, MDCH, and the business sector, collaboratively evaluate Michigan's variations in measures reported in the Dartmouth Atlas, and pilot cross-payer projects that advance the use of best practices to reduce variation.
2. In partnership with the Michigan Office of the State Employer and the business sector, collaboratively test payment methodologies that base full reimbursement on best-practice indicators. Consider expanding the Southeast Michigan Quality Initiative's (GDAHC) Save Lives Save Dollars[15] initiative.
3. Strengthen ties in Medicaid reimbursement to the practice of evidence-based medicine based on HEDIS measures.

Recommendations for Federal Action

1. Develop and fund pilot projects to induce the transfer of best practices to physician practice, especially around HEDIS measures and other widely accepted clinical protocols.
2. Develop payment methodologies for federal programs that base full reimbursement on evidence-based best practice in prevention and in treatment of acute and chronic conditions.
3. Expand the efficacy assessment activities enabled by the Medicare Modernization Act and lead national efforts to compare and disseminate results on the comparative efficacy of selected clinical and pharmaceutical treatments.
    a. Create funding for public-private partnerships that compare relative efficacy of selected interventions, in addition to funds appropriated to the Agency for Healthcare Research and Quality (AHRQ) for comparative efficacy studies.
    b. Endorse and disseminate quality metrics.
    c. Create vehicles for broad dissemination of results to purchasers and to consumers.
4. Implement a centralized office or certification panel to assess new technology, drugs, and biologicals for efficacy, advance adoption of desired technologies and best practice associated with them, and create technology ratings for use by consumers. This would expand technolgy assessment associated with the Medicare program research enabled by the Medicare Modernization Act.

Recommendation 4: Support Prescription Drug Reforms

Ranking of This Category of Recommendation

Priority: High
Financial Impact/ ROI: Moderate
Time Required for ROI: Short and Intermediate, 1-4 Years

Retail pharmaceutical costs will exceed $223 billion in 2005, accounting for 12 percent of the cost of all health care services and supplies. Private insurance will bear 47 percent of this cost, or more than $105 billion.[1] The percentage of an employer's premium spent on prescription drugs is dependent on the age of the workforce and retiree benefits, and ranges in Michigan from 12 to 35 percent with an average of 20 percent.[6] The Council of Economic Advisors calls for aggressive action to curb rising pharmacy costs and to increase transparency in relative efficacy of therapeutically equivalent drugs and drugs new to the market.

Recommendations for State Action

1. Apply findings of scientifically sound, comparative studies of pharmaceutical effectiveness to the benefit design and the purchase of pharmaceuticals for state-funded health programs.
2. Maximize the state's power and leverage as a major buyer of pharmaceuticals.
3. Explore partnerships among the Michigan Office of the State Employer, county and local government, and business to maximize purchasing leverage for pharmaceuticals.
4. Oppose any proposals to limit mail-order pharmacy operations, providing those operations meet FDA standards.

Recommendations for Federal Action

1. Lead scientifically sound, comparative studies of pharmaceutical effectiveness.
2. Expedite processes to approve generic equivalent bio-engineered drugs and biologicals (vaccines).
3. Develop a mandatory adverse drug reaction database, with appropriate liability protection.

Recommendation 5: Support Reduction of Medical Errors

Ranking of This Category of Recommendation

Priority: Very High
Financial Impact/ ROI: Very High
Time Required for ROI: Immediate and Sustained

The cost of medical errors exceeds $38 billion every year. Nearly $20 billion of this cost can be avoided every year by reducing preventable medical errors. [11]

Recommendations for State Action

1. Support the State Commission on Patient Safety[16] to build an agenda for state action on reduction of medical errors.

Recommendations for Federal Action

1. Take a leadership role to select and implement best-practice clinical platforms and operational systems for preventing inpatient hospital medication errors and other medical errors.
2. Use the model to encourage the practice of evidence-based medicine and to develop performance goals for pneumonia, congestive heart failure, and acute myocardial infarction in the Medicare Modernization Act (MMA).
3. Develop payment incentives for all government programs modeled after those in the MMA.
4. Advocate for persistent, vigorous federal leadership to foster the culture of safety across all health care settings to reduce medical errors.
5. Advocate for mandatory federal error reporting and adverse drug reaction databases, with appropriate liability protection.

Recommendation 6: Implement Economic and Programmatic Strategies That Enable Employers to Continue to/or Begin to Provide Health Care Benefits

Ranking of This Category of Recommendation

Priority: High
Financial Impact/ ROI: High, Sustained
Time Required for ROI: Immediate and Sustained

About 36 percent of the nation's health dollars come from private insurance, which is almost entirely employer-sponsored coverage.[17] However, the percentage of employers offering employee health insurance dropped from 69 percent in 2000 to 60 percent in 2005.[18] In Michigan, the auto manufacturers bear an extremely heavy burden in legacy costs, creating significant competitive disadvantage.

Recommendations for State Action

1. Sustain the full deductibility of health care costs from the state's Single Business Tax.
2. Monitor a variety of Michigan-based efforts underway to develop employer-sponsored coverage alternatives, such as the HR Policy Association's National Health Access[19] regional initiative in Detroit, the limited basic medical care products within the Detroit Regional Chamber's new insurance brand "Health First America," [20] and others. Evaluate results and support replication of successful models in other parts of Michigan.
3. Explore the feasibility and impact of legislation requiring individual health insurance coverage.

Recommendations for Federal Action

1. Through a federally funded pool and/or in combination with other initiatives, a bipartisan effort should move the federal government toward shared responsibility for the catastrophic component of all health care insurance, thereby making employer-sponsored and private coverage far more affordable and gaining significant efficiencies in pooling catastrophic risk.
2. Ensure availability to all Americans, regardless of the source of health insurance coverage.
3. In combination with other initiatives, implement tax incentives for employer-sponsored coverage of employee and retiree health insurance.
4. Monitor a variety of efforts underway to develop employer-sponsored coverage alternatives, such as the HR Policy Association's National Health Access[19], Southeast Michigan Quality Initiative's Save Lives Save Dollars[15] initiative, and others. Evaluate results and consider federal support for replication.

Recommendation 7: Cover the Uninsured and Underinsured

Ranking of This Category of Recommendation

Priority: High
Financial Impact/ ROI: Moderate
Time Required for ROI: Intermediate, 3-5 Years

Constant shifting of costs among underfunded government health care programs, private insurers, private payers, and providers contributes significantly to fluctuation and increase in employer costs and instability in the health care system. Cost shifting directly associated with uncompensated care to the uninsured will increase Michigan employer premiums by more than 6 percent in 2005.[9] This trend is not sustainable by the business community. The Council of Economic Advisors calls for coverage for and access to basic health care services for all Americans. Basic medical care must address wellness, prevention, and treatment.

Currently, 24 county-based programs for the uninsured operate in 67 Michigan counties. Others are investigating options for program development.

Recommendations for State Action

1. Reduce the number of uninsured Michigan residents by 50 percent within five years under an organized approach to:
   - Assure that all children are covered.
   - Assure that all adults eligible for coverage receive that coverage.
   - Build on Michigan-based coverage programs and insurance products, several of which are noted below.
2. Continue to facilitate and support availability of funds to county-based coverage programs for the uninsured.
3. Support development sustainability of existing and new "Third Share" programs in the state.
4. Conduct formal evaluations of Michigan's county-based and "Third Share" programs and use findings to enhance performance and replicate successful models.
5. Integrate activities under MDCH's three-year planning grant to address the uninsured with other private and public sector Michigan initiatives.
6. Advance the use of drug manufacturers' programs for free pharmaceuticals in Michigan, such as the Pfizer program for free drugs at certain Federally Qualified Health Centers (FQHCs), and others.
7. Continue the MI-Rx Prescription drug discount card.
8. Continue and expand, where necessary, the MIChild program, to provide insurance to Michigan children.

Recommendations for Federal Action

1. Make Medicare or Federal Employee Health Benefit Plan buy-in available to uninsured, pre-Medicare retirees.
2. Evaluate expansion of Medicare eligibility for long-term care benefits.
3. Revise the Federal Medical Assistance Percentage (FMAP) formula to make it more responsive and to more accurately reflect state economic conditions.
4. Continue SCHIP funding and sustain current funding of FQHCs.
5. Support legislation to create and sustain "Third Share" and other programs that provide uninsured employees of small businesses access to healthcare coverage.

Recommendation 8: Defeat Measures That Impose New Mandates

Ranking of This Category of Recommendation

Priority: Very High
Financial Impact/ ROI: Moderate
Time Required for ROI: Immediate and Sustained

The estimated cost impact of benefit mandates in states ranges from six to 29 percent of premium costs. The number of mandates applying to Michigan health plans is in the lower one third compared to other states. Accordingly, the estimated cost impact of benefit mandates may account for 12 to 14 percent of Michigan's health care premium costs.[8] Mandates impede employers' flexibility to offer health coverage plans within their means and constraints. As a result, employers are induced to avoid offering health coverage or to cease providing coverage. The federal and state governments and legislators should curb any benefit mandates that will add to the cost of health care or insurance.

Recommendations for State Action

1. Oppose all new mandated employee health benefits that will add to the cost of health care or insurance.
2. Carefully evaluate the financial impact of legislation related to retail/mail order pharmacy benefits.

Recommendations for Federal Action

1. Oppose all new benefit mandates.
2. Protect ERISA (Employee Retirement Income Security Act of 1974).

Recommendation 9: Strengthen Certificate of Need Program

Ranking of This Category of Recommendation

Priority: Very High
Financial Impact/ ROI: Moderate
Time Required for ROI: Intermediate/Long Term; 3 Years and Beyond

Michigan's Certificate of Need (CON) program is a key regulatory means of addressing the capacity and cost of health care technologies and services throughout the state. The program should be strong and credible.

Recommendations for State Action

1. Michigan should apply continuous improvement principles and practices to the ongoing evaluation and evolution of its CON program. Program improvements should assure a regulatory process that delivers:
    a. Objective, statewide standards.
    b. Reasonable, explicit exceptions or modifications to address rural and/or geographic circumstances.
    c. Appropriate enforcement.

Appendix I: References, Citations, and Data Sources

1. Source for all data is the Centers for Medicare and Medicaid Services, Office of the Actuary and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of Census, as reported in Heffler S., Smith S., et al. "U.S. Health Spending Projections for 2004–2014" *Health Affairs*—Web Exclusive February 23, 2005.

2. Estimates were calculated based on the *Health Affairs* total of $1.8 trillion in 2004 total expense for health care goods and services and using population and state-based per-capita spending data from the Centers for Medicare and Medicaid Services, Office of the Actuary; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

   Calculation A: Michigan's population accounted for 3.45 percent of the nation's population. This same percentage of the total health expense was $62.3 billion in 2004.

   Calculation B: In 2004, Michigan's percentage of the nation's total personal health care expense was 3.17 percent. This percentage applied to the nation's total health expense for 2004 was $57.2 billion.

3. Data from variety of sources within MDCH and other state agencies.

4. Source: *"The Economic Contribution of the U.S. Auto Industry and Major Competitiveness Challenges,"* DaimlerChrysler, Ford, General Motors 2005. Anecdotal estimates places 50 percent of expense in Michigan.

5. Anderson L.H., Martinson B.C. et al. *"Health Care Charges Associated with Physical Inactivity, Overweight, and Obesity."* Preventing Chronic Disease [serial online] 2005. Available at http://www.cec.gov/pcd/issues/2005/oct/04_0118.htm. Accessed 11/11/05.

6. Federal estimates noted in footnote 1 place prescription drugs at 12 percent of the nation's total health care expense. Anecdotal experience in Michigan indicates that, based on the level of retiree coverage, between 20 and 35 percent of an employer's health premium is attributable to prescription drugs.

7. *"Medical Care Expenditures Attributable to Cigarette Smoking"* Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention July 8, 1994.

8. *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Business.* United States General Accounting Office, Report to Congressional Requester. September 2003. Pages 11, 38-40.

9. *"Paying a Premium: The Added Cost of Care for the Uninsured."* Families USA Foundation, 2005.

10. Hillestad R., Bigelow J. et al. *"Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs,"* Health Affairs, 2005; 24[4]:1103-17. The authors estimate that savings accruing to private payers will average $31 billion per year over a 15-year period of adoption. According to the Centers for Medicare and Medicaid, health expenditures from private insurance in 2005 will be $1.045 trillion. Savings represent 4.5 percent of private insurance expense.

11. Institute of Medicine. To Err is Human: Building a Safer Health System. National Academy Press, 1999.

12. United States Department of Health & Human Services, Office of the National Coordinator for Health Information Technology (ONCHIT). Value of HIT. Available at http://www.os.dhhs.gov/healthit/valueHIT.html Accessed 11/07/05.

13. Managed Care Information Center. *First National Report Card on HealthCare In America: Recommended care received only half the time, study finds."* Available at http://www.themcic.com/industry/sow2.htm Accessed 11/04/04. Complete study available through RAND Corporation, 2004.

14. Taylor, Humphrey, *"Most Doctors Report Fear of Malpractice Liability Has Harmed Their Ability to Provide Quality Care: Caused Them to Order Unnecessary Tests, Provide Unnecessary Treatment and Make Unnecessary Referrals."* The Harris Poll^{R} #33, May 8, 2002.

15. *Save Lives, Save Dollars* is an initiative of the Greater Detroit Area Health Council to reduce unnecessary care and improve health outcomes in Southeast Michigan through community-wide application of evidence based medical practice and reimbursement incentives. http://www.gdahc.org/save.htm

16. State Commission on Patient Safety was appointed by Governor Granholm in 2004. http://www.mihealthandsafety.org/statecommission/index.html

17. United States Department of Health & Human Services, Centers for Medicare and Medicaid Services. The Nation's Health Dollar: 2003. Available at http://www.cms.hhs.gov/statistics/nhe/historical/chart.asp Accessed 11/07/05.

18. Kaiser Family Foundation and Health Research and Educational Trust (HRET). 2005 Annual Employer Health Benefits Survey.

19. *National Health Access* is a coverage initiative of the Human Resource Policy Association. http://www.hrpolicy.org

20. *Health First America* is a coverage initiative of the Detroit Regional Chamber of Commerce. http://www.detroitchamber.com

Appendix II: Recommendations of the CEA Health Care Costs Committee

Matrix of Recommendations for State and Federal Action

State Actions	Federal Actions
Advance Health Information Technology	
MDCH and MDIT cooperate to assess and advance HIT in Michigan Includes establishing a national presence, convening state stakeholders, seeking funding and capital, implementing HIT in governmental programs	Set standards and definitions for all components of HIT
Collaborate with private sector to tie HIT capacities to provider performance reporting	Continue to develop Regional Health Information Organizations and a nationwide Health Information Network
Implement strategies that result in 25% increase, in two years, the number of health records residing in interoperable systems in Michigan	Reduce intended development time of Electronic Health Records (EHRs) to five years
Implement strategies that result in 25% increase, in two years, the number of physician offices using electronic health records	Implement EHRs in all government health programs
	Offer low-rate loans and funding to foster conversion to EHRs in private sector
Improve the Health Status of Michigan's Workforce	
Require HMOs, insurers and BCBSM to incorporate wellness and personal responsibility options into all policies	None
Provide certification of worksite wellness programs	
Evaluate initiatives to help business embrace workplace wellness initiatives. Disseminate emerging tools	
Support "Best Practice" and Efficacy in Health Care	
Evaluate variations in medical practice using Dartmouth Atlas and other tools and pilot cross-payer projects that advance best practice	Develop and fund pilot projects to induce transfer of evidence-based care to physician practice
Test payment methodologies that base full reimbursement on best practice indicators	Develop payment methodologies for federal programs that base full reimbursement on evidence-based practice
Strengthen ties in Medicaid reimbursement to the practice of evidence-based medicine	Expand efficacy assessment activities for clinical and pharmaceutical treatments
	Implement centralized effort to assess new technology, drugs, and biologicals
Support Prescription Drug Reforms	
Apply scientific findings in pharmaceutical efficacy to benefit design and purchase of pharmaceuticals for all state health programs	Lead scientifically sound comparative studies of pharmaceutical effectiveness
Maximize the state's power and leverage as a major buyer of pharmaceuticals	Expedite processes to approve generic equivalent bio-engineered drugs, biologicals, and vaccines
Explore partnerships between Office of State Employer, county and local government, and business to maximize purchasing leverage for pharmaceuticals	Develop mandatory adverse drug reaction database
Oppose all proposals to limit mail-order pharmacy operations	

Appendix II: Recommendations of the CEA Health Care Costs Committee

Matrix of Recommendations for State and Federal Action (Continued)

State Actions	Federal Actions
Support Reduction of Medical Errors	
Support the State Commission on Patient Safety to build an agenda for state action	Identify best practice platforms and systems to prevent inpatient medical errors Develop mandatory federal error reporting and adverse drug reaction databases
Implement Economic & Programmatic Strategies That Support Employer-Sponsored Health Care Benefits	
Sustain full deductibility of health care costs from Single Business Tax Monitor employer-based alternative coverage models for potential replication Explore feasibility of legislation requiring individual health insurance coverage	Move toward federal responsibility for catastrophic component of all health care insurance, available to all Americans Implement tax incentives and other economic support for employer-sponsored coverage for employees and retirees
Cover the Uninsured and Underinsured	
Reduce the number of uninsured in Michigan by 50% within five years Facilitate and support county-based coverage for the uninsured Support and sustain "Third Share" programs Continue and expand existing supports including MIChild, Patient Assistance Programs for pharmaceuticals, MI-Rx drug discount card	Make Medicare or Federal Employee Health Benefit Program buy-in available to uninsured, pre-Medicare retirees Revise FMAP formula for state Medicaid funding to make it more responsive to state economic conditions Continue funding for SCHIP and Federally Qualified Health Centers
Defeat Measures That Impose New Mandated Health Benefits	
Oppose all new mandated employee health benefits Carefully evaluate impact of legislation related to mail order/retail pharmacy benefits	Oppose all new mandated health benefits Protect ERISA
Strengthen Certificate of Need Program	
Apply continuous improvement principles to the ongoing evaluation and evolution of Michigan's Certificate of Need program to assure objective, statewide standards, reasonable exceptions, and appropriate enforcement	None

Appendix III Glossary

AHRQ: Agency for Healthcare Research and Quality. An agency of the U.S. Department of Health & Human Services, AHRQ's mission includes both translating research findings into better patient care and providing policymakers and other health care leaders with information needed to make critical health care decisions.

Basic Medical Care: The Task Force uses this term to include a minimum set of wellness, prevention, and treatment services that, if provided to all citizens, will reduce or eliminate cost shifting and build a healthier workforce.

Best Practice: Refers to explicit diagnostic, prevention or treatment protocols identified through evidence-based medicine and agreed to by an explicit group of practitioners or purchasers.

County-Based Programs for the Uninsured: In Michigan, programs usually centered in county government that leverage local funds and resources, Medicaid matching funds, and other funds, to create local programs that provide limited health services to otherwise uninsured residents.

E-Prescribing: Also called "electronic prescribing," the term refers to the use of an automated data entry system to generate a prescription, rather than writing it on paper or verbally ordering it over a telephone. May apply to outpatient or inpatient hospital settings.

ERISA: The Employee Retirement Income Security Act of 1974, which covers most private sector employee benefit plans. ERISA provisions supersede most state and local laws that relate to an employee benefit plan.

Evidence-Based Medical Practice: Evidence-based medicine has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research."(1) More recently it has been described as the "integration of best research evidence with clinical expertise and patient values."(2)

1. David Sackett, et al. "Evidence Based Medicine: What It Is and What It Isn't," BMJ 312, no.7023 (1996).
2. David Sackett, et al. "Evidence-Based Medicine: How to Practice and Teach" EBM (New York: Churchill Livingstone, 2000), 1.

FDA: Food and Drug Administration of the U.S. Department of Health & Human Services.

Federally Qualified Health Centers (FQHC): Non-profit health care clinics providing primary care and other services in medically underserved areas and funded in part by federal grants to provide health care to the uninsured.

Federal Medical Assistance Percentage (FMAP): The formula used by the federal government to determine the relative percentages of a state's Medicaid program that will be funded by it and by the state.

GDAHC: Greater Detroit Area Health Council.

Health First America: Affordable and accessible insurance coverage products offered by the Detroit Regional Chamber of Commerce to lower the number of working uninsured.

HEDIS: Health Plan Employer Data and Information Set. A tool created by the National Committee for Quality Assurance to collect data about the quality of care and services provided by the health plans. HEDIS consists of a set of performance measures that compare how well health plans perform in key areas: quality of care, access to care, and member satisfaction with the health plan and doctors. Many quality-of-care measures are based on "best practice" for selected disease states and prevention strategies.

Interoperable Technologies: Refers to the capacity of diverse computer-based systems or databases to 'talk to each other' and utilize one another's data. For example, there is global interoperability among the ATM machines of a large variety of banks.

MDCH: Michigan Department of Community Health.

National Health Access: A private-sector program developed by the Affordable Health Care Solutions Coalition of the HR Policy Association to provide affordable health insurance for up to three million uninsured, employed Americans.

Office of the National Coordinator for Health Information Technology: Established by executive order in April 2004, the Office of the National Coordinator for Health Information Technology (ONCHIT) was created to implement President Bush's vision for widespread adoption of interoperable electronic health records within 10 years.

Save Lives, Save Dollars: A Southeast Michigan Quality Initiative (GDAHC) program that will offer differential reimbursement to providers for delivering high-quality, cost-effective care as reflected in 12 to 20 common clinical measures. The unique feature of this recommendation is that all payers would agree to standardize performance expectations in the clinical areas where clear evidence already exists for high quality care and cost impact.

SCHIP: State Children's Health Insurance Plan. The Balanced Budget Act of 1997 created a new children's health insurance program called the State Children's Health Insurance Program (SCHIP). This program gave each state permission to offer health insurance for children, up to age 19, who are not already insured. SCHIP is a state-administered program; each state sets its own guidelines regarding eligibility and services. Michigan's SCHIP is called MIChild.

State Commission on Patient Safety: In October 2004, Governor Granholm designated the Michigan Health and Safety Coalition as the State Commission on Patient Safety. Representing 15 professional organizations, the Commission will conduct public hearings and write a report containing recommendations for improvements in medical practice and a system for reducing errors, both in health facilities and in private practice.

Third Share Programs: A general term used to describe programs that engage resources from a community, its small employers, and employees to finance limited health insurance coverage for otherwise uninsured workers and their dependents.

TPA: Third Party Administrator.

Transparency: In purchasing health care services or coverage, the term refers to the ability of the purchaser or user of service or coverage to determine the comparative cost and outcomes of the "product" to determine the value of that service or coverage compared to other options.

Appendix IV:
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