

Date: January 4, 2010

To: Rep. Andy Dillon

From: Dustin Lipson, University of Michigan School of Public Health

Re: Additional Analysis of HB 5345, Michigan Health Benefits Act

In late November Rep. Marc Corriveau participated in a University of Michigan graduate health policy class to hear mock legislative testimony on a few active pieces of state legislation. I prepared testimony on HB 5345. The focus of my testimony was an analysis of the potential savings quoted by you in your white paper on the subject. I used different methods to arrive at estimates of cost savings based on available data and benchmarks, and included only savings that could be realized reasonably quickly. My intention in sending this to you is to provide an alternative method for calculating the savings potential of HB 5345 that is potentially more defensible than the method utilized in your original white paper. Based on the analysis, tangible savings in the short term could likely range between \$182MM to \$355MM with no increase in employee cost-sharing.

The major assumptions in my analysis are primarily based on benchmarks of insurance loading factors from academic literature, although somewhat dated, and from analysis of the Federal Employee Health Benefits Plan. This analysis revealed some interesting findings that are included below

My understanding of the goal of the bill is to reduce the cost of health care insurance while improving the quality of health care for public employees. The analysis below confirms that the legislation would result in three sources of immediate savings without increasing cost sharing by employees from: 1) reduced administrative costs; 2) increased purchasing leverage; 3) implementation of insurance structure best practices.¹

Administrative savings could come in two forms, reduced costs from centralizing the purchasing of health benefits and reductions in the administrative costs faced by insurers due to a radical decrease in the number of active plans under management. Centralization can deliver savings if in fact it means a real reduction in the total amount of work. Under HB 5345, this would likely be the case. Although the amount of savings is dependent on an important but lacking piece of information, the total number of public sector buying entities, based on limited data that number is likely to be at least 2,500,¹ which means that there are at least 2,500 people who spend part or all of their time purchasing and administering health benefits. By consolidating the number of plans, administration can be managed far more efficiently with fewer resources. Centralization also creates more opportunities to improve productivity through technological investment, as what was economically infeasible for an entity with 1400 beneficiaries is now feasible for an entity with 400,000. Lastly, the quality of organizational leadership would likely improve, as

the creation of a statewide program would merit the hiring of an expert leader in health benefits administration. Reasonable estimates of savings on internal administration costs range between \$10 million and \$40 million dollars. This calculation assumes that for an average buying entity the cost of .2 to .5 FTE (full time employee) is spent on health benefit administration and further subtracts the costs of state level administration.²

The second component of administrative savings, a reduction in insurer's costs due to fewer plans under management, is difficult to quantify on its own. But, it can be considered in the context of the overall loading factor charged by an insurance company. The overall loading factor includes not only administrative costs, but also non-administrative costs and profits. This leads us to the second source of potential savings: increased purchasing leverage. Larger employers, or larger purchasing pools, have more leverage with insurers. In other words, an insurer is willing to trade lower profitability for more volume. By understanding the range of loading factors charged to various sized employers, we can gauge the combined effect of reduced administrative costs and reduced profits. For groups of more than 1000 employees, benchmarks suggest loading factors between 5-8%, for 200-1000 employees the percentage is usually 8%-15%, this trend continues down to groups of 25 or less paying roughly 26-30%.^{3,4} Given the average city employs less than 1000 people, townships substantially less, and the average school district roughly 270, it is not unreasonable to expect an average loading factor well into the double digits.² In contrast, the Federal Employee Health Benefits Plan loading factor was 5.7% in 2007.⁵ The federal plan is significantly broader and more complex than a consolidated state program, so we should have every expectation of being able to drive this percentage even lower. Conservatively at \$4.0 billion in premium spend³, moving the loading factor from 10% to 5.7% would yield \$172MM in savings. Moving from 12% to 5% at \$4.5 billion in premium spend would yield \$315MM in savings.

In total, reductions in administration costs and increased purchasing leverage could yield savings of \$182MM to \$355MM. These savings are achieved without increasing the share of costs paid by employees.

The third area of savings is the implementation of insurance structure best practices the most promising of which is value based insurance design or VBID for short. The latest research would suggest that when implemented appropriately VBID saves money and improves health outcomes.⁶ We have no information indicating to what extent these programs are implemented across the state, so it is impossible to quantify potential savings. The implementation of these structures could occur with or without centralization, but would likely occur much faster with centralization. Moreover as best practices continue to emerge a centralized structure would be far more capable of realizing the benefits than our currently decentralized model.

The cost savings estimated here are a direct result of increasing the productivity of the insurance purchasing process and assumes no increase in cost sharing by

employees. Not only will centralization save money, it could also improve the quality of care public employees receive.

Should you have additional questions regarding this analysis, please do not hesitate to contact me. I can be reached by email at lipsond@umich.edu. Prior to coming to the University of Michigan I worked in financial services for over 10 years in finance, risk management, and general management.

Best Regards,

Dustin Lipson

¹ Dillon A. An in-depth look at the Michigan Health Benefits Program: The Dillon prescription for public-sector health care reform. NewIdeasforMichigan.org web site. <http://www.newideasformichigan.org/default.php>. Accessed November 22, 2009.

² Centralized internal cost estimates are based on a benchmark of the Federal Employee Health Benefits Plan. The FEHBP administers approximately 287 plans at an annual cost of roughly \$12MM.

³ Phelps C. *Health Economics*. 2nd ed. Reading, MA: Addison-Wesley; 1997:345-346.

⁴ Congressional Budget Office. *Key Issues in Analyzing Major Health Insurance Proposals*. Washington, DC: Congressional Budget Office; 2008.

⁵ Axene DV, et al. *Critical Issues in Health Reform: Administrative Expenses*. Washington, DC: American Academy of Actuaries; 2009.

⁶ Michigan Health Benefits Program Act: Hearing on H.B. 5345 Before the Comm. on Public Employee Health Care Reform, 95th Leg., Reg. Sess. (Mi. 2009). (statement of A. Mark Fendrick, M.D.).