

REMARKS OF NICK CIARAMITARO
DIR. OF LEGISLATION AND PUBLIC POLICY
MICHIGAN AFSCME COUNCIL 25
AND MSEA, AFSCME LOCAL 5
BEFORE HOUSE PUBLIC EMPLOYEE HEALTH CARE REFORM COMMITTEE
December 10, 2009

Thank you, Madam Chairperson and members of the Committee, for this opportunity to discuss House Bill 5345 and the proposal before you to consolidate public employee health care at the state level.

For the record, I am Nick Ciaramitaro, Director of Legislation and Public Policy for Michigan AFSCME Council 25 which represents over 90,000 public sector workers at all levels throughout the State of Michigan and MSEA, AFSCME Local 5, which represents about 5,000 state employees.

Michigan AFSCME shares the concerns of this Legislature around the high cost of health care. The problem of health care cost containment is a problem for all employers and all workers. In these tight fiscal times it is a particular problem for the public sector as each of you are aware. Finding a way to make health care available at a reasonable cost for all Michigan public employees – and for all Michigan citizens – is an important goal. I say for all citizens because the lack of insurance by some Michigan citizens is one of the reasons for the high cost of health insurance for those insured.

Among AFSCME members this is not a new issue and has become one which has captured more and more of our time in recent years. Mr. Hearn will discuss some of the things we have already done to try to bring the cost of health care down while making sure that our members continue to be protected.

AFSCME opposes House Bill 5345 as a flawed and potentially costly attempt to deal with this complex issue. History has long proven that reductions in benefits and cost shifting will have too high a cost in human terms and will likely increase the overall cost of health care rather than contain it in the long run.

The high cost of health care plagues public and private employers and employees alike. Shifting the cost from employers to employees does nothing to save money and often results in workers putting off life and cost saving procedures. You have already heard testimony from others on this issue in relationship to successful wellness efforts. A disincentive to timely screening and proper control of chronic conditions generates long term health consequences for our workforce, higher health care bills, absenteeism and loss of productivity for employers. Limiting plan options may mean that needed options for particularly subsets of workers are not available.

Consolidating cost containment efforts in one place prevents multiple efforts to experiment with reform. It assumes that the answers are obvious and simple. It further assumes that the State is the only entity which can achieve the goal. Our preliminary findings, compiled by our International Union demonstrate, the State of Michigan already is in line with other states on benefit levels but employers and employees jointly pay more in some cases for those benefits. This demonstrates two things: benefit changes are not the answer as they are only part of the cost of providing those benefits and the State does not always provide the lowest cost option.

The data presented supporting the approach taken in House Bill 5345, by its own terms, is based on averages at the local level. Some of local plans are more efficient than others. Some of those local plans provide better benefits at lower costs than the State plan. Indeed, local units of government have had the option for a number of years to buy into the current state plan but no locals have exercised that option. That suggests that many think that they can do better on their own -- and some have. The Chair has asked for more detailed information on local plans. While we are anxious to help develop that information -- and strongly believe you should make your decisions based on detailed facts rather than conjecture or averages -- Mr. McNeal will address some of the difficulties in compiling that information. Quite frankly, we would like to have that information as well.

We must also note the issue of Legislative efficiency in addressing this matter. As we speak, the United States Senate is debating health care reform. The United States House of Representatives has already acted. A conference committee is likely to make major changes in health care early next year. Much of that legislation will require state action in implementation and in reaction to changes made at the federal level. Those changes will affect public and private sector employers and employees. Whether you approve or disapprove of the federal legislation, you should be aware of what those changes are and make sure any action you take here maximizes the benefits to workers and taxpayers alike. And I am sure you don't want to redo all the work this committee will be undertaking a second time just a few weeks after it completes its efforts.

Finally, we note that we are skeptical of any claim that collective bargaining is protected when it is limited to first the question of whether or not we have health care benefits. The bill before you would limit collective bargaining to just three issues: whether a worker is provided any benefits, choosing from currently unknown benefit packages to be decided without their say, and how much of the cost they will pick up. The bill as introduced drastically limits the ability of workers to have a say on what type of health care benefits they are working for. It bifurcates negotiations concerning overall labor costs making collective bargaining more difficult for employer and employee alike and it jeopardizes one of the most important things most employees feel is one of the main reason they are working -- to assure health care for themselves and their families.

We look forward to working with the committee and through the work groups to find better solutions to these difficult problems. Madam Chair, if it is ok with you I would now like to turn our presentation over to Mr. Hearn and then to Mr. McNeal. I'll remain to answer any questions. Thank you.

Remarks of:

Shana Alderton

Field Services Director, Regions 5-11

Michigan **AFSCME** Council 25

Before:

House Public Employee Health Care Reform Committee

Tuesday, December 15, 2009

Thank you, Madam Chairperson and members of the Committee, for the opportunity to address you regarding House Bill 5345.

My name is Shana Alderton; currently I am the Director of Field Services for Michigan **AFSCME** Council 25, Regions 5-11. I Supervise 23 Staff who represent members across the State of Michigan, Regions 5-11 which includes every County except Wayne, Oakland and Macomb. Council 25 represents over 90,000 public and healthcare workers across this State.

Michigan **AFSCME** shares your concerns with regards to healthcare. In fact we have been working proactively with our members and employers for years in an attempt to address the continuing rising costs. We required that our Staff propose language in all negotiations which address this issue. We have worked tirelessly with our membership and their employers through negotiations and joint health care committees addressing cost containment, while continuing to focus on maintaining quality, affordable health insurance for our members and their families. We have bargained many contracts across the State which includes giving employees choices as to which health insurance option best suits the needs of their families. We recognize along with many of the employers we negotiate with that there is not just one cookie cutter solution to this ongoing problem. Many of our contracts include different options for employees to choose from based on the personal needs of their families and the area in which they live. What works in Detroit or Grand Rapids may not work in the Upper Peninsula. In fact in the Upper Peninsula one of the cost containments that have been proven effective is adding what is referred to by Blue Cross as the "UP Blue Rider". Something that is only available to groups in the UP. While working as a Staff Representative for Michigan **AFSCME**, my first experience with this rider was at the Dickinson County Hospital in Iron Mountain. This group was seeing thirty percent (30%) plus increases each year, the first renewal rate they received after adding this rider to their health insurance saw a decreased cost, something that had not been seen in that

area in years. Often hospital contracts will include as an option waiving deductibles and co-pays for employees utilizing their hospital, pharmacies or hospital physicians. These are examples of cost saving that are not available to all Public Sector groups. We have many groups that have found higher deductible plans with either Health Savings Accounts (H.S.A.) or Health Reimbursement Accounts (H.R.A.) to be cost effective and beneficial. Wellness programs and incentives are effective for others. The Public Sector includes a diverse group of employees and employers who do not necessarily all share the same needs when it comes to health care. Taking the ability of these employers and employees to address their issues within their local communities is not the solution.

Our Staff and members work continually to address the issue of health care within their Local Unions; we have joined with employers in many areas to create health care committees which effectively address the issue of health care at a local level. We monitor data and review utilization reports regularly with these committees. Labor and Management teams jointly attend conferences so that they are educated together regarding options available to them.

While we are deeply concerned with the ongoing healthcare crisis we believe our members, their employers and the residents of this State will not be better off with "Public Employee Health Care Reform" as addressed by HB 5345. We are supportive of Health Care Reform at a National Level but are concerned about the Bill before you and its impact on our communities and our members.

Thank you for your time and this opportunity to bring to you the concerns of our members.

Remarks Of

Edward L. McNeil

Special Assistant to the President

Michigan **AFSCME** Council 25

Before

House Public Employee Health Care Reform Committee

Thursday December 10, 2009

Thank you, Madam Chairperson and members of the Committee, for this opportunity to discuss House Bill 5345 and the issue before you to consolidate public employee healthcare at the state level. I am Edward L. McNeil, Special Assistant to Albert Garrett, President of Michigan **AFSCME** Council 25. We represent over 90,000 public sector workers at all levels throughout the State of Michigan.

Michigan **AFSCME** Council 25 shares your concerns regarding the high cost of healthcare; however we oppose House Bill 5345. **AFSCME** has been involved for many years with the issue of healthcare cost containment. The high cost of healthcare has been a burden for public and private employers and the members we serve for a long time. Cost shifting from employer to employees fails to fix the problem. Workers struggle to pay higher premiums, deductibles and co-payments, on reduced salaries, forcing many workers to delay getting needed medical attention. Some employees decline coverage for themselves or their families because of the cost of healthcare. Healthcare continues to rise five times the rate of inflation, according to the center for studying healthcare.

My belief is more discussion on this topic will be better served as the debate goes from a national prospective, **AFSCME** has been involved in healthcare cost containment for many years. The staff of Council 25 request information and data from the employer for the plans that are offered to the workers. The request to the employer is the number of employees with single, two-person and family coverage. The staff would also request utilization reports to better understand and manage the healthcare plan. Securing the data from the employer and healthcare providers is a useful tool in the bargaining process.

There are healthcare cost containment committees, who continue to focus on cost containment by discussions, exploration and implementing measures in an effort to reduce cost. There has been implementation of various programs to manage healthcare. There has been reviewing of the data which helps in looking into problems of high utilization and the effects that the committee reviews. Could be air quality that may have a bearing on asthmatics, or the use of proper equipment as to reduce back problems employees may face. A disincentive to timely screening and proper controls of chronic conditions generates long term and costly consequences to the workforce and loss of productivity for employers. This all must be done at the local level. Shifting this discussion to the State would eliminate our ability to deal with the specific problems of specific types of employees.

It is my understanding the information you have requested for review as I previously explained in my presentation would require an enormous amount of time to compile and format in a spreadsheet for review. The data is not currently readily available and frequently changes. I certainly want to thank you for the time allowed to come before you to discuss this most important issue.

**REMARKS OF Jimmy Hearn
Administrative Director
Michigan AFSCME Council 25
BEFORE HOUSE PUBLIC EMPLOYEE HEALTH CARE REFORM COMMITTEE
December 10, 2009**

Thank you to the members of the Committee for this opportunity to discuss House Bill 5345.

My name is Jimmy Hearn Regional Administrative Director of Field Services for Michigan AFSCME Council 25 which represents over 90,000 public and private sector workers at all levels throughout the State of Michigan. In my capacity as Director I personally review all contracts negotiated by twenty-three (23) Staff Representatives in Wayne, Oakland, Macomb and Washtenaw Counties, additionally I negotiate contracts as well.

Michigan AFSCME Council 25 is also concerned about the high cost of health care but opposes House Bill 5345. AFSCME has been involved for many years with the issue of health care cost containment.

The high cost of health care has long been a burden for public and private employers and the members we serve. Shifting the cost from employer to employees does nothing to the long term problem; our focus should be toward a more permanent long term solution much like National Health care as being discussed by our representatives in Washington. It is my belief that further discussion on this topic will be better served once we've determined where the debate goes from a national prospective.

Let me discuss with you some of the ways in which Michigan AFSCME has been involved in health care cost containment. All my Staff are required to negotiate into their Collective Bargaining Agreements language that establishes cost containment committees. As a first step this allows for discussion, exploration and implementation of measures to cut cost. As an example, often the employer and the Union have agreed to reduce the number of plans available, create and implement coordination of benefits language within the Collective Bargaining Agreement, create wellness program incentives, bargain for capitation plans thru HMO's and shop for competitive rates among carriers, often resulting in measurable cost reduction. Additionally Staff are directed to meet on a regular basis with employers to discuss changes in the utilization and rate structure where trends begin to occur, with the hopes of getting a handle on a problem before it becomes too vast to get our arms around it, thereby causing a blow up of the rates, which leads to higher costs for the employer and our membership.

I am not prepared to give you a dollar amount of the savings that's been generated through these cost containment committees, partly because we have not broken out this statistic, and partly because we were just doing what we believed to be the right thing on behalf of our members. There are no simple answers, no single proposal, no one idea that will solve for us what has taken years to present itself; let's not be foolish enough to think so. Thank You.