

Q1 HEALTH CARE REPORT

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Cost, Quality and Access-to-Care Issues in the U.S. / Ohio / Northeast Ohio

BY [TOM CAMPANELLA](#)

Director, Health Care MBA Program, Baldwin-Wallace College

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Tom Campanella joined Baldwin-Wallace College as director of the Health Care MBA Program in 2003. He is also an attorney (of counsel) with the law firm Baker & Hostetler, Cleveland, in health care law and has nearly 20 years' experience in the health care industry. He was vice president of healthcare finance and care management at Blue Cross & Blue Shield of Ohio and Medical Mutual of Ohio from 1989 to 1997 and was associate dean of the Ohio University College of Osteopathic Medicine and manager of its physician clinics in Athens, Ohio, from 1997 to 2000.

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INTRODUCTION

The primary focus of this issue of the Quarterly Healthcare Report is on Consumer Driven Health Care. This initiative is being touted by many, including the Bush Administration, as the catalyst to a major positive impact on healthcare costs, access to healthcare services and quality healthcare. We review some of the comments from subject experts, both pro and con, and finally provide readers with our perspective on the issue.

COSTS

U.S. Healthcare Spending to Double by 2015

Overall healthcare spending in the U.S. is expected to increase at a slower rate (7.4% in 2005 vs. 7.9% in 2004), but that rate trend is still sufficient to double national health expenditures in a decade (\$2.1 trillion in 2006 to \$4 trillion in 2015), according to a recent study published in Health Affairs by the Office of Actuary, Centers for Medicare and Medicaid Services. Health spending is expected to consistently outpace gross domestic product (GDP) over the coming decade, accounting for 20% of GDP by 2015 (up from 16% in 2005). (Health Affairs 2/22/06)

Tom's Comments

The growth of healthcare spending as a percentage of the GDP has a potentially devastating impact on our economy from a number of perspectives. While an increase in revenue is a positive to the healthcare industry the ultimate burden of the healthcare-related expenses fall on employers, state and federal government and the consumer. Employers are attempting to compete on a local, regional, national and now international basis, and they can ill afford this increase in healthcare expenses. Governments on both the state and federal levels are attempting to meet all of their respective priorities, and increases in healthcare related expenses, negatively impact its' other competing priorities (egg., education, public safety, etc.). Finally, consumers, especially those of lesser income, have to balance this increase in healthcare costs against their daily living requirements.

Healthcare Cost Trends

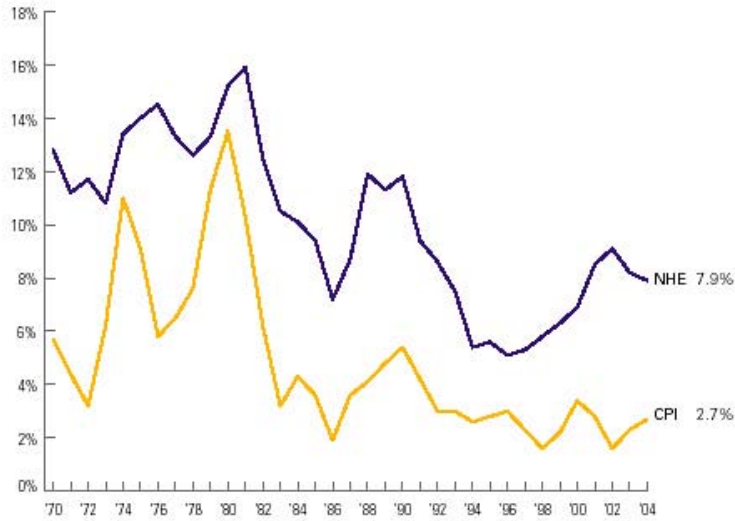
Health spending continues to exceed the pace of inflation.

([Health Care Costs 101](#), pg. 15)

Exhibit I

Annual Growth Rates NHE vs. CPI

Increase Over Prior Year



Note: CPI is the consumer price index.

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary; Bureau of Labor Statistics (CPI-U, U.S. city average, annual figure).

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Health Care Costs 101

Growth Trends

<< PREVIOUS

NEXT >>

Health spending has been increasing at a faster pace than inflation.

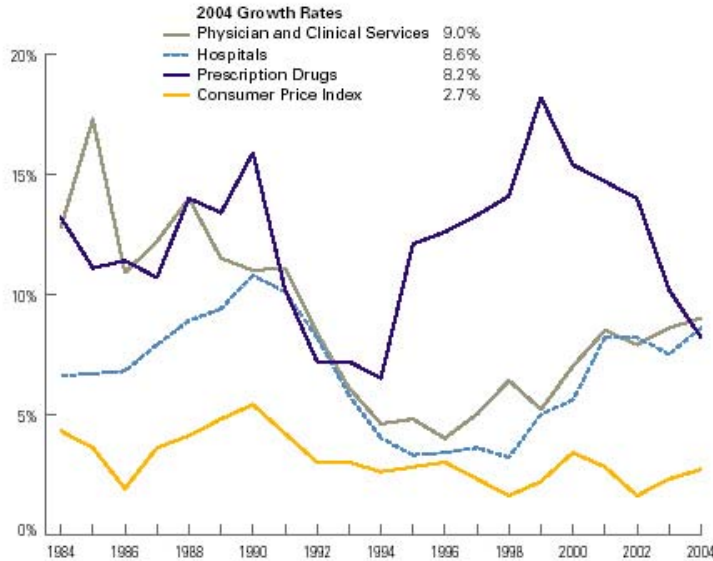
15

Prescription drug spending is decreasing at a rate similar to other services; it's now below 10% for the first time in a decade.

([Health Care Costs 101](#), pg. 17)

Exhibit 2

Annual Growth Rates by Health Spending Categories



Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

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Health Care Costs 101

Growth Trends

<< PREVIOUS NEXT >>

Growth in prescription drug spending has fallen to a rate similar to other services; its rate of growth is now below 10 percent for the first time in a decade.

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Blockbuster drugs potentially going off-patent in 2006. These events threaten \$10 billion in potential drug sales with generic substitutions.

([Medical Cost Reference Guide](#), pg. 39)

Exhibit 3

Blockbuster Drugs Potentially Going Off-Patent

With five blockbuster drugs likely facing patent expiration in 2006, over \$10 billion is potentially vulnerable to generic substitution.

Possible Patent Expiration	Drug Brand Name	Use	2004 U.S. Sales* (Billions)
2006	Zocor (Merck)	Hyperlipidemia	\$5.5
	Zoloft (Pfizer)	Depression	\$3.0
	Pravachol (Bristol-Myers Squibb)	Hyperlipidemia	\$1.9
	Ambien (Sanofi)	Insomnia	\$1.8
	Allegra (Aventis)	Allergies	\$1.5

* Based on prescription data and wholesale average cost (WAC) for retail, mail order, clinics, hospitals, long-term care and home health organizations and other non-retail channels according to WebMD.
 Source: Drug Trend Report: Managing Generation Rx. © 2005 Medco Health Solutions, Inc., NDCHealth Data - Top 200 Prescriptions for 2004 (http://www.rxlist.com/top200_sales_2004.html)

Healthcare Benefit Design Trends

A strategy that many companies followed in 2005 for restraining cost increases for health benefits was to raise employee costs at the point of service. Observes Blaine Bos, a consultant at Mercer, "Employers kept the cost of the plan down for all employees by shifting costs to those who use it most." Mercer Human Resource Consulting National Survey of Employer-Sponsored Health Plans shows in Exhibit 4 how this cost-shifting strategy manifested in PPOs last year. (Managing Benefit Plans, March 2006, pg. 2)

Use of Cost-Sharing Provisions: PPO Sponsors
 (Managing Benefit Plans, pg. 2)
 Exhibit 4

Table 1. Use of Cost-Sharing Provisions: PPO Sponsors				
	All Employers		Large (>500) employers	
	2004	2005	2004	2005
Require in-network deductible	73%	80%	75%	79%
Median Deductible amount	\$500	\$500	\$250	\$300
Require deductible of US \$1,000 or more	29%	34%	6%	9%
Require coinsurance for in-network office visits	5%	9%	18%	22%
Require coinsurance for in-network hospital stays	54%	58%	66%	70%
Source: Mercer Human Resource Consulting				

Consumer Choice: Can it Cure the Nation's Healthcare ills?

While there is much debate in healthcare circles relating to potential approaches to the healthcare problems in the U.S., there is general agreement involving the magnitude of the problem. The problems we face in healthcare fall within three buckets: 1) cost of care, 2) quality of care and 3) access to care. The Bush Administration has been a champion of the Consumer Driven Health Care (CDHC) approach as a major solution in the short- and long-run to our healthcare cost, access and quality concerns. We will attempt at a high-level to provide the reader an overview of opinions relating to the effectiveness of CDHC in addressing concerns of cost, access and quality. Finally, rather than providing the reader a detailed explanation of CDHC (which would include Health Savings Accounts), we refer you to the October 2005 issue of the Quarterly Health Care Report:
www.bw.edu/academics/bus/programs/hcmba/nl/HQC3Report2005.pdf

Cost of Healthcare

Will consumerism effectively address the overall cost of healthcare?

Pro

Per Joseph Antos of the American Enterprise Institute, most people have health insurance that pays for nearly all of the cost of health services, including routine and affordable care. This creates what economists call "moral hazard," which means that consumers purchase more health services than they would if they were fully aware of the true costs. Moral hazard has contributed to the unsustainable rapid growth of health spending in this country. Consumer driven healthcare is one approach that could break this health inflationary spending spiral by helping consumers become aware of costs. When people realize they are spending their own money, they are likely to be more interested in how that money is spent. Mr. Antos states that simply imposing an economic incentive to reduce the use of care is not sufficient without taking steps to improve decision making by consumers and healthcare providers. Mr. Antos is a proponent of providing cost and quality information to both consumers and physicians.

(Wallstreet Journal, Dec. 13, 2005 pg. 2)

Mr. Goodman, President of the National Center for Policy Analysis, stated that currently deposits to Health Savings Accounts are relatively small. However, over the course of a work-life, the balance of these accounts will grow quite large and HSAs will potentially be a factor in every healthcare decision – even for the most expensive services. (Wallstreet Journal, Dec. 13, 2005, pg. 5)

Karen Baiker, a member of President Bush's Council of Economic Advisors said that HSAs would help curb healthcare expenditures, which currently comprise 16% of the U.S. gross domestic product (GDP). She cited projections that the percentage will reach 20% by 2015 and 24% by 2025. (BNA, Feb. 27th, pg. 2/3)

Con

Karen Davis, President of the Commonwealth Fund, said the Bush HSA-related proposals "are not going to do much toward really addressing the fundamental problem of rising healthcare costs and declining health insurance coverage. Per Davis the Bush Administration is promoting HSAs

as a way to control costs by making Americans better healthcare shoppers, but “the real cost problems are not in the small bills.” Davis said that 10% of people account for 70% of healthcare expenditures, and the people with chronic conditions like diabetes and cancer are costing the most money. Ultimately, Davis said these patients' costs would far exceed the deductibles in high deductible plans that are required by law to be linked with HSAs. (BNA Feb. 2, pg. 2)

Access to Healthcare

Will consumerism effectively address access to healthcare services for Americans?

Pro

Allan Hubbard, an economic policy advisor to the president and the director of the National Economic Council, stated that of the 3 million people who have set up HSAs, so far, 37% were previously uninsured and 40% earn less than \$50,000 a year. (BNA Feb. 2, pg. 3)

Con

Karen Davis countered Hubbard's argument by saying it has always been the case that one-third of buyers of high deductible plans were previously uninsured, because the population typically has no other option due to a lack of funds to afford higher-priced, first dollar health insurance. (BNA Feb 2)

Of the uninsured, Davis also said that 55% are in the zero tax brackets and 39% are either in a 10% or 15% tax bracket, and just 6% are in 27% bracket or above. The tax breaks aren't going to be a major force in inducing the uninsured to buy a high deductible health plan." (BNA Feb. 2, pg. 2/3)

Quality of Healthcare

Will consumerism improve quality of healthcare services?

Pro

The theory behind Consumer Driven Health Care (CDHC) is that it will provide the necessary accountability and incentives to evolve the consumer to be a prudent purchaser of healthcare services. Proponents state that consumer decisions will be made on both a cost and quality basis. CDHC will also be the catalyst for more organizations to provide consumers with user-friendly cost and quality information. In turn this search for cost and quality information will provide the necessary market forces to reward healthcare entities who provide cost-effective quality care.

Con

Consumerism, per Joseph Antos, is adding to the pressure from employers and Medicare that already exists to produce cost, quality and effectiveness of care. Even with such information, patients will need physician advice on treatment alternatives, lifestyle changes, and other actions that can contribute to better health. Simply imposing an economic incentive to reduce the use of care will not be sufficient without taking other steps to improve decision making by consumers and healthcare providers (Wallstreet Journal Dec. 13th, pg, 2)

Per Robert Reischauer, President of Urban Institute, employers will continue to increase cost sharing, and this trend is more likely to reestablish the cost-sharing burden prevalent several decades ago than to constitute a movement to true Consumer Directed Health Care (CDHC). Whatever the outcome, this trend will shift more of the costs of healthcare onto the sick, especially those with chronic conditions, larger families, and older workers and reduce the burden on the young, the healthy and singles. To be both effective and equitable, CDHC requires educated consumers, a sophisticated information infrastructure, and a complex mechanism for subsidizing premiums and determining contributions to individuals' health spending accounts. None of these exist today. (Wallstreet Journal, Dec. 13th, pg 3)

Tom's Comments

I believe that Consumer Driven Health Care (CDHC) is a piece of the puzzle, but a relatively small piece as it exists today. The theory behind CDHC has merit, but there are many practical implications. I believe there is a consensus that we have major challenges in the U.S. when it comes to the cost of healthcare and access to healthcare and, while we have made significant progress in providing quality healthcare services, we are still in need of great improvement. Our current system of health insurance does indeed insulate most Americans from the real cost of

healthcare services. Americans also need to be more accountable for their own health, especially as noted in this issue, i.e. lifestyle-based chronic diseases account for 75% of the nation's medical costs.

CDHC products as they exist today may have a small impact on short and long-term healthcare costs, but these products will have little or no effect on the real issues impacting healthcare costs. Statistically, 1% of healthcare utilizers impacts 30% of healthcare costs and 10% of utilizers impact 70% of healthcare costs. Clearly CDHC products will not have an impact on these utilizers, and in fact CDHC could potentially have a negative impact on these utilizers if it incepts them not to seek healthcare services when needed.

Since, as noted by Joseph Antos above, "simply imposing an economic incentive to reduce the use of care is not sufficient without taking steps to improve decision making by consumers and healthcare providers," in effect, CDHC products without user-friendly cost and quality data are strictly cost-shifting to the employees. We are also still many years away from user-friendly "real cost and quality data" that would evolve the consumer to becoming a prudent purchaser of healthcare services.

CDHC products may be attractive to some of the uninsured, especially those individuals that are young, healthy or wealthy. This is not to say that assisting these segments of the uninsured is not worthwhile. The real issue with the uninsured focuses on those individuals who do not have the discretionary income to afford HSAs. Many of them have relatively low paying jobs at small businesses that neither offer health insurance, nor pensions.

CDHC cannot have an impact on quality since there is currently not available user-friendly quality information on providers. In fact, this effort may be the most difficult to achieve, especially given our last experience with Cleveland Health Quality Choice in the 1990s.

If the Administration is looking to use market forces to positively influence healthcare entities to provide cost effective quality services, it would be more effective to turn to employers and the government to accomplish this task than to rely on individual consumers. Employers or employer coalitions and the government who, because of their market force, are in better position to leverage user-friendly cost and quality information relating to healthcare providers. Employers/Coalitions with the use of this data could design tiered networks (possibly even by specialty) to incent members to go to the most cost-effective quality providers. While programs and products are needed to incent consumers to become

more accountable for healthcare expenses, the employers, employer coalitions, and the government, with the clout of their purchasing power have the most potential to positively affect cost and quality of healthcare services, which would also then make healthcare more affordable to the masses. In addition, the resulting savings to these payors could be used to help fund healthcare for the neediest. Finally, the major payors (employers/coalitions/government) have the ability to have a greater impact on cost and quality since the dollars they spend on healthcare will have more of influence on healthcare providers than the much smaller employee portion in the form of a larger deductibles.

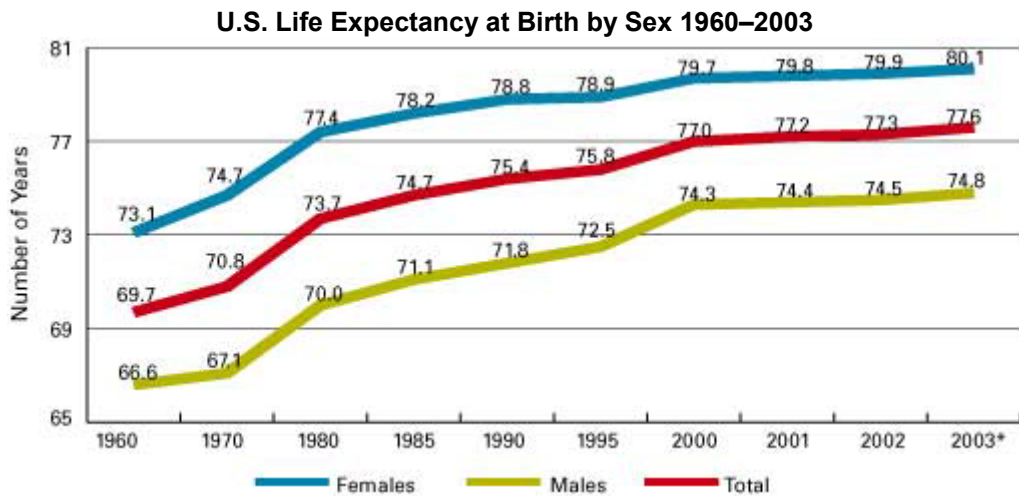
QUALITY

Selected Quality Healthcare Trends

Overall Life Expectancy at Birth by Sex 1960-2003

([Medical Cost Reference Guide](#) – 2006, Blue Cross and Blue Shield Association, pg. 73)

Exhibit General Health Statistics



*Based on preliminary data.

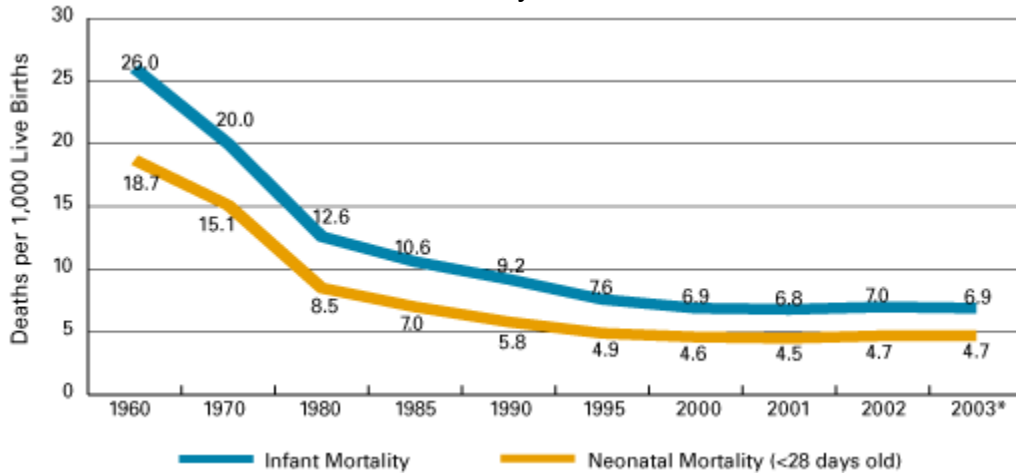
Source: Centers for Disease Control and Prevention (2004d)

Infant and Neonatal Mortality Rates in the U.S. 1960-2003

([Medical Cost Reference Guide](#), pg. 74)

Exhibit

Infant mortality rates are generally considered to be an important indicator of a country's health status. Considerable progress has been made in reducing infant mortality rates.



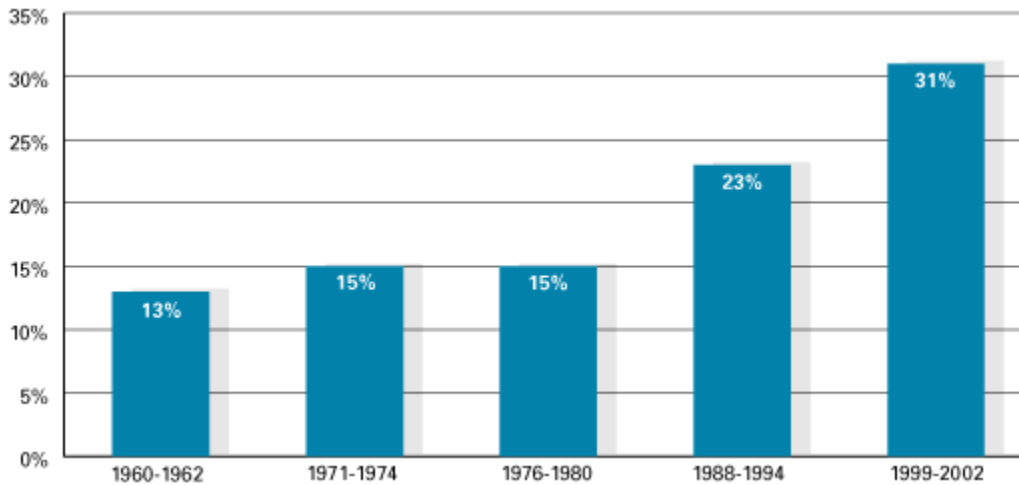
*Based on preliminary data.
Source: Centers for Disease Control and Prevention (2004d)

Percent Obese in the U.S. Among Persons Aged 20-74 1960-2002

([Medical Cost Reference Guide](#), Pg. 24)

Exhibit

Obesity in the U.S. adult population has increased substantially over time, with 31% of adults being obese by 2002.



Note: Obese is defined as having a body mass index (BMI) greater than or equal to 30.
Source: Centers for Disease Control and Prevention (2004d)

Fast Facts

(You are what you Eat, pg. 1)

- The Centers for Disease Control (CDC) estimates the lifestyle-based chronic diseases account for 75% of the nation's medical care costs.
- In a study by the American Cancer Society, various life-style and non lifestyle-based elements were attributed to the risk of developing cancer. In aggregate, 82% of the risks were lifestyle-based conditions, including diet, smoking, sexual behavior, occupation, alcohol, and sun radiation.

Does the Search for Quality Result in only Better Outcomes, or Does it Result in Lower Healthcare Costs, too?

Per Carolyn M. Clancy, MD, Director of the Agency for Healthcare Research and Quality, quality is the new paradigm in healthcare --- the model to build around as we address the many challenges in our healthcare system. While for years the primary focus of reform was placed narrowly on containing healthcare costs, today there is major consensus that the real issue is value. The volume of dollars spent is important, but the real goal is to maximize the value realized for each of those dollars. And the key to value is quality of care --- delivering the right treatment, at the right time, and in the right way to the patient.

When we see the consequences of poor quality---repeated treatments, readmissions, missed opportunities, not to mention outright harm to the patient --- it becomes evident that as a society, we can no longer afford anything less than high-quality care.

Building on quality and realizing value will require a partnership effort across the healthcare spectrum. Government has an important role, both as a convener where standards are needed (for example, in building an interoperable health information network), and as a neutral party with access to the most extensive information about healthcare utilization and

outcomes for publicly insured beneficiaries. In addition, the government has a strong interest in ensuring the products of federally supported research are used to improve health and healthcare. This information constitutes the hard evidence that can inform quality choice.

As a trusted source of science-based information about the effectiveness of alternative treatments, government can contribute significantly to the base of information needed to achieve high value for the healthcare dollar. Through government supported information, clinicians and patients can have ready access to unbiased information for making choices about treatments.

To achieve a true quality based healthcare system, three mechanisms need to be in place:

- Payment systems must reward evidence-based practice and good health outcomes.
- The fundamentals of modern health IT need to be put in place nationally, which means electronic health records for Americans and clinical decision support for providers.
- The best available information about treatments and outcomes, including comparative information about drugs and other interventions, needs to be systematically developed and made accessible to patients, providers, and payors.

The Agency for Healthcare Research and Quality has an active role in each of the above three areas (AHRQ). AHRQ, in 2005, launched its new Effective Health Care Program. The program initially focused on areas of special importance to the Medicare program. However, the program will ultimately address the questions most pressing for the quality of healthcare of Americans of all ages. The Effective Healthcare Program will be focus on the following:

- **Synthesis of existing evidence.** Focusing on treatments for significant conditions. AHRQ will synthesize currently available scientific evidence, including both published and unpublished studies. For each topic, evidence-based practice centers will issue a report and findings.
- **Generation of new knowledge.** A new network of research centers has been created to address gaps in our knowledge.
- **Evidence translation.** A new Clinical Decisions and Communication Science Center has been created to ensure that the findings of the program are usable for all those who need them.

Of special interest is the role of health IT in greatly expanding the capacity and contribution of effective research. The ability to conduct

accelerated “real world” data analysis can be transformed through the new availability of clinical data that will be made possible by health IT. At the same time, health IT presents new opportunities for disseminating findings widely, as well as delivering information and alerts through clinical decision-support tools. (Healthcare Financial Management, March 2006, pg. 64)

Tom's Comments

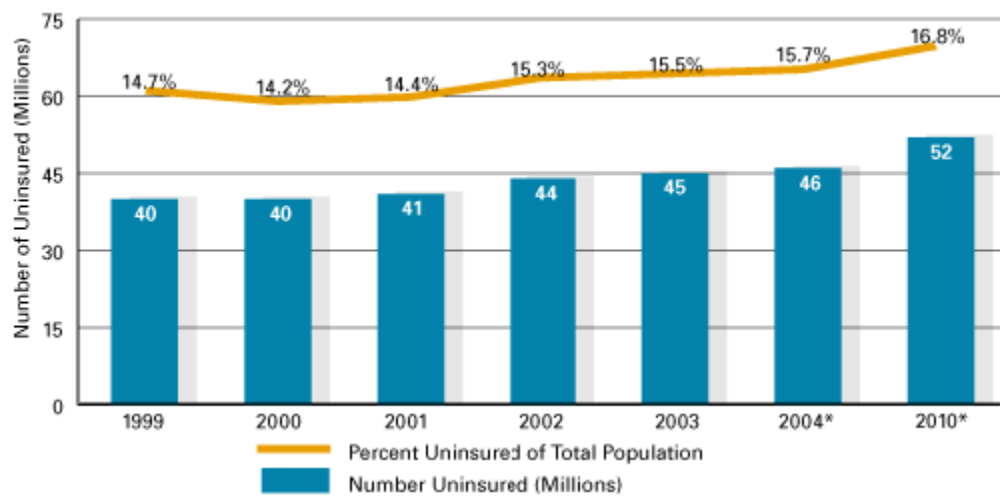
One cannot argue with Dr. Clancy's premise, that the focus on evidence-based medicine is the best way to ensure that the optimum level of cost-effective quality services is being provided. Currently every Managed Care Organization and hospital has developed guidelines based on evidence-based medicine. There are a few sources for these evidence-based guidelines (egg., Medicare, Milliman U.S.A. etc.). The government is positioned to be the focal point for facilitating research relating to evidence-based medicine. The government, with its vast resources and ability to mandate, is also in the position to assimilate and distribute this information. There is also some merit to housing this information in an independent body separate from the political process (similar to the Federal Reserve). We discussed another potential option related to this in our January 2006 issue that focused on The Institute of Medicine's recommendation for a Federal Panel that would oversee the creation of a National Health Quality System.

ACCESS TO CARE

Trends Relating to Access to Healthcare Services

The Uninsured in Millions 1999-2010

([Medical Cost Reference Guide](#), pg. 55)



Fast Facts

([Medical Cost Reference Guide](#), pg. 56)

- Medical Costs are a factor in approximately half of all bankruptcies.
- Among those filing for bankruptcy in which medical costs were a factor, 20% had private coverage initially but lost coverage during the course of illness.

OHIO

State Adds Assisted Living Option to Services for Seniors

Ohio will add a new assisted living waiver program as an option for 1,800 seniors and adults with disabilities on Medicaid who are in need of long-term care. Assisted living is a popular alternative for families as an intermediate form of care and previously was not an option under Ohio's Medicaid program. In its January 2005 report, the Ohio Commission to Reform Medicaid recommended that the state provide assisted living waivers as an alternative to costly nursing home care. Statewide enrollment for the assisted living services waiver will begin July 1. Ohioans interested in participating in the waiver program should contact the local area agency of aging at 1-866/243-5678 on or after July 1. To be eligible, a person must already be a nursing facility resident who would remain in the facility if not for the waiver, or a participant enrolled in a Medicaid waiver program including PASSPOR, CHOICES, Ohio Home Care or Transitions Carve-out who would move to a nursing home facility if not for the waiver. Finally, licensed residential care facilities interested in being providers should immediately contact their area agencies on aging at 1-866/243-5678 to be certified. (The Hannah Report, July 1, 2005, pg. 2)

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- **Free Healthcare Consulting Services:** Students in the Baldwin-Wallace College Health Care MBA program, as part of their course curriculum, will be offering free consulting services to interested organizations in the healthcare industry. If your organization is interested in receiving free consultative services, please contact Tom Campanella by phone (440-826-3559) or by e-mail (tcamp@bw.edu).

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