Q3 HEALTH CARE REPORT

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

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Sources cited in this Quarterly Health Care Report are listed at the end of each article.

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INTRODUCTION

This issue of the Quarterly Health Care Report provides the reader with a wide spectrum of articles under the heading of cost, quality and access to care. In addition, this issue will attempt to provider the reader with a view of future challenges and opportunities for those individuals and organizations that are in the healthcare industry.

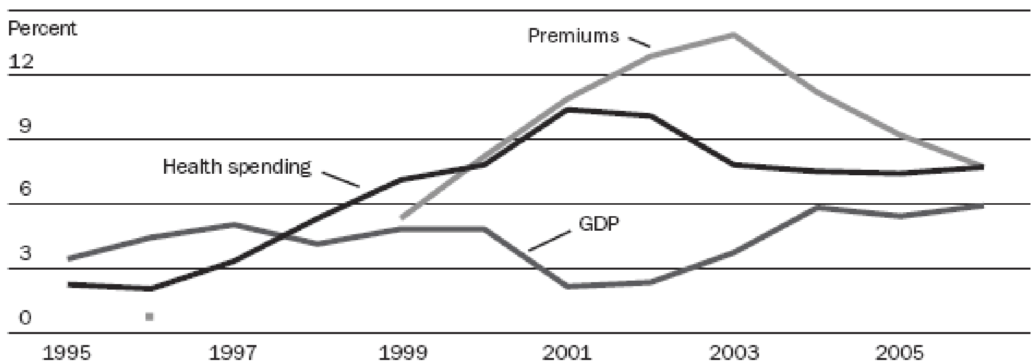
COSTS

Current Trends in Healthcare Insurance Premiums and Costs

For the third consecutive year, surveys of employers in 2006 point to a deceleration in premium growth for employment-based coverage – this time to 7.7% - following the peak increase of 13.9% in 2003. Nevertheless, premium growth continues to outpace growth in the economy (5.9%) and workers' earnings (3.8%) by a wide margin, making healthcare benefits increasingly unaffordable for employers and employees alike. **Ultimately high premium growth is a function of rapid growth in spending on healthcare services covered by private health insurance. Consequently, rising healthcare costs remain a focus of current policy debates.**

While growth in total healthcare spending in 2005 was virtually unchanged compared with 2004 and 2003, spending trends varied among the health service categories. Meanwhile, the slowdown in health insurance premium growth continued in 2006, although premium growth slowed less from 2005 to 2006 than it did from 2004 to 2005. This likely reflects the lagging relationship between underlying cost trends and premium trends. The stabilization of cost trend at a relatively high rate – in relation to incomes – may foreshadow a similar development for premiums in the near future **(See Exhibit 1).**

EXHIBIT 1
Annual Percentage Increases In Health Insurance Premiums, Gross Domestic Product (GDP), And Total Health Spending, 1995–2006



SOURCES: Premiums: G. Claxton et al., "Health Benefits in 2006: Premium Increases Moderate, Enrollment in Consumer-Directed Health Plans Remains Modest," *Health Affairs* 25 (2006): w476–w485 (published online 26 September 2006; 10.1377/hlthaff.25.w476). Health spending: Milliman Health Cost Index 2005 series (zero deductible). GDP: U.S. Department of Commerce, Bureau of Economic Analysis.
NOTE: Data on premium increases are not available for all years; they are shown for 1996 and then for 1999–2006.

Total health care spending per privately insured person increased 7.4% in 2005 **(Exhibit 2**), a rate of growth that was virtually unchanged from 2004 (7.5%). This stabilization is a departure from the slowdown in 2002 and 2003, when spending growth declined by more than two percentage points from a peak increase of 10.4% in 2001.

Total **hospital spending** increases accelerated slightly, from 8.5% in 2004 to 9% in 2005. This composite value reflects a **considerable acceleration in the hospital inpatient cost trend and a slight deceleration in outpatient spending trends**. Growth in spending on hospital inpatient services per privately insured person increased to 7.1% in 2005, up from 5.3% in 2004. In contrast, the trend for spending on hospital outpatient care per privately insured person slowed slightly in 2005: It increased 10.4% compared with 11.2% in 2004. Growth in spending on inpatient and outpatient hospital care accounted for 51% of the total increase in healthcare spending in 2005.

EXHIBIT 2

Annual Percentage Change In Health Care Spending Per Privately Insured Person And Gross Domestic Product (GDP) Per Capita

	Percent change in spending on type of health care service						
Year	All services	Hospital inpatient	Hospital outpatient	Physician	Prescription drugs	All other	Percent change in GDP
1995	2.2	−3.5	7.9	1.9	10.6	–[a]	3.4
1996	2.0	−4.4	7.7	1.6	11.0	–[a]	4.4
1997	3.3	−5.3	9.5	3.4	11.5	–[a]	5.0
1998	5.3	−0.2	7.5	4.7	14.1	–[a]	4.1
1999	7.1	1.6	10.2	5.0	18.4	–[a]	4.8
2000	7.8	4.1	9.8	6.3	14.5	–[a]	4.8
2001	10.0	8.7	14.6	6.7	13.8	–[a]	2.1
2001	10.4	8.5	14.6	7.7	13.5	8.5	2.1
2002	10.1	8.2	13.0	7.9	13.1	6.9	2.3
2003	7.8	6.1	11.1	6.3	8.9	4.1	3.7
2004	7.5	5.3	11.2	6.0	8.3	6.3	5.8
2005	7.4	7.1	10.4	7.1	4.8	12.0	5.4

SOURCE: Health care spending data are from the Milliman Health Cost Index 2005 Series (zero deductible). GDP is from the U.S. Department of Commerce, Bureau of Economic Analysis.

NOTES: GDP is in nominal dollars. Estimates may differ from past reports because of data revisions by Milliman and the Bureau of Economic Analysis. Data for 1995 through 2001 (first entry) use weights for a traditional comprehensive plan. Data for the second 2001 entry through 2006 use weights for a blend of that plan and one that has significant copays on a number of services and that is subject to aggressive medical management.

[a] Not available.

[b] Compares January–March 2006 with the same months in 2005.

The trend for **hospital utilization** increased 4.5% in 2005, compared with an increase of only 1.3% in 2004 and 0.7% in 2003. At the same time, growth in

unit prices for hospital services fell sharply to 4.3% in 2005; from 7.1% in 2004 **(See Exhibit 3).** This increasing utilization trend might be attributable in part to the especially severe flu season in 2005 and a shortage of vaccinations that might have contributed to increased hospital use. The price trend might have slowed from the increasing share of services provided in non-hospital facilities as well as the effects of a more competitive market.

EXHIBIT 3
Decomposition Of The Hospital Spending Trend

	Annual percent change per capita		
Year	Spending on hospital services	Hospital prices	Quantity[a]
1995	0.8	3.7	−2.8
1996	0.5	1.8	−1.2
1997	1.3	1.7	−0.4
1998	3.5	1.9	1.5
1999	5.8	2.5	3.2
2000	7.0	3.3	3.6
2001	11.8	3.6	7.8
2001	11.5	3.6	7.6
2002	10.7	5.2	5.2
2003	8.7	8.0	0.7
2004	8.5	7.1	1.3
2005	9.0	4.3	4.5

SOURCES: Data on hospital spending are from the Milliman Health Cost Index 2005 Series (zero deductible) and include both hospital inpatient and outpatient services. Hospital prices are from the Bureau of Labor Statistics "all other payers" Producer Price Index (PPI) series for general and surgical hospitals (data accessed 27 June 2006).

NOTE: Estimates may differ from past reports because of data revisions by Milliman and the Bureau of Labor Statistics. Data for 1995 through 2001 (first entry) use weights for a traditional comprehensive plan. Data for the second 2001 entry through 2006 use weights for a blend of that plan and one that has significant copays on a number of services and that is subject to aggressive medical management.

[a] Calculated as the residual of the hospital spending and hospital price trends.

[b] Compares January–March 2006 with the same months in 2005.

The trend in **prescription drugs** spending decelerated in 2005 for the sixth year in a row, with a particularly sharp drop from a 8.3% increase in 2004 to a 4.8% increase in 2005 **(See Exhibit 4).** In 2005, growth in drug spending accounted for only 14% of the total increase in healthcare spending, well below its contribution in previous years, especially compared with the late 1990s, when it accounted for almost half.

Virtually all of the slowing in the **prescription drug** spending trend is attributable to a slowing in the growth of usage (known as quantity in **Exhibit 3) -** from 4.8% in 2004 to 1.2% in 2005. Generally an increase in news about drug side effects (especially the COX- 2 inhibitors, egg., Vioxx), not only negatively impacted the utilization of COX-2 inhibitors it may have affected the use of other classes of drugs.

Exhibit 4

Decomposition Of The Prescription Drug Spending Trend

	Annual percent change per capita		
Year	**Spending on prescription drugs**	**Prescription drug prices**	**Quantity[a]**
1995	10.6	1.9	8.5
1996	11.0	3.3	7.4
1997	11.5	2.6	8.6
1998	14.1	3.8	9.9
1999	18.4	5.7	12.0
2000	14.5	4.4	9.6
2001	13.8	5.4	8.0
2001	13.5	5.4	7.7
2002	13.1	5.2	7.5
2003	8.9	5.2[b]	3.5
2004	8.3	3.3	4.8
2005	4.8	3.5	1.2

SOURCES: Data on prescription drug spending are from the Milliman Health Cost Index 2005 Series (zero deductible). Prescription drug prices are from the Bureau of Labor Statistics Consumer Price Index (CPI) for prescription drugs and medical supplies (data accessed 27 June 2006).

NOTES: Data for 1995 through 2001 (first entry) use weights for a traditional comprehensive plan. Data for the second 2001 entry through 2006 use weights for a blend of that plan and one that has significant copays on a number of services and that is subject to aggressive medical management.

[a] Calculated as the residual of the prescription drug spending and price trends.

[b] We used an adjusted estimate of drug price growth in 2003 rather than the published estimate (3.1 percent) because the prescription drug CPI continued to include Claritin and Prilosec in 2003, despite the fact that both had been reclassified to over-the-counter status. For further discussion, see Note 15 in text.

Spending on **physician care** increased 7.1% in 2005, compared with a 6% increase in 2004 **(Exhibit 2).** Decomposition into price and utilization factors indicates that all of the increase in the spending trend reflects utilization (5.1% versus 1.9% for price increase). Some of the utilization increase reflects expansions of ancillary services provided in physicians' offices. Also, some of the increased spending on specialty pharmaceuticals – the fastest-growing component of drug spending – could be a factor in the physician services component, as many are

administered in physicians' offices and are recorded as spending for physician services.
("Tracking Health Care Costs: Continued Stability but at High Rates in 2005," Health Affairs, October 3, 2006)

Tom's Comments:
As noted in the above narrative, "high premium growth is a function of a rapid growth in spending on healthcare services covered by private health insurance. Consequently, rising healthcare costs remain a focus of current policy debates." Escalating healthcare costs not only have a negative impact on employers who are attempting to compete in a regional, national and now international marketplace, but also increasingly on employees as a result of cost-shifting by employers in the form of greater co-pays, deductibles, and a greater share of the premium expense. Finally, high healthcare costs also adversely impact overall access to healthcare services since employers (especially smaller companies) are increasingly dropping their employee healthcare coverage altogether.

There will be continued pressure placed on controlling healthcare cost for all of the above reasons. There is hope that, through the effective use of technology and innovation, efficiencies will occur in our healthcare infrastructure. An increased focus on wellness and disease management also needs to occur simultaneously with a serious look at end of life issues, especially as they relate to a greater role for hospice services.

Bush Orders Transparency on Health Care Costs and Quality

On August 22, 2006, President Bush signed an executive order requiring the Health and Human Services Department, the Defense Department, the Veterans Affairs Department and the Federal Employees Health Benefit Program to take certain steps to increase healthcare pricing and quality transparency, to enhance health information technology interoperability, and promote "quality and efficiency of care" through consumer-directed health insurance products. The order was designed to help consumers make more informed decisions about their healthcare, including which doctors and hospitals they choose for care.

Specifically, the order directs Federal agencies that sponsor or administer Federal health care programs to:

- **Increase Transparency in Pricing.** Required to share information about prices paid to health care providers for procedures with beneficiaries.
- **Increase Transparency in Quality.** Required to develop programs to measure quality of service provided by doctors, hospitals, and other health care providers, based on standards developed by "multi-stakeholder entities."
- **Encourage Adoption of Health Information Technology (IT) Standards.** Required to use improved health IT systems to facilitate the rapid exchanges of health information, through "recognized interoperability standards," and to require contractors to do the same "where available."
- **Provide Options that Promote Quality and Efficiency in Health Care.** Required to develop and identify approaches that facilitate high quality and efficient care.

Additional information about the Executive Order is available at: www.whitehouse.gov/news/releases/2006/08/20060822-4.html (Benfitslink.com, Deloitte's Washington Bulletin, 8/31/2006)

Tom's Comments:

The October 2006 issue of the Healthcare Financial Management magazine has a series of articles relating to price transparency and consumerism in the hospital setting. The overall theme of the articles is to recommend that hospitals address these issues by reevaluating the overall pricing strategy of the organization and develop proactive strategies to take advantage of the new marketplace. See http://www.hfma.org/hfm/. For a further review of the Price and Quality Transparency issues please refer to the July 2006 issue of the Quarterly Health Care Report.

Financial Incentives Alone not enough to Curb Healthcare Costs

Employers that rely only on financial incentives for employees to help cut healthcare costs may find themselves not meeting their savings goals, an analysis by Watson Wyatt reveals (Washington, www.watsonwyatt.com).

The reason: the bulk of employers costs actually come from a small group of employees who have chronic or catastrophic illnesses. Approximately 4% of employees with serious health conditions account for 49% of costs. The average annual healthcare cost of these individuals is $10,000 each. Meanwhile, those who are not sick – those in the early stages of chronic conditions or with acute health episodes – account for 40% of costs, while healthy individuals, comprising 72% of the workforce, account for only 11% of costs (See Exhibit 5)

"This analysis makes clear that efforts to create better healthcare consumers must involve more than high-deductible health plans," said Sylvester J. Schieber, U.S. Director of Benefits Consulting at Watson Wyatt. Mr. Schieber further states, "Employers need to develop targeted approaches that use different strategies to engage different segments of the population covered by health benefit plans."

Exhibit 5
Percent of Health Plan Participants Who Consume the Most Resources, by Health Plan Expenditure per Individual

Percent of Health Plan Participants Who Consume the Most Resources By Health Plan Expenditures per Individual		
Average health care Cost per Individual	Percentage of plan Participants	Percentage of 2004 Health Care Costs
< $1,500	72%	11%
$1,500 - $9,999	24	40
>$10,000	4	49
Source: Watson Wyatt		

Tom's Comments:
The statistical relationship as noted in Exhibit 5 approximates data which is widely accepted in the healthcare industry. Historically, data appears to validate that 1% of members in a large group account for 30% of the healthcare costs and 10% of members account for approximately 70% of healthcare costs. The top 1% of members do not stay in that percentile on a long-term basis since they will usually recover (or need less intense services) or die. The top 10% of members however might stay in that category on a long-term basis. Employers need to develop proactive strategies and initiatives, in conjunction with their healthcare plan, to target the various segments of utilizers. As stated above, case

management is the most effective approach to addressing the top tier of utilzers. Disease management programs can in conjunction with case management programs; best address the top 10% of members. Wellness programs can also be effective in addressing current and potential healthcare needs of the overall employee population. Managed care organizations and specialized consultants are also working with employers to develop programs that attempt to target members that have the "health profile" to potentially become a high utilizer. Through the use of Health Risk Appraisals which reflect family, medical and drug history, along with the current age and health condition of the member, these organizations are able to predict the likelihood of future health issues. The employer with the assistance of the "experts" can then design specific programs that hopefully will allow the member to advert these future potential health problems.

Fast Facts:

- 50% of drugs consumed are generics (vs. brand named), up from 40% five years. (BenefitNews.com, September 13, 2006)
- 12% of drugs are purchased by mail order, up from 9% five years ago. (BenefitNews.com, September 13, 2006)

QUALITY

Wellness Winners Share Their Success Strategies

The companies with leading wellness programs say support on all management levels is crucial to implementing a successful program. Texas Instruments aims for "strong communication resources driven in a way to really change behaviors. This means using many lines of communication: direct email, employee intranet, brochures, posters, hardcopy distribution of memos, newsletters, invitations, information tables, healthy events calendars and more in an effort to grab employees and keep them involved.

The best wellness programs strike a balance between basic explanations of health issues and intricate incentive structures. The leading companies all recommend employees take health risk assessments. Some companies make completion a mandatory prerequisite to use the program, and for others it's required if a participant hopes to take advantage of incentives.

Paula Sauer, Vice President at Medical Mutual of Ohio states, "A strategic wellness program based on assessment of company needs, measurement and goals is most effective. Instead of developing initiatives and tossing them out like a net in an effort to attract employees, you need to spend more time in the design phase to learn the biggest risks to their employees and what programs spark their interest. The best wellness programs are customized to a unique employee population." (BenefitNews.com, September 18, 2006)

According to Dee Edington, PhD, Director of the Health Management Research Center at the University of Michigan, research shows a return of $3 for $1 spent by employers for wellness programs. The savings come from reduced absenteeism and increased productivity. But he adds that companies need about an 80% participation rate to achieve those savings, and about $200 incentive per employee appears to be the tipping point. (Managed Care, July 2006).

Tom's Comments:
Employers need to be sensitive to the potential legal issues when they implement a wellness program. I strongly suggest that employers talk to their legal counsel prior to the implementation of any proactive wellness or disease management program that is linked to incentives or sanctions. There are a number of laws on the federal and state level that could potentially impact the legality of any incentive/sanction laden wellness or disease management program. Examples of laws that would impact these programs include the Americans with Disability Act (ADA), the Health Insurance Portability Act (HIPAA), and various state laws.

Institute of Medicine states that Medicare should use "Pay for Performance" to Improve Quality of Health Care Service"

Medicare's provider reimbursement system provides few incentives to improve quality of care delivered to its 42 million beneficiaries and so should be scrapped in favor of a pay-for-performance (P4P) system, so stated the Institute of Medicine (IOM).

Given the scarcity of data on the effectiveness of P4P, IOM recommended Medicare phase in performance-based payment systems for its providers over three to five years. Some healthcare providers, such as hospitals, home health agencies, and Medicare managed care plans, could transition to P4P immediately, the report stated. The current payment system for healthcare is flawed because it places no emphasis on whether the care delivered is of high or low quality. IOM stated that there have been 100 P4P programs implemented in recent years, and the results are still being evaluated.

Performance measures vary by provider type. For example, hospitals participating in a Medicare quality demonstration project report on such treatments as an acute myocardial infarction responses and track measures such as the existence of adult smoking cessation counseling programs, whether the patient was given aspirin when arriving at the hospital, and whether aspirin and beta blockers were prescribed at discharge. In addition the hospital provides data about patient survival rates. The IOM report is available at http://www.nap.edu.
("IOM Says Medicare Should Use P4P Plan to Improve Quality of Health Care Services," BNA's Health Care Daily Report, Volume 11, Number 184)

Small Doctor Groups Eligible for Bonuses under Quality Measure Demonstration of the Centers for Medicare and Medicaid Services

Small or solo physician practices in four states that participate in a demonstration project could earn thousands of dollars in bonuses for reporting, and then following, quality measures for chronically ill patients. Funded jointly by the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality, the Medicare Care Management Performance (MCMP) demonstration will allow practices to earn an annual incentive of up to $10,000 per physician and up to $50,000 per practice year.

Approximately 800 practices or 2,800 physicians in Arkansas, California, Massachusetts, and Utah will be recruited to participate in the three-year demonstration. In order to be eligible, physicians must be the main provider of primary care to at least 50 fee-for-services Medicare beneficiaries and participate in their state's Doctor's Office Quality-IT program.

The pay-for-performance demonstration will begin as a pay-for-reporting demonstration. In the first three years, participants will provide baseline data on up to 26 quality measures. These are related to the care of patients with diabetes, congestive heart failure, and coronary artery disease, as well as the provision of preventive health services such as immunizations and cancer screening to high risk patients with a range of chronic diseases.

After that, they will be measured and possibly rewarded for how well they provided the services. For example, a measure for a diabetic patient will be lipid and cholesterol measurements and for a heart failure patient, beta blocker therapy.

Information on the CMS demonstrations is available at http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp.
(BNA's Health Care Daily Report, Volume 11, Number 200, October 17, 2006)

Potential 2007 Measures for the Medicare Physician Voluntary Reporting Program (PVRP)

The Centers for Medicare and Medicaid Services has been working with physician groups and other stakeholders toward the goal of implementing measures appropriate for the Medicare population for every physician specialty to report under the PVRP for 2007. The list contains 86 unique quality measures that CMS currently expects to be available for 2007. CMS plans to select a subset of these measures as the 2007 PVRP measures in order to achieve an appropriate balance of metrics that can be reported by different specialties.

Developers of the quality measures follow a standardized procedure to prepare evidence-based measures with detailed specifications for data collection and calculation. Physician measure developers include the American Medical Association, the National Committee for Quality Assurance (NCQA), and additional organizations.

The fact sheet and quality measures are available at:
http://www.cms.hhs.gov/PVRP/Downloads/qualmeasures.pdf

CMA welcomes questions and comments about the measures list and the PVRP. Submit to PVRP@cms.hhs.gov

Tom's Comments:
The above three articles highlight government initiatives that show much promise. The government is in the best position to both design and implement such quality oriented programs. The government has both the financial resources and the leverage to make these initiatives successful. The government (Medicare, Medicaid, Workers' Compensation) will usually represent 40% to 60% of a provider's revenue. The government also has the ability to set mandates, but currently the focus of these initiatives relies on financial incentives to enhance participation.

Historically the managed care industry has patterned many of its initiatives off of Medicare (egg., DRGs, RBRVS, APCs, etc.). While there has been some experimentation with P4P by the private sector, the successful implementation of these programs by the government can definitely have a ripple effect.

The key for success of these programs will be clear objectives that are measurable and linked to incentives that would be significant enough to impact behaviors. Finally, the long-term sustainability of such programs must also demonstrate a strong positive relationship between objectives and overall healthcare costs and quality.

Medicare Hospitalizations Deaths Decline as Gap Grows Between Best, Worst Hospitals

A typical hospital patient on Medicare has a 69% lower chance of dying at the top-rated U.S. hospitals than at a lowest-rated one, and the quality chasm between 1-star and 5-star hospitals has grown by about 5% since 2005, according to a study issued by HealthGrades Inc.

Since 2003, the risk-adjusted mortality rates of hospitalized Medicare patients have steadily declined, 8% on average. But the degree of improvement varied widely by procedure and diagnosis studied, the study found. However, the study found considerable variation in quality among hospitals studied and a worsening of mortality risk at some.

The Ninth Annual HealthGrades Hospital Quality in America Study examined records from 40.6 million Medicare hospitalizations from the years 2003 through 2005 to rate the quality of care at more than 5,000 nonfederal hospitals.

According to the study, more than 300,000 Medicare lives could have been saved during 2003 through 2005 if all hospitals performed at the level of hospitals rated with 5 stars across all 18 procedures and diagnoses studied. In fact, 50% of the potential preventable deaths were associated with just four diagnoses: heart failure, community-acquired pneumonia, sepsis, and respiratory failure.

This study is available at
http://www.healthgrades.com/media/dms/pdf/HealthGradesNinthAnnualHospitalQualityinAmericaStudy.pdf

Hospital specific scores by HealthGrades can be accessed at
www.healthgrades.com
(BNA's Health Care Daily Report, Volume 11, Number 200, October 17, 2006)

Tom's Comments:
HealthGrades is an example of one of the private initiatives that has focused on cost and quality ratings. HealthGrades has been in existence for a number of years and its overall data base is impressive. The market place has spawned many other rating companies. It is difficult to drive down a highway without spotting a billboard that displays a hospital rating (egg., Best Eye Hospital per the I.C.U. rating organization).

Eventually there will probably be a shake out in this "hospital rating industry" similar to what occurred in some other sectors (egg., mutual funds –Morningstar, automobile-Consumer Reports). The government is actually in the best position to produce such ratings (resources/leverage/data base, etc.), but politically it maybe difficult for the government to provide a “user friendly” rating system such as 5*s due to backlash from the various interest groups.

Fast Facts

- Nearly half of short-term disability claims are linked to heart conditions, trauma, cancer, mental disorders and pulmonary conditions, according to a recent MetLife study. Those five illnesses, which are usually expensive to treat, are responsible for an average of 60% of lost work days due to disability leave. (BenefitNews Connect, August 3, 2006)

Tom’s Comments:
Many people seem to focus on the direct costs relating to healthcare conditions (egg., hospital, physician, drug, etc.), but other associated conditions, such as disability, can be just as costly to employers. Employers should also take into consideration any disability costs, including lost time, etc. when developing initiatives that focus on the root causes of a problem. As noted above, a few medical conditions stand out in regards to their impact on disability time off.

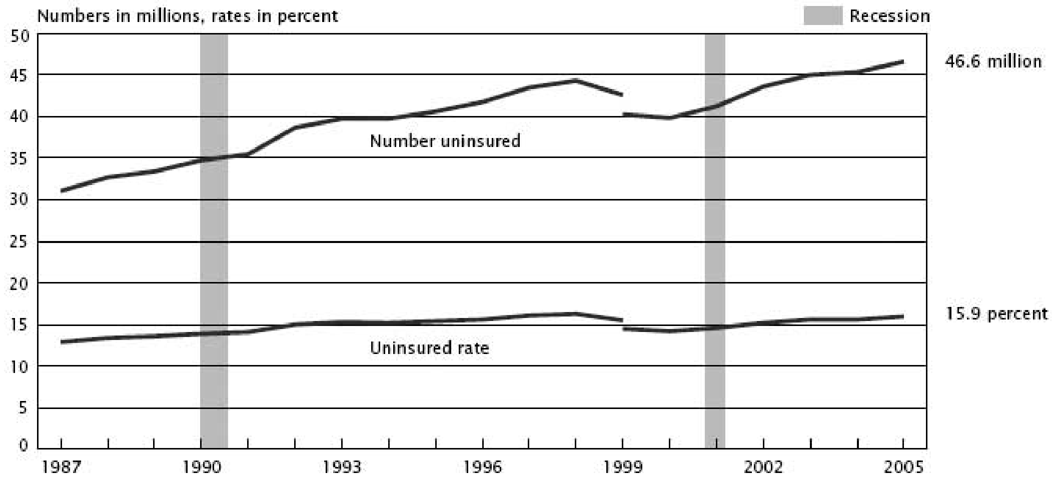
ACCESS TO CARE

Fast Facts

- The number of people without health insurance grew significantly for the fifth year in a row. Nearly 46.6 million Americans were uninsured in 2005 – up almost 7 million since 2000. The percentage of those without insurance has grown from 14.2% in 2000 to 15.9% in 2005. (“Health Insurance Eroding for Working Families,” Economic Policy Institute Briefing Paper, Elise Gould, September 28, 2006)
- According to figures from the U.S. Census Current Population Survey the percentage of uninsured peaked at 16.3% in 1998, the rate fell for 2 years in a row to 14.2% in 2000. **(See Exhibit 6)** (U.S. Census Bureau, “Income, Poverty, and Health Insurance Coverage in the United States: 2005”)

Exhibit 6

Number Uninsured and Uninsured Rate: 1987 to 2005



Notes: Respondents were not asked detailed health insurance questions before the 1988 CPS. Implementation of Census 2000-based population controls occurred for the 2000 ASEC, which collected data for 1999. These estimates also reflect the results of follow-up verification questions that were asked of people who responded "no" to all questions about specific types of health insurance coverage in order to verify whether they were actually uninsured. This change increased the number and percentage of people covered by health insurance, bringing the CPS more in line with estimates from other national surveys.
The 2004 data have been revised to reflect a correction to the weights in the 2005 ASEC. The estimates also reflect improvements to the algorithm that assigns coverage to dependents.
The data points are placed at the midpoints of the respective years.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2006 Annual Social and Economic Supplements.

Tom's Comments:
There continues to be an increase in the number of uninsured in the U.S. with no let up in sight. As stated previously in this report, the percentages of employers that offer health insurance to employees continue to decrease, especially among small employers. A number of states, including Massachusetts, are implementing various versions of universal coverage. While some may disagree with such initiatives we will at least have an opportunity to evaluate these programs in action (rather that just talk about them).

State Healthcare Update

New Ohio Law Requires Disclosure of more Performance, Cost Information

Ohio Hospitals must disclose more performance and cost information to the state and consumers beginning in April 2007, under legislation (H.B. 197) signed August, 9, 2006 by Governor Bob Taft. The law updates current reporting requirements by adding information on dozens of quality indicators to reports that hospitals file with the Ohio Department of Health. This information, in turn, will be posted on the department's Web site, enabling consumers to make better-informed medical decisions.

In addition, hospitals will be required to report average charges for their top 60 inpatient procedures and top 60 outpatient services. Performance measures reports will be filed with the state semiannually, with the first due by April 2007. Cost reports will be due beginning May 2007 and must be filed in a format that complies with the federal Health Insurance Portability and Accountability Act's electronic transactions standards.

Currently, hospitals must report data on 136 performance measures within nine service areas. The new disclosure law adds performance standards developed by the Joint Commission on Accreditation Healthcare Organizations and other national groups.

Full text of the bill is available at
http://www.legislature.state.oh.us/bills.cfm?ID=126_HB_0197
(BNA's Health Care Daily Report, Volume 11, Number 157, August, 15, 2006)

Tom's Comments:
This law was enacted in response to various efforts on the national and local level to provide cost and quality information to consumers. The type of data that this initiative will provide will not be very user-friendly or even helpful since it focuses on hospital charges, which realistically do not have any relevancy in the "real world."

NORTHEAST OHIO

What's Really Propping up the Economy?

Without the increase in healthcare related jobs the nation's labor market would be in a deep coma. Since 2001, 1.7 million new jobs **(See Exhibit 7)** have been added in the healthcare sector, which includes related industries such as pharmaceuticals and health insurance.

Meanwhile, the number of private sector jobs outside of health care is no higher than it was five years ago.

With more than $2 trillion in spending – half public, half private – health care is propping up local job markets in the Northeast, Midwest, and South, the regions hit hardest by globalization and the collapse of manufacturing.

Nowhere is that truer than in Cleveland where the Cleveland Clinic, with 29,000 employees, is the biggest employer by far. Next largest is another hospital system, University Hospitals System, with 21,600 staffers. Then comes insurer Progressive Corp. and Key Corp., each with fewer than 10,000 workers in the area.

The expansion of healthcare is also spinning off related jobs. Cleveland Clinic Innovations, a unit that funds startups, has already created 19 companies in its five years of existence. Together these companies employ about 186 people, including more than 50 in the Cleveland area.

Using healthcare spending to create the vast majority of new jobs, while beneficial in the short-run, is not desirable over the long-run. A well-balanced economy needs to provide a wide variety of jobs. Many believe that breakthroughs in technology offer enticing possibilities for making healthcare less labor-intensive over the long-run.

Exhibit 7

A NEW VIEW OF HEALTH CARE

	THOUSANDS OF JOBS JULY, 2006*	RISE IN NUMBER OF JOBS, IN THOUSANDS JULY, 2001-JULY, 2006*
PRIVATE HEALTH-CARE SERVICES	12,479	1,447
GOVERNMENT HOSPITALS	1,277	86
DRUGSTORES AND OPTICAL-GOODS STORES	803	7
HEALTH-INSURANCE CARRIERS	439	106
WHOLESALE MEDICAL EQUIPMENT AND DRUGS	394	45
MEDICAL SUPPLIES AND EQUIPMENT	379	0
PHARMACEUTICAL COMPANIES	290	12
HEALTH CHARITIES AND RELATED ORGANIZATIONS	39	3
TOTAL	16,100	1,707
SHARE OF TOTAL NONFARM EMPLOYMENT	12%	

*Average for 12 months ending in July, 2006

Data: Bureau of Labor Statistics

("What's Really Propping up the Economy," Michael Mandel, Business Week, September 25, 2006)

Tom's Comments:

Healthcare is indeed a booming business. Specifically for the Northeast Ohio economy, the healthcare industry has been its life-preserver. Northeast Ohio has many challenges and, while we need to focus on a number of sectors of our economy, we cannot lose focus on the importance of the healthcare industry. The healthcare industry and the people who work in it will also be facing many challenges as employers and the government attempt to address escalating healthcare costs. The loss in population in Northeast Ohio will also eventually have a negative effect on the healthcare industry. All of this should not mean a death keel for the healthcare industry, but should provide an incentive to find better and more efficient ways to address the healthcare needs of not only our local population, but also the national and international healthcare marketplace, which is within our reach.

The healthcare industry will continue to evolve, which will create challenges for the workers within it, but those challenges will also create opportunities for those individuals and organizations that have the vision, competency and fortitude to succeed.

MARK YOUR CALENDAR

If you are interested in possibly enrolling in the Health Care MBA program at Baldwin-Wallace College for the session Starting in January of 2007 you need to contact Barb Peterson at 440-826-2064 or e-mail her at bpeterso@bw.edu

Keep track of upcoming events in the Business Division of Baldwin-Wallace College on our website: http://www.bw.edu/academics/bus/events/

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