

# Q1 HEALTH CARE REPORT April 2005 Vol. 2

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

## BY TOM CAMPANELLA

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Baldwin-Wallace College provides Professor Tom Campanella's Quarterly Health Care Report as a courtesy to those in the health care sector. Comments, opinions, emphasis and content decisions are solely those of Tom Campanella.

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# COSTS

## COSTS: ABOUT TO EXPLODE

### Health Care Costs Could Approach 19% of GDP by 2014

The nation's tab for health care – already the highest per person in the industrialized world – could hit \$3.6 trillion by 2014, according to a USA Today report on a sobering government projection. That would equal almost 19% of the Gross Domestic Product (GDP), up from 15.4% today. By 2014, the nation's spending for health care will nearly double, reaching \$11,045 for every man, woman and child, compared to \$6,423 this year, according to a report released by the Centers for Medicare & Medicaid Services. The numbers are not adjusted for inflation. (Appleby).

A number of key variables will have an impact on the cost of health care in the future. Even in the most optimistic of the scenarios, projected cost increases will be a challenge for all Americans individually, for the private sector and for government. The impact will be universal. Finally, as our world becomes more internationally focused, our ability to compete in the global marketplace will be threatened. What does all of this mean? We as a society need to address health care issues of cost, quality and access, for the short- and long-term, and we must do it pro-actively. Otherwise, crisis is inevitable.

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## DIABETES: HEALTH COSTS, ECONOMIC COSTS

Diabetes is a chronic condition affecting 18.2 million Americans — nearly 6% of children and adults nationwide. Methods for controlling diabetes and minimizing its impact on the health status of the individual are well documented. From a financial standpoint, costs related to complications from this disease are significant, both for the individual and for the health care system in general.

## Key facts about diabetes and its complications:

- National inpatient hospital costs for diabetes with complications were nearly \$3.8 billion in 2001.
- The risk of hospitalization from cardiovascular disease is two to four times higher for women with diabetes than for women without diabetes.
- Patients hospitalized with diabetes are 28 times more likely to have an amputation than patients without diabetes.
- With appropriate primary care for diabetes complications, nearly \$2.5 billion in hospital costs might be averted.

According to the federal government's Healthcare Cost and Utilization Project (H-CUP), hospitalizations for complications of diabetes are generally considered to be preventable if patients receive high-quality health care – and if they adhere to treatment, including proper diet and regular exercise. (AHRQ)

We have discussed the issues of diabetes in prior editions of the Health Care Quarterly Report. Its negative impact on an individual's quality of life, as well as its impact on costs – from an individual and a societal perspective – is well documented. It is frustrating that most Type II Diabetes (which is the most common type) is preventable, or at least manageable. Solutions need to actively involve the patient as well as the physician. Since patient adherence to diet and exercise is critical to short- and long-term success, perhaps it would be appropriate to develop and demand incentives and accountabilities that encourage pro-active patient involvement.

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AHRQ (Agency for Healthcare Research and Quality). H-CUP Highlights. Publication No. 05-0034. January 2005. To access on line, go to <http://www.ahrq.gov/browse/diabetes.htm>

# PHYSICIAN INVOLVEMENT CRUCIAL IN DISEASE-MANAGEMENT PROGRAMS

Historically, many doctors have viewed disease-management programs with suspicion. In some doctors' minds, these programs have been imposed by health plans, sometimes with less-than-scientific research to back them up. Typically, these programs have had direct contact with health-plan subscribers, leaving doctors resentful that they have been left out of the process.

Now, top disease-management companies are saying that 2005 initiatives will involve doctors, and invite medical practices to take a more central role. "The disease-management programs are finding that to be more successful, they need to partner much more effectively with the physicians," according to Sandeep Wadhwa, M.D., a vice-president with San Francisco-based McKesson Corp., a national disease-management contractor. In an article in an American Medical Association publication, Dr. Wadhwa said some disease management programs will begin to link more directly to quality-management programs that monitor physician performance, making use of disease-management data to award health plan bonuses. (Kazel)

Historically, most managed-care organizations and disease-management organizations have relied on direct interaction with the plan member. The physician has been either "out of the loop" or has received a "courtesy copy" of the communication between plan and member. When asked to name their closest medical adviser, most people will respond, "My doctor," – especially in time of need. It is not uncommon for a person to have a long-standing relationship with a primary care physician. It is critical to the success of any disease-management program to have the physician's active involvement, or at least his or her support and awareness. The challenge here is that most physicians interact with patients whose health care coverage comes from more than one health care plan, often including Medicare and/or Medicaid. The various plans will potentially have different disease-management programs for its members. However, in the continuing drive to contain health care costs, this type of pro-active idea must be evaluated and implemented.

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# EMPLOYER EFFORTS TO CONTROL RISING DRUG COSTS

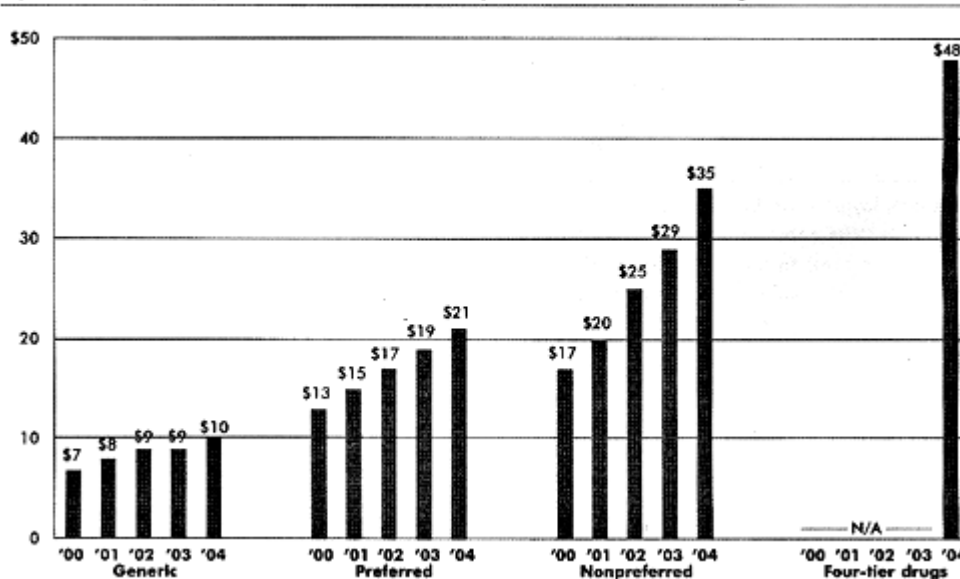
As discussed in the Q4 Health Care Report, many employers have moved to tiered cost-sharing arrangements with employees and mail-order discount plans to keep a lid on prescription drug costs. According to the Kaiser Family Foundation's 2004 Survey of Employee Health Benefits, some are even turning to four-tier programs and the mandatory use of generic drugs.

Some salient points from the Kaiser survey:

- 65% of insured workers are now enrolled in three-tier plans
- 3% of workers are in four-tier arrangements (focused on life-style or injectable drugs) (Figure 1)
- Average co-pays are \$10 for generic drugs / \$21 for preferred drugs / \$35 for non-preferred drugs /\$48 for lifestyle and injectable drugs (Figure 2)
- For workers with co-insurance instead of co-pays for prescription drugs, cost-sharing levels are 20% for generic drugs / 26% for preferred drugs / 31% for nonpreferred drugs / 31% for four-tier drugs (Figure 3)
- 19% of all covered workers in 2004 faced mandatory use of generic drugs.

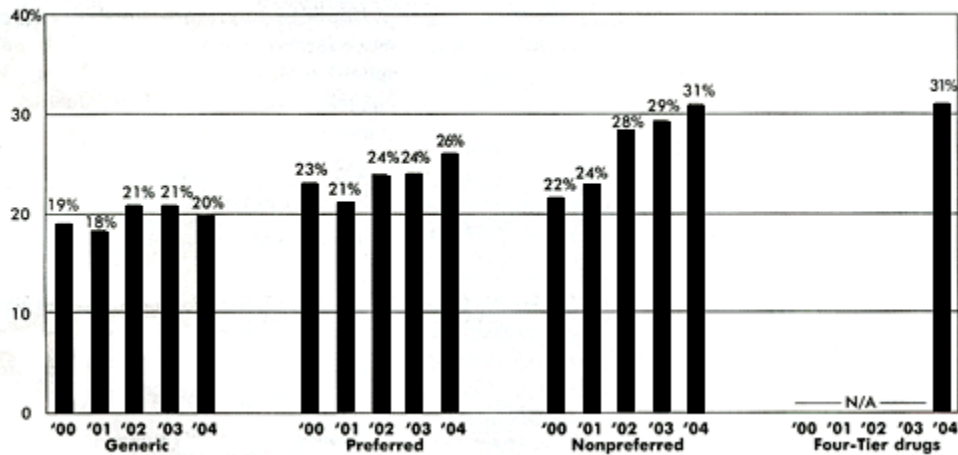
(IOMA)

**Figure 2. Average Copays for Generic, Preferred, Nonpreferred, and Four-Tier Drugs: 2000 to 2004**



(IOMA)

Figure 3. Average Co-Insurance Rates for Generic, Preferred, Nonpreferred, and Four-Tier Drugs: 2000 to 2004



(IOMA)

As we discussed in previous editions of the Quarterly Health Care Report, the effective management of prescription-drug programs is the surest way to achieve short- and long-term cost savings for the payor, whether it is an employer or the government.

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IOMA / Managing Benefits Plans. Institute of Management & Administration, Inc. March 2005, Issue 05-03, pg. 1. For more information, go to <http://www.IOMA.com>

## HOW CONSUMERS WEIGH LOWER COSTS VS. BROADER CHOICE

Consumer demand for a broader choice of health care providers was a driving force behind the managed-care backlash of the mid-1990s. Under pressure from employers and consumers, health plans broadened provider networks and eased other care restrictions, but these changes were accompanied by rapidly rising health insurance premiums. In response, many employers in 2002 began increasing patient cost-sharing through higher deductibles, co-payments, and co-insurance.

In polls of working-age Americans, The Center for Studying Health System Change determined that the number of people willing to trade broad choice for lower costs rose somewhat.

## Percentage of working-age Americans willing to trade broad choice for lower costs

(Center for Studying Health System Change)

**1997 - 2000**  
**55%**

**2001-2003**  
**59%**

As with any poll, one can interpret results in different ways. Ideally, we would review results of previous similar polls, from both a historical and a real-world perspective, to test the validity of the conclusions – but we have no prior data. The percentage increase in the two surveys is relatively small, but it may be valid to conclude that this may be the beginning of a trend, as the public becomes increasingly aware of rising health costs. As noted in previous Quarterly Health Care Reports, health care costs increasingly have direct and indirect impact on workers. If this trend continues, which it surely will, employees will learn to evaluate seriously any alternative to cost increases or loss of coverage.

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## QUALITY

### CONSUMER ORGANIZATION WANTS REPORTS ON HOSPITAL QUALITY

The Consumers Union, which publishes the popular magazine Consumer Reports, wants hospitals to report to the public on patients who have gotten infections at hospitals, according to an Associated Press story in the New York Times. That's because each year there are 2 million healthcare-related infections – including 90,000 that cause deaths, the story said, citing figures from the Centers for Disease Control and Prevention. The consumer push for better health information has already prompted four states – Florida, Illinois, Missouri and Pennsylvania – to require reports of this data. (Group Wants Hospitals to Report)

As consumers bear more of the cost of health care, their demand will increase for information on cost and health care quality. Information

providers such as the Consumers Union and Morningstar have built their reputations on providing that data in user-friendly formats, and providing comparisons of complicated services or products. As we discussed in previous issues of the Quarterly Health Care Report, the government has also been actively involved in comparisons of quality among health care providers.

Northeast Ohio had been far ahead of these efforts since the introduction in the early 1990s of the Health Action Council's "Cleveland Health Quality Choice" initiative. This visionary effort was short-circuited for various reasons, including its own high costs. It is unfortunate that the parties involved did not find a way to continue that effort.

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For more information, go to:

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<http://www.apic.org> (Association for Professionals in Infection Control and Epidemiology)

<http://www.aha.org> (American Hospital Association)

<http://www.consumersunion.org> (Consumers Union)

## LIFE EXPECTANCY INCREASES IN THE U.S.

Declines in death rates from most major causes – including heart disease and cancer – have pushed the life expectancy of the average American to a record 77.6 years, according to news reports on new federal government statistics. But, while the overall news was good from the CDC – the federal government's Centers for Disease Control and Prevention – statistics still trail those in several other countries, according to the World Health Organization. (Life expectancy)

### **Life Expectancy around the World**

#### **2002 figures from the World Health Organization**

(Life Expectancy)

Japan	81.9 years
Monaco	81.2
San Marino	80.6
Switzerland	80.6
Australia	80.4
Andorra	80.3
Iceland	80.1

Other countries topping the U.S.'s figure include Austria, Belgium, Canada, Finland, France, Germany, Greece, Israel, Italy, Norway, Spain and the United Kingdom. (Life Expectancy)

Life expectancy is one measure of the quality of a health care system, but it is difficult to draw broad conclusions on any system based solely on life expectancy. A better indicator for measuring the effectiveness of a health care system is "quality of life." As you would expect, this indicator is far more subjective than the quantitative life-expectancy statistics, and much more difficult to measure.

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## ACCESS TO CARE

A recent study by the Employee Benefit Research Institute (EBRI) concluded that 18% of the U.S.'s uninsured are individuals with family income greater than \$50,000. (Note: There were 44.7 million uninsured non-elderly Americans in the U.S. in 2003.) The organization noted that the figure may actually be somewhat lower, but further research is needed. (EBRI)

What is the correct figure? Are many of the uninsured young people who would rather spend their money elsewhere? No matter the answers; the number of Americans who cannot afford health insurance is still too high. One can argue statistics, but the clear reality in the marketplace is that many of the jobs being created today offer little or no health insurance, and provide too little pay for workers to purchase their own. The problem is further exacerbated by employers who hire part-time workers whom employers don't have to insure.

The bottom line: Regardless of income, too many Americans are uninsured.

The National Association of Community Health Centers reported that the federal government has set in motion a five-year initiative to fund 1,200 new or expanded community health centers to serve an additional 6.1 million people. These health centers deliver preventive and primary care in medically under-served communities across America. (Bush)

Community health centers play a key role in addressing the access-to-care issues in under-served communities across the U.S. In many counties in Ohio – particularly southeast Ohio – community health centers fill the

vital need for preventive and primary care medical services. While there may be disagreement on some of the broad national health care policy issues, one hopes there is consensus on initiatives such as this.

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# OHIO

## STATES TAKE MEDICAID HIT

Medicaid stakeholders on a national basis continue to respond to the federal government's initiative to trim \$60 billion from the Medicaid program, while pursuing \$16.5 billion in new Medicaid and State Children's Health Insurance Program spending. The \$60 billion in proposed Medicaid spending reductions, which will take place over 10 years, are intended to curb inappropriate state spending, according to the U.S. Department of Health and Human Services. (FY 2006 Budget Cuts)

According to an opinion piece in the New York Times, the key problem with Medicaid is that it has been deputized to do jobs it wasn't created to do. Intended as a health insurance program for families on welfare and people with disabilities, Medicaid has gradually been stretched to cover for Congress's failure to deal with the millions of low-income workers without health insurance, and the refusal of Medicare to pay for long-term nursing care for the elderly. (Medicaid in the Cross Hairs)

Ohio is experiencing the same problems as most states when it comes to Medicaid. Ohio's problems are exacerbated because for years, this state has not addressed some fundamental expense and revenue issues that have significant effects on the overall state budget.

Ohio must take pro-active steps to make Medicaid programs more cost-effective. As noted in the New York Times piece, one fundamental issue with Medicaid in Ohio is the broadening of the program's focus, especially in the area of long-term care. One could easily have predicted this problem: It has become a significant element of financial planning for many Ohio families struggling to identify creative ways to drain mom's or dad's assets in order to become eligible for Medicaid for nursing home services. Ohio has a number of "blue ribbon" committees addressing

these multiple issues, but the hard part will be taking the appropriate steps to actually make a difference.

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## NORTHEAST OHIO

Northeast Ohio is fortunate to have a number of organizations focused on the overall economic well-being of the community and the vital role that health care plays. There appears to be a consensus that health care and its related sectors will have a major impact on our region's economic future. Organizations such as BioEnterprise, which explores the region's biotech future, and Team NEO, the regional economic development organization, are focusing aggressively on health care as a key sector.

At a "Meet the Champions Breakfast" on April 13, an exciting health-related initiative was unveiled. Jack Kleinhenz, formerly an economist for the Federal Reserve Bank of Cleveland, and local entrepreneur Terence Murphy have teamed up to explore the potential for a Center for Health and Disease Management in Northeast Ohio. They plan to integrate resources from the region's existing health care firms to develop "predict and prevent" medicine alongside "see and treat" medicine as a driver of the regional economy. The pair won a \$30,000 grant from the Civic Innovation Lab, which was launched by the Cleveland Foundation in 2003 to "support individuals with great ideas to grow Cleveland."

Congratulations to Jack and Terry, and to the others awarded Civic Innovation Lab grants: Melissa Williams, director of business development for the Buckeye Area Community Development Corp. in Cleveland's Buckeye neighborhood, and John Zitzner, president and founder of E City Cleveland. Both have B-W ties – students in our campus chapter of Students in Free Enterprise (SIFE) are mentors for high school students involved in an E City project with the Cleveland Municipal Schools, and Melissa had help from the B-W Business Plan Clinic in developing the business plan that accompanied her proposal to match entrepreneurs and potential small-businesspersons with local vacant storefronts. My colleague Phil Bessler, director of the B-W Business Plan Clinic and our SIFE chapter adviser, represented B-W at the breakfast.

# MARK YOUR CALENDAR

## B-W MBA OPEN HOUSES

If you're considering advancing your education, join us for an open house to meet the B-W faculty and learn about our MBA programs, including the Health Care MBA.

**Wednesday, April 20**

6 p.m.

Baldwin-Wallace College - Berea

**Tuesday, June 28**

6 p.m.

Beachwood Location

**Thursday, June 30**

6 p.m.

Baldwin-Wallace College – Berea

Berea Location:

120 E Grand Street

Strosacker Student Union

Room: Sandstone III

Berea, OH 44017

[Driving directions](#)

<http://www.bw.edu/quickfacts/directions/union/>

Beachwood Location:

25700 Science Park Dr. #100

Beachwood, OH 44122

[Driving Directions:](#)

<http://www.bw.edu/lifelearn/othersites/bwe/map/>

Please call 440-826-2392 for more information.



**Second Annual BioEnterprise Northeast Ohio Bioscience  
Industry  
Year In Review**

**Thursday, May 19th, 2005**

**HealthSpace Cleveland**  
**8911 Euclid Avenue**  
**5:30 - 7:30 p.m.**

BioEnterprise President Baiju R. Shah, in concert with officials from BioEnterprise's founding institutions, will present the annual review of the regional bioscience industry in Northeast Ohio on Thursday, May 19th, 2005 from 5:30 to 7:30 p.m. at HealthSpace Cleveland, 8911 Euclid Avenue.

The event will also feature presentations by Frank Samuel, Science and Technology Advisor to Ohio Governor Bob Taft, who will offer an overview of the Governor's Third Frontier program and its relationship to bioscience activity in the region, and John Rice, Managing Partner at Triathlon Medical Ventures in Cincinnati, who will discuss bioscience activity across the Midwest.

Shah will present a variety of data measuring activity in the region during 2004. His presentation will be followed by a panel discussion including Joe Hahn, M.D., Chairman of CCF Innovations at The Cleveland Clinic, Mark Coticchia, Vice President, Technology & Research Administration at Case Western Reserve University, and Michael Wojno, CEO of Summa Enterprise Group.

The event is free and open to the public, but will require pre-registration. Parking is available onsite in the HealthSpace lot, accessible off East 89th Street just north of Euclid Avenue. Overflow parking is available across the street on East 89th in the Mellon Center parking lot.

To register or for more information, contact BioEnterprise at [info@bioenterprise.com](mailto:info@bioenterprise.com) or by calling Mia Smith at 216.658.3973.

<http://www.bioenterprise.com/events/index.html>

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