Q4 HEALTH CARE REPORT

January 2006 Vol. 5

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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Sources cited in this Quarterly Health Care Report are listed at the end of each article. In addition, a complete source list may be found at the end of this e-newsletter.

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

This issue of the Quarterly Health Care Report continues the discussion on healthcare reform in the U.S. We will discuss ideas and initiatives from a variety of perspectives along with international comparisons.

COSTS

Trends Indicate Health Benefits Will Supersede Retirement Costs as the Largest Sector of Benefit Costs – What's the Long-term Implication?

Health benefits increased the most as a percentage of benefit spending from 1950 to 2004 of the three major benefit categories (retirement, health, other: Unemployment insurance, Workers' Compensation and Group life insurance). If these trends continue health benefits will replace retirement costs as the largest sector of benefit costs.

In 1950, health benefits accounted for 8.8% of all benefit spending; retirement benefits, 56.3%; and other benefits, 33.8%. By 2004, health benefits accounted for 43.2% of all benefit spending; retirement benefits, 47.1%, and other benefits, 9.8% (Figure 1). Since 1950, wages and salaries have declined as a share of total compensation (from 95% in 1950 to 81% in 2004), while benefits (driven mainly by health costs) have more than doubled from 5.5% to 19.0% over the same period (Figure 2). (EBRI)

Figure 1

The Changing Share of Employer Spending on Benefits, 1950–2004

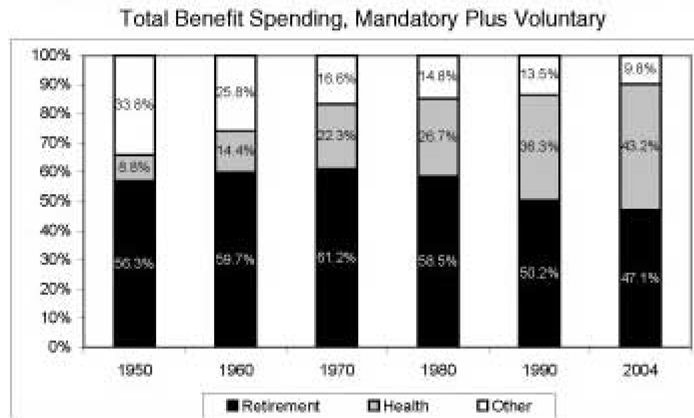
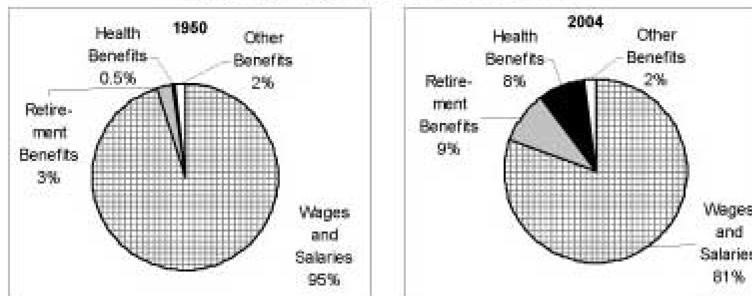


Figure 2

Changes in Total Compensation, 1950 and 2004
(including wages & salaries and benefits)



Source: Employee Benefit Research Institute tabulations based on U.S. Department of Commerce, Bureau of Economic Analysis, www.bea.gov/bea/dn/nipaweb/index.asp

Tom's Comments

As noted above, healthcare benefits will soon surpass retirement benefits as the largest segment of employer benefit costs as a result of: 1) the rapid escalation of healthcare expenses, and 2) the gradual reduction in employers' commitment to retirement benefits. A number of years ago it was common for many employers (especially large employers) to provide generous defined benefit programs that ensured a certain level of benefits to retirees.

Over time, these defined benefit programs were supplemented by employers generous matching in the employees' 401-k programs. The next step in the transition was the replacement of defined benefit plans with defined contribution programs, which limits the employer's financial liability. Now in has become more common in the private sector to

provide retirement plans that only include a 401-k plan that is only partially matched by the employer.
We are beginning to see the same phenomenon in the healthcare benefits world. Currently less that 60% of employers provide healthcare benefits to their employees, a steady decline from 69% in 2000 (The New York Times).

It was the Bush Administration's hope that high deductible programs (such as Health Savings Accounts) could potentially provide a vehicle for employers to begin offering health insurance to their employees. While some data supports this assumption, much of the growth of HSAs has been with employers that already offer health insurance to employees. Employers, small and large, are facing unprecedented competition on the local, regional, national and international marketplace. It would be a very realistic assumption that, given this competition, there will be a continued erosion of employers offering health benefits to their employees. The implications of this trend will be discussed further under the healthcare reform section of this QHCR.

Works Cited

McDonnell, Ken. "Finances of Employee Benefits: Health Costs Drive Changing Trends." Employee Benefit Research Institute (EBRI). Vol. 26, No. 12, December 2005.

QUALITY

Can Proactive Strategies Significantly Impact the Costly Side-Effects of Diabetes, Improving Patient Quality of Life?

The New England Journal of Medicine reported recently, a 17-year federal study confirmed intense control of blood sugar can reduce the risk of heart attacks and strokes among diabetics by almost 50%. The study involved those with Type 1 diabetes, which usually arises early in life and involves the death of insulin-secreting cells. Dr. Judith Fradkin, who directs diabetes research at the National Institute of Diabetes and Digestive and

Kidney Diseases, expects that the results would hold for Type 2 diabetes. (Note: Type 2 diabetes occurs later in life.)

Another large federal study is focusing on the correlation between controlling blood sugar with Type 2 diabetics and the impact on heart attacks and strokes. Per Dr. Fradkin, it is known that tight control of blood sugar in Type 2 diabetes protects against nerve, kidney, and eye damage, just as it does with Type 1 diabetes. "We want patients to say to their doctor, 'What is my A1c level? What should it be? And what can I do to get it there?" Dr. Fradkin said (The New York Times).

Tom's Comments

We have previously discussed diabetes and its impact on cost and quality of life in our April issue. As noted above, the negative side effects of both Type 1 and Type 2 diabetes can be controlled with proactive involvement by patients and physicians. Given the direct and indirect costs related to diabetes it would be in the payors' (employers and government) best interest to design a system that rewards the diabetic patients and their physicians for achieving clearly defined goals and targets for blood sugar levels.

Such a program, which initially may be a challenge to develop, could be relatively easy to monitor and maintain, especially for self-insured employers. Finally, any healthcare reform initiatives should include the necessary incentives that allow for employers, providers and patients to "win" when cost-effective quality care is provided, similar to the diabetic program noted above. See the healthcare reform section of this QHCR for further discussion on this topic.

Work Cited:

Kolata, Gina. "Diabetes Study Verifies Lifesaving Tactic". The New York Times. December 22, 2005.

Calls for a Federal Panel that Oversees the Creation of a National Health Quality System

The Institute of Medicine (IOM) recently called on Congress to form a federal panel of experts and fund it from the Medicare Trust Fund so as to create a national quality performance and measuring system for providers. In its report, IOM said the patchwork of voluntary public and private health care quality initiatives is unlikely to produce a coherent national quality program, necessitating federal leadership.

The IOM stated in its report that the NQCB should have seven key functions: 1) specify the purpose and aims for American health care; 2) establish short and long-term national goals for improving the health care system; 3) develop standardized performance measures; 4) ensure the creation of data collection and aggregation; 5) establish public reporting methods; 6) identify and fund research; and 7) evaluate the impact of performance measures on pay-for-performance and quality improvement programs.

Without national leadership, the report said attempts to incorporate quality programs into the nation's health care system will likely fail because national goals are unlikely to be set and translated into performance measures, the report stated.

Tom's Comments
Government leadership does not necessarily mean government control. The Federal Government, through its financial resources and its ability to mandate and tax, is in a very powerful position to play a leadership role in positively impacting healthcare cost, access and quality. The government, through its Medicare and Medicaid programs, and the National Institute of Health (NIH) already play a role, directly and indirectly, in the "quality" arena. As the IOM stated above in its report, "The patchwork of voluntary public and private health care quality initiatives is unlikely to produce a coherent national quality program which necessitates federal leadership."

We have discussed this "quality of care" issue in prior issues of the Quarterly Health Care Report. There are currently many quality initiatives occurring in the U.S. Initiatives are sponsored by MCOs, employer purchasing coalitions, state governments, etc. Medicare has also been

actively involved in the quality arena. Finally, a number of credible private organizations, (egg., Health Grades, see July 2005 issue of the Quarterly Health Care Report) have done a fine job in this area.

While all of the above represent noble efforts, as the IOM stated, "these are too fragmented and lack both the funding and the uniformity to make a measurable differences in quality." The added benefit to this centralized effort would be to marry this quality information with the "real cost information for healthcare services" so as to make purchasers of healthcare services, both payors (employers and government) and consumers, better decision makers. We will discuss this topic further under the healthcare reform section of this QHCR.

Work Cited

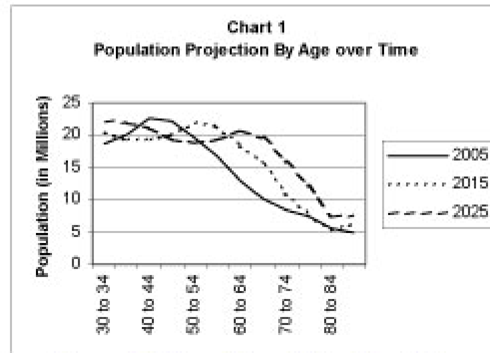
"IOM Recommends Federal Panel Oversee Creation of National Health Quality System," BNA's Health Care Daily Report, Volume 10, Number 231, December 2, 2005.

ACCESS TO CARE

Is Long-term Care Insurance a Good Investment From an Individual and Societal Perspective?

In 2000, adults over age 65 totaled 35 million individuals (12.4% of the population) but by 2030, this group will represent more than 70 million individuals or 20% of the population (see Chart 1 below) The impact of the growth of the over-65 population is expected to be felt beginning around the year 2010 when the baby boomers begin to turn 65. By 2040, the U.S. will see a threefold increase in the number of seniors over the age of 85. This trend creates a nagging problem for the insurance industry, tax payers and legislators alike: Who will pay their long-term care?

Chart 1 (Milliman Consultants)



Source: U.S. Census Bureau, National Population Projections-Summary Tables

Medicaid covers roughly two-thirds of nursing home residents, but this payment system is already hamstrung and is getting more precarious. States are aggressively looking at ways to control their Medicaid budgets and there will be increased scrutiny on "financial planning" approaches of spending down personal assets to achieve Medicaid eligibility for nursing home services.

Many Americans mistakenly assume that Medicare or private health insurance will cover the cost of long-term care. Because they believe that nursing home costs are covered by other sources, they fail to plan for their future long-term care needs. Only about 3% of people have long-term care insurance. However, the New England Journal of Medicine estimates that 43% of people turning 65 will eventually enter a nursing home. Nursing home services are expensive. The average annual cost of a semi-private room in a nursing home is $57,765.

More employers, including the federal government and many state governments, are making long-term care insurance available through payroll deduction, but participation rates among eligible employees are typically only 6% to 15%. Employee participation in these payroll deduction programs is negatively affected due to the fact that few employers contribute to the cost of the coverage and that the employee can only contribute after-tax dollars.

If we continue to ignore the need to plan for the aging population and their care needs, we will find ourselves in a state of crisis hurting millions of American families. The negative impact will affect families, employers, the government, the long-term care industry and will cost billions of dollars to society. Creating a safety-net to protect employees against the

financial destitution of a welfare system is the answer. If we act now and work collaboratively, investing for the future, we can avoid this looming crisis and ensure quality care for our loved ones and ourselves.

Work Cited

Shreve, John and Van Den Bos, Jill. "Long-term Care Coverage: The Missing Element in the Employee Safety Net." Milliman Consultants and Actuaries. 2005.

Tom's Comments

The data used to predict the pending crisis in long-term care is not hypothetical; it is indeed based on facts. These facts relating to the aging baby boomers and their impact on access to long-term care for the elderly have obviously been known for years. The next logical question should be if this pending crisis is inevitable why we have not addressed this proactively on a societal basis. Sadly, we have actually compounded the problems for the current and future elderly by failing to address the pending Medicare and Social Security crisis.

Two additional trends are occurring: 1) more employers are eliminating healthcare coverage for their retirees and 2) pensions once looked at as the safe harbor for the retiree are also under financial stress, which could impact their availability for millions of Americans (see Tom's Comments under the "Cost" section of this QHCR).

There has been some recent progress by Congress to address this long-term care insurance issue, but it is only the tip of the iceberg. "A new bipartisan bill (S 1602) sponsored by Sens. Chuck Grassley (R-I0wa), Hillary Rodham Clinton (D-NY) and Evan Bayh (D-Ind.) would attempt to address part of the issue by creating incentives for middle-income consumers to buy private long-term care insurance. The bill would require states to disregard benefits paid under LTC insurance when determining Medicaid eligibility and offer policyholders tax breaks for qualified LTC premiums." (California Healthline).

Any healthcare reform initiative should look at ways to incent employers, employees, providers and government to provide a "win-win" scenario. Self-interest drives a market system, and if stakeholders "win" by achieving a better societal good, we all win. Could an effective long-term insurance program be developed that encourages employees to withhold some of their pre-tax earnings starting at a young age to purchase long-term care insurance? If the contribution is small, uses pre-tax dollars and is partially matched by the employer there could be greater involvement by younger employees, which in turn would lower

the cost of the overall risk pool by the insurance company, which translates to lower costs for the older insured person.

For this approach to work, government (both state and federal) would need to provide tax incentives to employers and employees. The federal government would also need to develop a strict monitoring system for private long-term care insurance companies to ensure solvency of the organization. These organizations would be required to purchase "re-insurance" from the government or a reputable third-party to protect against bankruptcy. Ultimately both the federal and the state government will "win" if a larger percentage of retirees have long-term care insurance.

Finally, if there was a steady flow of guaranteed dollars flowing through this insurance system, providers would be incented to invest into creative long-term care ventures ranging from "quality services in the home, to long-term care communities, etc. that would provide a better "quality of life" opportunity for the senior.

Work Cited

Capozza, Karen. "Experts Debate Possible Effects of Long-term Care Insurance Bill." California Healthline, California Healthcare Foundation, October 19, 2005.

Healthcare Reform Ideas and Initiatives

Tom's Comments

The following is a continuation of the discussion on healthcare reform that began in the last issue of the QHCR. The cry for healthcare reform is increasing in the U.S. Issues of healthcare costs (as discussed in the first article in this issue of QHCR) will increasingly force employers to reevaluate ways to mitigate expenses, which in turn has resulted in more employers eliminating healthcare coverage (especially employers having fewer than 50 employees – see **"Ohio"** section of this report) for their employees.

All of this translates to 45 million uninsured Americans and many more Americans underinsured (see articles on this topic in all of the prior issues of the QHCR). Quality of care issues continue to become more of a problem in the U.S. (see January 2005 and July 2005 QHCR and the article in this issue relating to the creation of a national health quality system).

Finally, as stated in our last issue of the QHCR, we welcome feedback and ideas from our readers. If you have ideas, papers, etc. that you have prepared that express your perspective on the issues of cost, access and quality please forward them to me. Space permitting, we will use this publication as a forum for ideas on these important healthcare issues.

Should there be Limits on the Tax-exemption of Healthcare Benefits?

The initial focus of our discussion concerning healthcare reform will be directed to the financing side of healthcare benefits, that is the tax status of employee health care benefits. There is currently much debate in Washington D.C. concerning the proposal introduced in November of 2005 by the President's Advisory Panel on Federal Tax Reform.

Under the proposal, tax breaks for both employers and their employees for health benefits are limited to $11,500 of coverage for a family and $5,000 for an individual (these tax-exempt coverage's would apply to all taxpayers). Under current law, there are no limits to how much coverage is exempt from payroll and income taxes, and individual taxpayers currently cannot fully deduct the price of their health insurance from their taxes, it is subject to limitations).

The tax panel states in its report that tax benefits associated with health care cost approximately $141 billion or 12% of all federal income tax revenue in 2006. "The largest component of this cost is the employee exclusion from employer-provided health insurance and medical care, a tax expenditure of $126 billion," the panel said in its report. Moreover, the cost of the employee exclusion for employer-provided health insurance has tripled since 1986, that panel said.

Health tax expenditures disproportionately benefit higher-income taxpayers, according to the report. Citing estimates for the Lewin Group, the report said that, in 2004, families earning more than $1,000,000 annually received 27% of the tax benefits for health spending while families in this income sector represented 15% of the population.

"The current structure of the health insurance exclusion creates incentives that lead to inefficiencies in the market for health care. Because of the

tax-preferred status of health insurance, people are more likely to buy health insurance that provides more coverage than they would in the absence of the incentive," the tax panel said. In turn, workers who buy more health coverage likely would use more health services, thus increasing overall health spending, the report said. "Estimates are imprecise, but removing subsidies for employer-provided health insurance could lower private spending on health care by 5% to 20%," the report stated.

Finally, the report pointed to estimates by the Treasury Department that the panel's recommendation to cap the exclusion at the average health insurance premium and provide an equal deduction to all taxpayers who buy coverage in the individual health insurance market would reduce the number of uninsured Americans by 1 million to 2 million people. (BNA – 10)

Work Cited

"Opposition Looms to Limits on Tax Break for Employer-Provided Health Benefits," BNA's Health Care Daily Report, Volume 10, Number 227, November 28, 2005. The tax panel's report is available at http://www.taxreformpanel.gov/final-report/ The health care recommendations are explained in Chapter 5, pages 78 through 82.

Tom's Comments

The tax-exempt status of healthcare benefits has its roots in the wage and price controls era of the 1940s. The tax-exempt status of healthcare benefits was also a major catalyst in the increase in employer based insurance in the U.S. The down side to health insurance as noted in the Advisory Report is the fact that is does insulate the consumer of healthcare from the real costs of healthcare services, which further results in less accountability on their part.

There is merit in reviewing this issue of tax-exemption of healthcare benefits. Realistically, this tax-exemption will not be going away, at least in the near future. There may be a need for some upward limits on tax deductibility as stated in the Advisory Board's recommendations, and the ability for all taxpayers to have the ability to use pre-tax dollars to purchase health insurance definitely makes sense.

The problem with an idea like the Advisory Board is that it is too narrowly focused. Ideally, it should be part of an overall plan that addresses cost, access and quality issues on a more comprehensive basis. This incremental approach for change, while politically more popular, has the

risk of developing a fragmented solution that would not address the issues of cost, access and quality on a long-term and sustainable basis.

Two Proposals for Health Care Reform

I have included by reference two comprehensive proposals relating to healthcare reform. The first is by John A. Begala, A Senior Fellow for the Center for Community Solutions in Cleveland, Ohio. John is also an adjunct-professor in Baldwin-Wallace College's Health Care MBA program and he teaches "Power and Ethics." For the fill text of John Begala's paper titled, "The Methuselah Complex and the Right to Health Care" visit http://www.communitysolutions.com/store/item.asp?ITEM_ID=655&DEPARTMENT_ID=91

John's thoughtful paper identifies a number of interesting facts that support his assertion that the healthcare industry is an economic power and it will continue to grow in the U.S. John states, "The cornucopia of American health care accounted for 15.4% of 2004 gross domestic product (GDP), up from13.9% in 2001, and is projected by the federal Center for Medicare and Medicaid to increase to 19% over the next 10 years."

John further states that our competitors in the "new global economy" spend, by comparison, an average of 8.2% for the 30 countries in the OECD and an average of 5.4% of the GDP for non-OECD countries. John adds to his point that, "abundance in American health care is not limited to financial measures. Between 1992 and 2002, the number of health service jobs increased by 3.4 million to a total of 12 million, creating employment opportunities at every income and skill category."

John then cites, "The most obvious paradox to the above "abundance" is the fact that about 43 million citizens are without health insurance. Further – paradox within a paradox - they are not by and large the poor, who are insured by Medicaid and other public programs. Rather, the uninsured come primarily from working families whose breadwinners do not receive employer-based coverage.

John then discusses the ramifications of the aging of Americans in much detail and its implications on healthcare costs. Finally, John makes some very interesting observations and recommendations that should be read

in detail in his paper. John in his recommendations "combines the best ideas of conservatives and liberals into a new synthesis attuned to the realities of the day." Of specific note, is how he capitalized on his experience with Ohio's Commission to Reform Medicaid from 2003 to 2005 to ask that "is it possible for people with seemingly conflicting world views to reach agreement on literally hundreds of incremental steps to address problems of access and cost?" (Begala)

A comprehensive report by Leif Wellington Hasse is also attached for your reading. His report titled, "A New Deal for Health, How to Cover Everyone and Get Medical Costs under Control," "proposes, outlines, and defends the design of a new national health insurance system. The full text is available online at
http://www.tcf.org/Publications/HealthCare/newdealhealth.pdf
Such a system would be government sponsored, though not government run. The government would negotiate with private insurers, set minimum benefit packages for several levels of care, and make annual contribution for each American toward the purchase of a premium for a health care plan. This system would offer a basic, floor healthcare plan for all Americans while encouraging those who want more comprehensive coverage to join higher-end insurance plans."

Leif Wellington Hasse goes into much detail outlining and justifying his plan. He also reviews and comments on "other plans and initiatives" that are being discussed. He also believes that he has captured the best ideas from liberals and conservatives in designing this plan. As he states, "liberals ought to like this plan's universal coverage, insurance risk pooling, government sponsorship, and emphasis on public health. Conservatives ought to applaud the greater visibility of healthcare costs to the consumers and the emphasis on choice and competition under the plan." (Haase)

Tom's Comments
I like the approach that both John Begala and Leif Wellington Haase use to develop their recommendations. They focused on the real issues of cost, access and quality from both a micro and macro perspective, relied on their "real world experiences" and developed recommendations that were not strictly tied to a "philosophical ideology." There are multiple issues impacting healthcare today and we should focus on the "best solutions" based on facts, rather than strictly on an ideological bent. This would equally apply to both "liberals" and "conservatives." This is not to say that the potential solutions could not be based on a "market approach" to the problems or an overall "governmental approach" as

long as the ultimate objective is not to support a philosophy, but to make a better healthcare system.

Work Cited:

Begala, John A., "The Methuselah Complex and the Right to Health Care," Copyright 2005, The Center for Community Solutions, Cleveland, Ohio.

Haase, Leif Wellington, "A New Deal for Health, How to Cover Everyone and get Medical Costs under Control," A Century Foundation Report, 2005

International Comparisons

Tom's Comments

In prior QHCRs we discussed the potential value of studying healthcare systems from different countries. While there may not be a perfect fit for the U.S. we could learn from other countries experiences regarding what programs or initiatives could be beneficial to the U.S. I will attempt to provide below some information and websites for the readers to further study this issue.

"U.S. Health Care Spending in an International Context", Uwe E. Reinhardt, Peter S. Hussey, and Gerald F. Anderson, Health Affairs, 23 (3): 10-25, May/June 2004. This study used the most recent data from the Organization for Economic Cooperation and Development to explore why U.S. health care costs are so much greater than costs in other countries with much older populations. The authors point to several reasons for higher U.S. health costs: the fragmented financing system entails higher administrative costs; health care providers have greater market power than health care purchasers, allowing prices to soar above levels of other countries where the government exercises collective bargaining power; and the U.S. provides a more specialized, intensive form of care. (The Commonwealth Fund).

"Disease Management Programs in Germany's Statutory Health Insurance System," Reinhard Busse, Health Affairs, 23 (3): 56-57, May/June 2004. This study focuses on the introduction of disease management programs in 2002 into Germany's statutory health insurance pools, which cover

about 88% of the population. The author notes that this approach may be of interest in the U.S., where adverse selection has thus far hindered managed care efforts among the Medicare population. (The Commonwealth Fund).

"Reference Pricing for Drugs: Is it Compatible with U.S. Health Care?" Panos Kanavos and Uwe Reinhardt, Health Affairs, 22 (3): 16-30, May/June 2003. Reference pricing – in which insurers cover only the low-cost, benchmark drugs in a therapeutic class and patients pay the difference in price if they want higher-cost alternatives – is being used in Canada, Germany, and elsewhere in an attempt to control spending on prescription drugs. The technique has more commonly been used by insurers for such items as eyeglasses and wheelchairs, and its application to prescription drugs is rather novel. This study explores arguments for and against reference pricing, and discusses approaches that might work in the U.S. (The Commonwealth Fund)

Finally, we discussed in the January 2005 issue of the QHCR several articles by The Economist, July 15, 2004, edition, which focused on health care issues in the U.S. and other parts of the world. The theme of these articles is the importance of fostering competition in healthcare, and they sight some international comparisons that support their arguments.
(The Economist)

Work Cited

"Literature Review: International Issues of Health Affairs," http://www.cmwf.org/publications/publications_show.htm?doc_id=239397 The Commonwealth Fund, November 10, 2005.

"The health of nations," July 15, 2004, the Economist. http://www.economist.com/PrinterFriendly.cfm?Story_ID=2895909 Accessed July 21, 2004

"Keep taking the medicine." July 15, 2004. The Economist. http://www.economist.com/PrinterFriendly.cfm?Story_ID=2896004 Accessed July 21, 2004

OHIO

Only 44% of Firms in Ohio With Fewer Than 50 Employees Offer Health Insurance.

	Firms Providing Health Insurance to Employees	
	Ohio %	U.S. %
Firms with Fewer than 50 Employees	44.0	43.2
Firms with 50 Employees or More	98.5	95.4

Work Cited

Statehealthfacts.org, The Henry Kaiser Family Foundation, October, 2005.

Tom's Comments
The above statistics are very relevant to both Ohio and Northeast Ohio residents where much of the growth in employment is with firms with fewer than 50 employees.

NORTHEAST OHIO

Town Hall Meeting Set to Discuss Healthcare Access for the Elderly

Fingerhut, Spada & Kucinich representative Headline Meeting

WHAT: The future of healthcare access for the elderly in America's cities is the topic of a town hall meeting set at Baldwin-Wallace College. The town hall meeting is co-sponsored by Baldwin-Wallace College's Center for Innovation and Growth and OMNI Home Care. The meeting is open to the public.

WHEN: Saturday, January 21, 2006
1:30 p.m.-3:30 p.m.

WHERE: Baldwin-Wallace College
Ballroom
Strosacker Hall College Union
120 E. Grand Street
Berea, Ohio 44017

WHO: The town hall meeting panelists are:

- A Representative from U.S. Rep. Dennis Kucinich, D-Ohio
- State Sen. Eric Fingerhut, director, Baldwin-Wallace College Economic Development Education and Entrepreneurship
- State Sen. Robert Spada
- Ron Hill, executive director of The Western Reserve Area Agency on Aging
- Melvin Pye, administrator of Fairfax nursing home in Cleveland, Ohio
- Shirley Simon, Attorney

To register for the town hall meeting, or for additional information, please contact Gabriella Haslam of OMNI Home Care at 216-447-8339. The deadline to register is Friday, January.20, 2006.

# # #

Media Contact: Mary Hightower or Daryn Graham
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mhightower@tilsonpr.com, dgraham@tilsonpr.com

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