Q2 HEALTH CARE REPORT July 2005 Vol. 3

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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SOURCES

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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If you have any comments or observations concerning this Quarterly Health Care Report or you are interested in more information on Baldwin-Wallace College's Health Care MBA Program, you can contact Tom Campanella at: tcamp@bw.edu.

COSTS

HEALTH CARE SPENDING TRENDS

The total health spending per privately insured person increased 8.2% in 2004 (Exhibit 1), a rate of growth that was virtually unchanged from 2003. Health spending outpaced overall economic growth by a wide margin (2.6%), despite a 5.6% nominal increase for the U.S. economy, as measured by per capita gross domestic product (GDP). A review of the changes in health care spending over the last 10 years (Exhibit 1) provides a better understanding of the drivers of today's health care costs. As noted in Exhibit 1 below, the trend for spending on hospital outpatient services was by far the fastest growing category of health care spending. Taken together, growth in spending on inpatient and outpatient hospital care accounted for 54% of the total increase in health care spending in 2004.

EXHIBIT 1
Annual Per Capita Percentage Change In Health Care Spending And Gross Domestic Product (GDP), 1994–2004

Year	Change in spending on type of health care service (%)						Percent of GDP
	All services	Hospital inpatient	Hospital outpatient	Physician	Prescription drugs	All other	
1994	3.5	-2.3	8.0	2.1	5.1	12.3	4.9
1995	4.2	-3.7	7.0	2.6	10.7	8.6	3.4
1996	4.2	-4.6	7.0	2.2	10.8	12.0	4.4
1997	5.6	-5.4	8.9	4.1	11.4	11.8	5.0
1998	7.1	0.0	7.7	5.6	13.6	7.6	4.1
1999	9.9	2.6	11.6	6.7	18.1	5.5	4.8
2000	9.3	4.0	9.8	7.7	14.2	4.4	4.8
2001	11.3	8.6	14.5	7.8	13.5	9.1	2.1
2002	10.7	8.2	13.0	7.9	13.1	6.2	2.5
2003	8.4	6.1	11.1	6.4	8.9	5.8	3.9
2004	8.2	6.2	11.3	6.4	7.2	6.0	5.6

SOURCE: Health care spending data are from the Milliman Health Cost Index ($0 deductible, revised weights). Gross domestic product (GDP) is from the U.S. Department of Commerce, Bureau of Economic Analysis (BEA).
NOTES: GDP is in nominal dollars. Estimates differ from past reports because of data revisions by Milliman and the BEA.

Trends in prescription drug spending, while continuing to be significant (21% of the total increase in health care spending in 2004), decelerated for the fifth year in a row. The continuing slowdown in 2004 is largely the result of slower growth in drug prices rather than a change in use (Exhibit 2). Prescription drug prices increased just 3.3% in 2004 compared with 5.2% in both 2002 and 2003. This likely reflects, in part, a movement toward three-tier co-payments, which have now become common in health benefit offerings, as well as the continuing growth of those co-payments across all three tiers. (Note: See April's 2005 issue of the Quarterly Health Care Report for more information on "Employer Efforts to Control Rising Drug Costs.")

Exhibit 2

Decomposition Of The Prescription Drug Spending Trend, 1995–2004

Year	Annual percent change per capita		
	Spending on prescription drugs	Prescription drug prices	Quantity[a]
1995	10.7	1.9	8.6
1996	10.8	3.3	7.3
1997	11.4	2.6	8.5
1998	13.6	3.8	9.5
1999	18.1	5.7	11.7
2000	14.2	4.4	9.3
2001	13.5	5.4	7.7
2002	13.1	5.2	7.5
2003	8.9	5.2[b]	3.5
2004	7.2	3.3	3.8

SOURCES: Data on prescription drug spending are from the Milliman Health Cost Index ($0 deductible). Prescription drug prices are from the Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) for prescription drugs and medical supplies (data accessed 15 April 2005).

NOTE: Estimates differ from past reports because of data revisions by Milliman and the BLS.

[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 18 in text.

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"Tracking Health Care Costs: Declining Growth Trend Pauses in 2004," Center for Studying Health System Change, June 21, 2005.

DOCTORS LEVEL CHARGES AT HEALTH INSURER

Three medical associations representing physicians from the St. Louis area notified United Healthcare in May, 2005 that its pilot program that steers patients to select providers is a violation of the standard contract the insurer executes with all of its network physicians. United has said it created the "Performance" product to identify high-quality, moderate- to low-cost physicians in 13 pilot markets. It used its claims database to evaluate doctors on adherence to accepted standards of clinical practice and cost efficiencies. This methodology was attacked by area physicians, stating that, among the shortcomings, United's approach did not adequately account for the severity of the patient's illness. The benefit design varies among the companies, but generally, employees who use "star" providers get a better insurance benefit. They can still select a non-star doctor from the broader United Healthcare network and receive services at a standard discount negotiated by United. Early adopters to this product include General Motors Corp. and Daimler Chrysler Corp. (VandeWater).

I am not in the position to evaluate the merits of the argument that the above managed care product is a violation of the standard contract between the St. Louis area physicians and United Healthcare. However, I do know this overall issue is not going away. Employers such as General Motors are demanding that managed care organizations find more effective ways to control healthcare costs. The theory behind selecting physicians based on cost and quality criteria has been debated for years in the world of managed care. As a result of economic pressures on companies, there will continue to be increased cost shifting to employees that will result in significant increases in co-pays and deductibles. Also, as noted in the Access section of this issue of the Quarterly Health Care Report, the numbers of underinsured and uninsured continue to grow. The combination of this negative impact on employers and consumers will increase the demand for user-friendly data on health care providers. For further discussion on this issue refer to the three articles in January 2005 issue of the Quarterly Health Care Report, "Consumer-Directed Health Plans," "Hospital Quality," and "Nursing Home Quality" .Additional discussion on this issue can be reviewed in the April 2005 issue of the QHCR, "Consumer Organizations Want Reports on Hospital Quality." Finally, see the Quality Section of this issue of the QHCR for an up-to-date review of quality initiatives.

WORKS CITED

"Doctors level charges at health insurer," St. Louis Post-Dispatch, May 26, 2005.

QUALITY

SAFETY GAP WIDENS BETWEEN BEST, WORST HOSPITALS

Hospital-based patient safety incidents have increased slightly at the nation's hospitals, yet the highest performing facilities have become even safer. This situation has resulted in a widened gap in patient safety incident rates among the nation's best and worst hospitals, according to a study of 39 million patients' records released recently by HealthGrades. "A 'culture of safety' requires rapid identification of errors and root causes and the successful implementation of improvement strategies, which can only be achieved through strong leadership, critical thinking, and commitment to excellence. For patients, it's important to know which hospitals meet this standard, as they are, on average, 50% less likely to have an incident at hospitals in the top 10%, according to a recent study in American Hospitals Report. http://www.healthgrades.com/media/DMS/pdf/PatientSafetyinAmericanHospitalsReportFinal42905Post.pdf

In the April issue of the Quarterly Health Care Report we discussed Medicare efforts to report "Hospital Quality. There is also a Web site called "Hospital Compare," which was created by the Hospital Quality Alliance, a public-private collaboration that includes the Centers for Medicare & Medicaid (CMS), a number of health care and consumer organizations, and other federal agencies (http:n//www.hospitalcompare.hhs.gov)

http://www.healthgrades.com/media/DMS/pdf/PatientSafetyin

WORKS CITED

"Safety Gap Widens Between Best, Worst Hospitals, Study Says," BNA's Health Care Daily, Volume 10 Number 85, May 4, 2005.

WELLNESS PROGRAMS ARE GAINING MOMENTUM

Ninety-five percent of employers surveyed recently by accounting firm Deloitte & Touche USA LLP either have implemented or are considering implementing wellness programs. One of the biggest challenges to wellness programs is convincing employees to participate. This survey found that nearly two-thirds of the companies surveyed had 25% or less participation. Employers are recognizing the need for incentive programs to spur employee participation. Incentives can take the form of cash payments, reduced co-pays, and rebates on program costs, as well as gift certificates, prizes and free membership to on-site exercise rooms. (Jennifer Gordon)

WORKS CITED
"Wellness bandwagon draws companies," Jennifer Gordon, Dallas Business Journal, July 4, 2005.

Recently, similar to the private sector, state and county governments have expanded their wellness programs. King County in Florida is an example of such a trend. Its program works as follows: All county employees will be given a choice – participate or don't. Those who ignore the program will see co-pays, deductibles, and co-insurance rates rise to the most expensive of three pricing tiers. Employees who participate will score points for a variety of activities and lifestyle choices. More points translate into lower out-of-pocket costs. Initially, participants will meet with a physician to develop a health assessment and personal goals. The assessment might include such goals as increased exercise, eating more fruits and vegetables, or cutting back on alcohol consumption. Individual health assessments will never be seen by county overseers but will instead be passed along to a third party agency, yet the overseers will monitor employee participation and progress. The agency will protect the employees' privacy, telling the county only whether an employee is participating. At each year's end, employees will receive a report card that determines how much they will pay. (Dean Paton)

While the jury is still out as to the exact short and long-term financial benefit to the employer for implementing wellness programs, it is very clear that incentives increase the likelihood of compliance. The combination of increased education and appropriate incentives should result in a more effective wellness initiative. Employers should also attempt to publicize individual success stories to further enhance the programs.

WORKS CITED
"How it will pay to stay fit in Seattle," The Christian Science Monitor, May 5, 2005.

ACCESS TO CARE

HOW MANY ADULTS ARE UNDERINSURED?

Estimates of the number of insured people whose coverage is inadequate will clearly vary depending on the method and measures used to categorize insurance. A study by the Commonwealth Fund attempts to calculate this underinsured number using a number of assumptions. The study used indicators of financial risk to define underinsured, as it assessed risk by comparing cost exposure to family income. About 25% of adults – an estimated forty-five million people – were uninsured for all or part of 2003, based on the survey (Exhibit 3). When uninsured adults were added to those who were underinsured based on the financial indicators, the study found that an estimated sixty-one million adults or 35% of the population ages 19-64 had either no insurance, sporadic coverage, or insurance that exposed them to catastrophic medical costs during 2003.
(Health Affairs, June 14, 2005).

EXHIBIT 2
Percentage Of People Ages 19–64 Who Were Uninsured And Underinsured, By Various Characteristics, 2003

Characteristic	People ages 19–64: Insured, not underinsured (n = 2,031)	Underinsured (n = 310)	Uninsured during the year (n = 952)	Among insured adults, percent who were underinsured (n = 310)
All adults, millions	110.9	15.6	45.5	15.6
All adults, percent	65%	9%	26%	12.%
Age (years)				
19–29	51%	9%	40%	16%
30–49	66	8	26	11
50–64	74	11	15	13
Sex				
Male	67	6	27	9
Female	62	12	26	16
Race				
White, non-Hispanic	70	9	21	12
Black, non-Hispanic	54	9	37	15
Hispanic	44	9	47	17
Income				
Less than $20,000	31	17	53	36
$20,000–$34,999	47	17	35	27
$35,000–$59,999	79	5	16	6
$60,000 or more	93	3	4	3
Poverty status				
Under 200% of poverty	32	19	49	38
200% of poverty or more	83	4	13	5
Health status				
Excellent/very good	73	7	21	8
Good	60	9	30	13
Fair/poor	46	17	37	27
Chronic conditions				
Heart disease, cancer, diabetes, or arthritis	61	15	24	19
None of the above	66	7	27	10
Health status				
Healthier	69	7	24	9
Sicker[a]	57	13	30	19
Family structure				
Single, no children	53	10	36	16
Single, with children	51	10	38	17
Married, no children	76	8	17	9
Married, with children	70	9	22	11

SOURCE: Commonwealth Fund Biennial Health Insurance Survey, 2003.

NOTES: Exhibits indicate unweighted sample size and adult population estimates in millions. Rows may not add to 100 percent because of rounding.

[a] Includes adults in fair/poor health with any of the four chronic diseases or a disability.

As with any study one could attack the conclusions based upon a number of perspectives. Were the assumptions appropriate? Were the survey methodology and numbers of respondents statistically significant?
Were the conclusions of the study supported by the data? Also as with many studies the predisposition of the reader may cause someone to agree or disagree with the findings. I believe that most objective readers would agree that there is a significant number of underinsured in the U.S. Is that number 16 million as noted in this study? Rather than getting bogged down in detail, I believe it would be reasonable to conclude that the underinsured represents a statistically significant number, which has grown over the last few years as a result of significant increases in cost-sharing. All of this will have an impact on future U.S. health care policy decisions as we struggle to address the cost, quality and access to care.

WORKS CITED

"Insured But Not Protected: How Many Adults are Underinsured?" Health Affairs, June 14, 2005.

CHARACTERISTICS OF THE UNINSURED: A VIEW FROM THE STATES

The Robert Wood Johnson Foundation (RWJF) commissioned the State Health Access Data Assistance Center (SHADAC), located at the University of Minnesota School of Public Health, to develop a comprehensive state-by-state analysis of Americans without health care coverage. To have access to this report go to the State Health Access Data Assistance Center Web Site: www.shadac.org

OHIO

We are becoming all too aware on a daily basis about the extent of the State of Ohio's budgetary crisis. Much of the focus is on the current financial problems facing the state. As significant as these issues are they could be dwarfed by the potential long-term financial issues facing the state. Except for certain pockets in the state (egg., Columbus), most of the state is experiencing an economic downturn. The loss of jobs has been especially significant in the areas of the state that historically relied on manufacturing. Many people are counting on the sustained growth of the health care sector, along with the emergence of the biotech industry, as our hope for the future. While there is much promise in these areas, we must develop a comprehensive short and long-term public-private partnership that goes beyond the self-interest of each of the participants. While it may sound trite, efforts that will ultimately allow us to increase the "size of the pie" in regards to economic growth will result in sufficient slices of the pie for all of the participants. There will continue to be major cutbacks to our core state priorities in the areas of education, health care, and long-term care if we do not aggressively address these issues.

NORTHEAST OHIO

National Conference for Community and Justice

A disturbing, yet uplifting all-day program on access to care issues occurred in February. The program was titled, "Unequal Treatment." It was facilitated by The National Conference for Community and Justice (NCCJ) and confronted racial and ethnic disparities in healthcare. The day was disturbing in that it brought to light both the presence of racial and ethnic disparities in healthcare and the real impact on lives. The day was uplifting due to the high energy in the room and the combined message of proactive education and confrontation. If you would like more information on this issue, The National Conference for Community and Justice, 3645 Warrensville Center Road, Suite 320, Cleveland, Ohio 44122; Telephone: 216-752-3000;
Website: www.nccj-northernohio.org

Team Northeast Ohio (NEO)

Team Northeast Ohio (NEO) is a private-sector-led, non-profit regional economic development organization. It acts as the regional catalyst to understand the needs of the key industries of the region and develop public-private partnerships to provide solutions to address them. Through this role, Team NEO serves as the first point of contact for businesses in targeted industries that are seeking to locate or expand in Northeast Ohio.

The region has a rich asset base in health care and bioscience, including 62 hospitals, 7 educational institutions supporting health care and bioscience PhD programs, 400 bioscience companies and more than 350,000 health care/bioscience workers. These are businesses that can leverage the availability of medical and clinical technicians, the high investment in research and development, the presence of world class educational institutions and the low real estate costs to best position themselves to drive economic growth.

Northeast Ohio is characterized by:

- World class provider institutions such as the Cleveland Clinic Foundation, the University Hospitals Health System, The MetroHealth System and Summa Healthcare
- Research institutions including Case Western Reserve University, the Cleveland Clinic and the Lerner Research Institute, Cleveland State University and University Hospitals of Cleveland
- Suppliers like SourceOne, Philips and Hitachi Medical Systems, STERIS Corporation, and Invacare

- Bioscience companies and incubators including Ricerca and BioEnterprise; the region offers fertile ground for health care and bioscience firms to grow.
- Clinical areas including cardiovascular, cancer, neurological diseases, pediatrics, respiratory and urology.
- Industries promising high growth potential include bioinformatics, bio-manufacturing/processing, biomaterials (bio-fuel/bioenergy, bioplastics), bio-remediation/environment, biosafety (detection, sterilization), cancer, cardiovascular, children, diagnostics and imaging, medical devices and regenerative medicine, neurological diseases, nutraceuticals/food processing, respiratory, and translational medicine (care delivery, medical support, clinical trials).

For more information, contact Susan Luria, Industry Lead for Healthcare/Bioscience, at (216) 363-5414 or sluria@teamneo.org.

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- What will be the future of health care in the U.S., and how will it effect your organization?

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Contact Pat Ray to register
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"Doctors level charges at health insurer," St. Louis Post-Dispatch, May 26, 2005.

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