

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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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.

Baldwin-Wallace College, founded in 1845 in Berea, Ohio, combines the personalized attention of a small school with the degree and course options of a large university. The Business Division's Health Care MBA, International MBA, Executive MBA, Entrepreneurship MBA, Accounting MBA and Human Resources MBA programs, as well as undergraduate programs, provide a unique blend of business theory and hands-on application, calling on a distinguished faculty who are scholarly, yet grounded in real-world experience.

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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 by e-mail at: tcamp@bw.edu

INTRODUCTION

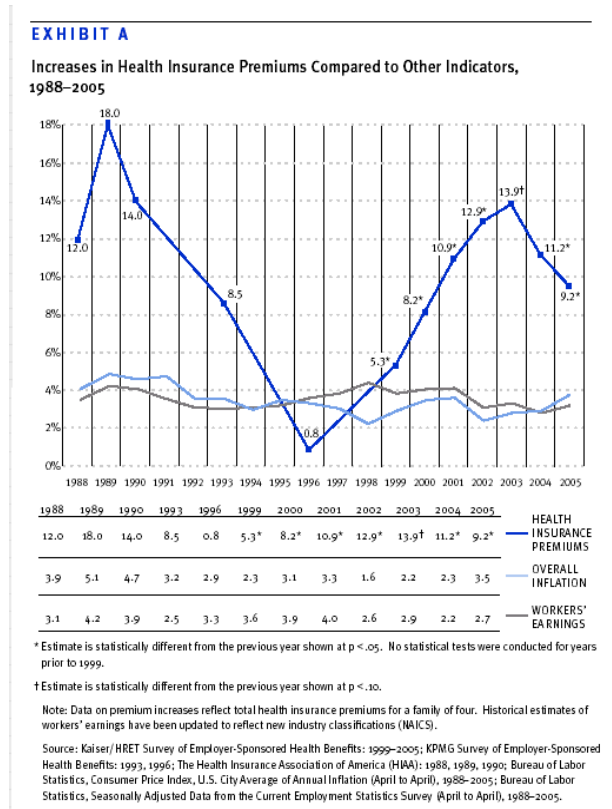
This issue of the Quarterly Health Care Report focuses on issues of cost, access and quality of care from the consumer and employer perspective. It also offers a discussion on a variety of approaches to U.S. healthcare reform.

COSTS

Premium Growth Slows, but Employers Still Continue to Drop Health Insurance

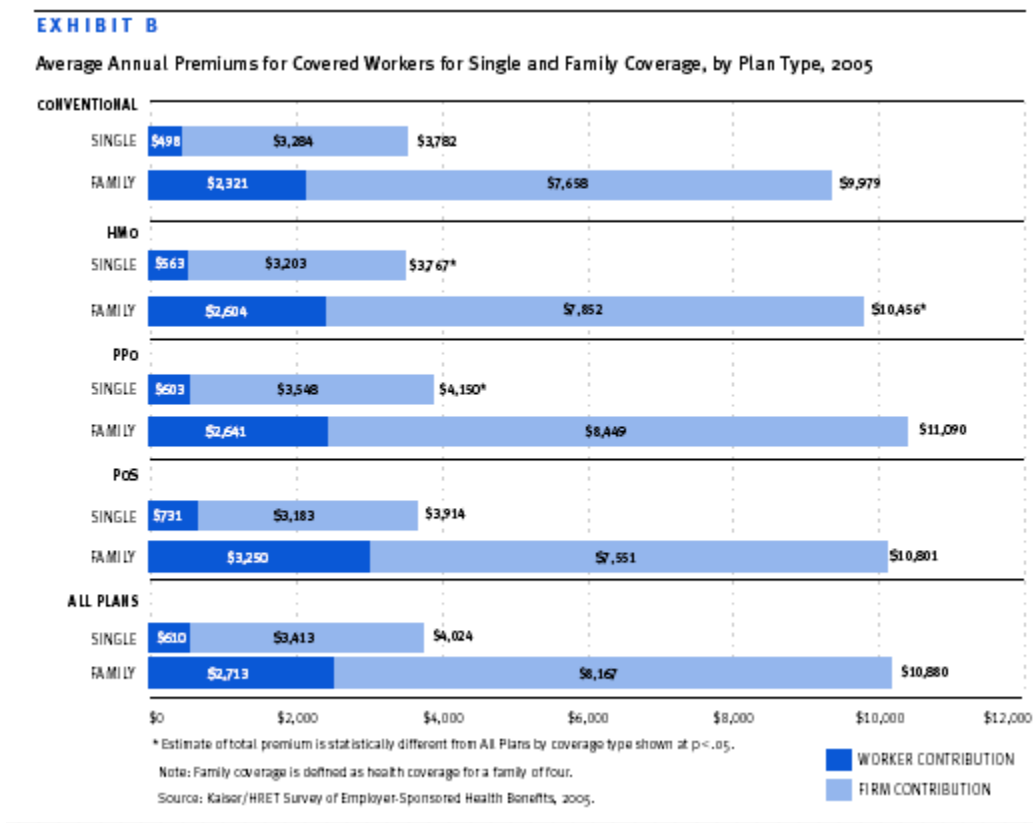
The key finding from Kaiser Family Foundation and the Health Research and Educational Trust 2005 survey shows that the rate of growth of health insurance premiums declined for the second straight year, slowing to 9.2% in 2005 (Exhibit A), and the percentage of all firms offering health benefits to their employees has fallen significantly from 69% to 60% over the last 5 years.

Exhibit A



Despite this slowdown, premiums continued to increase much more quickly than overall inflation and wage gains. Since 2000, premiums for family coverage have increased by 73% compared with inflation growth of 14%. During this same period, wages increased by 15%. Average premiums for employer-sponsored coverage rose to \$4,024 for single coverage and \$10,880 for family coverage (Exhibit B)

Exhibit B



Note: Hewitt Associates and Mercer Human Resources separately reported increases in healthcare costs for employers of 9.2% in 2005. Hewitt is projecting a 9.9% increase in 2006 and Mercer is projecting a 10% increase (assuming no changes in benefits).

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What are Health Savings Accounts (HSAs)?

Akin to an individual retirement account, contributions may be made with pretax dollars to HSAs. Their balances may be withdrawn to pay medical claims, again without payment of tax. If not spent, HSA contributions accumulate, are invested, and can be spent on health services in subsequent years. Better yet, unspent balances belong to the account holder, not the employer, and can be moved when the enrollee leaves a job. Funds can be spent only on services considered by the IRS to be medically related, but the range of qualified services is broader than the coverage provided by most insurance policies and may include dental, vision, and complementary medicine services. The HSA expands the tax preference for health-related expenditures beyond the premium paid by the employer to encompass the out-of-pocket costs incurred by the employee, and, best of all, it can easily be used by persons who purchase insurance without an employer subsidy.

HSAs receive favorable tax treatment only when accompanied by an insurance policy with a high deductible. Typically they are managed by a preferred-provider organization (PPO) or managed care organization (MCO), to cover the expenses of a catastrophic illness. By law, HSA-compatible deductibles must be at least \$1,000 for an individual and \$2,000 for a family, but substantially higher deductibles can be found in the insurance market. When paying for medical services, the enrollee first uses funds from the HSA until the funds are exhausted, and then uses personal, after-tax income (the so-called doughnut hole) until expenses reach the deductible threshold. The enrollee then continues paying part of the costs incurred, typically 20 to 30 percent, until the annual maximum for out-of-pocket payments is reached, after which the PPO/MCO pays all the costs.

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How Do Health Savings Accounts (HSAs) and other Consumer-Directed Health Plans (CDHPs) Impact Quality and Cost of Care?

In September, Cheryl L. Damberg, Ph.D, provided a summary of findings to the Department of Insurance for the State of California concerning a recently released RAND-California HealthCare Foundation report on the effectiveness of Consumer-Directed Health Plan approaches. She specifically looked at high deductible plans (with and without personal HSAs). A Senior Policy Researcher for the RAND Corporation, Ms. Damberg, concluded there would be a one time savings to the employer of 4% to 15%. It is not known whether high deductibles will constrain the growth in spending or just lead to this one-time reduction.

There is evidence that most of this growth in spending can be attributed to technology innovation, and there is little evidence that greater cost shifting to employees will slow the adoption of new technology.

There is also emerging evidence that the newest HSA products may initially be more popular among small businesses and individuals; some smaller businesses that might not otherwise offer health insurance see these as a way to provide low cost coverage.

(Note: About 2% of all firms offering benefits reported offering an HSA-qualified High Deductible Health Plan (HDHP). In firms with these plans, about 15% of workers participate; although the participation rate in larger firms is significantly lower (3%). About 810,000 are covered by an HSA-qualified HDHP offered by their employer-about 1.2% all covered workers. (Health Affairs)

Finally, Ms. Damberg discussed the importance of information and decision support as consumers are asked to weigh trade-offs in selecting providers or treatment options – decisions that have both financial and health implications. Per Ms. Damberg, various problems exist today in the provision of consumer information:

- 1) limited information collected and publicly available;
- 2) a lack of standardization in measurement and reporting to enable consumers to compare performance across providers and treatment;
- 3) the information currently provided to consumers is not easily evaluated and consequently may be confusing or create the potential for the consumer to make the wrong choice.

Presentation format and design is critical in influencing how people weigh their choices and whether they focus on and comprehend the information. The evaluation of the information becomes critically important because there is

more at stake, the choices are more complex, and the volume of information is likely to be greater – all of which may overwhelm the consumer. (Damberg)

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Damberg, Cheryl L. "Consumer –Directed Health Plans, Research on Implications for Health Care Quality and Cost, Testimony before the California Department of Insurance on September 20, 2005" Rand Corporation Testimony Series. California: The RAND Corporation, 2005. <www.rand.org/>

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Without User-Friendly Consumer Health Information on Cost and Quality of Services, HSAs and CDHPs represent only Cost-shifting to the Employees.

As noted in the RAND Study above, consumer health information is critical to the success of Consumer Directed Health Plans (CHHP). Beyond the impact on CDHPs, per Joshua Seidman, Ph.D, Executive Director, Center for Information Therapy in Washington D.C., consumer-centered health care offers opportunities to empower patients with knowledge, improve overall health, deliver services more efficiently, and save money. But these opportunities could be lost if consumer health information and tools become a roadblock instead of a bridge. National standards need to be developed which focus on meeting the information needs of consumers in ways that maximize the likelihood of high-quality (cost-effective) care.

Among the key issues needing study are:

- The critical elements that would enable a robust interaction of electronic content, tools, and infrastructure.
- Mechanisms for translating clinical terminology into lay terminology.
- Common protocols for transmitting consumer content.
- A common vocabulary that accommodates all moments of care.
- The types and range of tools necessary to achieve a smooth flow of consumer-friendly information.
- Ways to evaluate the quality of consumer health information – its credibility, accuracy, and comprehensiveness.

Dr. Siedman concluded his remarks by stating national standards would provide common ground for advances in consumer-centered health care. Without standards, the efficiency of services, patient empowerment, cost savings, and better consumer health promises could be seriously compromised in the years ahead.

Tom's Comments:

The government through its power to tax, regulate and spend dollars (Medicare, Medicaid, etc.) is in a powerful position to influence healthcare policy. Dr. Siedman expresses a concern that there is a need for standardization of consumer healthcare information. There is some merit to his concerns. The current state of consumer healthcare information is lacking both substance and simplicity. This statement is not as contradictory as it might sound. Credible data needs to take into consideration the acuity of the patients, but its conclusions must be presented in a user-friendly manner (egg. graphs, trend lines, star ratings). A simplistic example of such a reporting system would be Morningstar's comparison of mutual funds based on quality, risk, cost, historical factors. Morningstar uses a combination of stars and number ratings along with graphs to illustrate its conclusions. Another example would be Consumer Report's ratings of automobiles. Both of these examples are simplistic, yet illustrative.

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Siedman, Joshua. "Consumer Health Information in an 'Interoperable' World, Issue Brief", California Health Care Foundation. Washington D.C., Sept. 2005. <www.chcf.org>

Would You Buy a Car without Cost and Quality Information?

Tom's Comments

Would anyone ever think about buying a car, house, clothes, etc. without knowing the actual price of the product? Comparison shopping for healthcare services does not exist. Employers and consumers cannot obtain the actual costs of hospital, physician, and ancillary services. They may get averages if they are lucky, but they will not get adequate cost information to make prudent purchasing decisions. Consumers need real cost-information with user-friendly quality and service information to make an informed decision.

Why is this information important to employers? Employers who are either self-insured (bears the risk of claims utilization) or fully-insured (pays an annual premium to an insurance company who bears the risk) cannot effectively control healthcare costs or initiate quality programs for employees without this data.

Why is this information important to employees? They are impacted by the real cost of healthcare when it is applied against their deductibles. This was less of an issue for employees when they had little or no deductible as part of health insurance plans. As deductibles now begin to increase and as many employers

begin to shift to Consumer Directed Health Plans (CDHP), employees will see the impact of the "real costs of healthcare services."

The theory behind CDHPs is that this new incremental cost burden will transform the consumer to a prudent purchaser of healthcare services. Unless the consumer has "real cost and quality data" at the point of service, it becomes a mere cost shifting rather than an exercise in prudent purchasing. Obviously this will have cost and quality of care implications for consumers.

Employees are also impacted indirectly by not having "real cost" and quality information. Employers absorb the majority of healthcare costs. Consequently cost increases will also adversely effect healthcare coverage, salaries, wages, and retirement benefits. Beyond this immediate impact to the employee, in this era of regional, national and international competition, sky-rocketing healthcare costs affects the very survivability of the employer (egg. General Motors, etc.).

Some managed care organizations are beginning to evaluate the feasibility of supplying some "real cost" information to employers and employees, but this is just in its infancy. This "real cost" information could then be combined with quality information which would conform to national standards as discussed in the prior article. In our market-based economy, the more employers and employees demand access to this information the greater the likelihood of accessing this information. If this marketplace approach fails, the government (state and/or federal) might be forced to legislate such a requirement.

In summary, the introduction of credible, user-friendly data on cost and quality of healthcare services would provide an opportunity to positively reshape the healthcare industry. This search for value (cost-effective quality care) by employers, consumers and the government would force the healthcare industry to respond. There are examples of this revolution with other industries such as automotive, computer, airline, telecommunication, etc.

QUALITY

Good Health Pays Off! The Fundamentals of Health Promotion Incentives

Researchers estimate preventable illness makes up approximately 70% of the total cost of health care. Preventable illnesses are related to a reasonably standardized and well-researched set of modifiable health risk factors including nutrition, weight control, exercise, cholesterol, blood pressure, safety, and mental well-being. A theoretical view of the stages of cognitive behavior is shown in Figure 1 below. Individuals attempting a change will progress through the stages as their motivational readiness increases.

Figure 1
The Stages of Change

1. Precontemplation	Not considering change
2. Contemplation	Considering change
3. Preparation	Planning to act
4. Action	Practicing the new behavior
5. Maintenance	Sustaining the new behavior

Movement beyond the first two stages requires awareness, which can be achieved by educating employees about the benefits of positive lifestyles and the detriments of unhealthy behaviors. Education alone, while an important first step, will motivate only a small percentage of a population to take action. Stronger motivational forces are necessary for most of us. This is where incentives come into play.

An optimum incentive program utilizes the simplest, most cost-effective incentives that cause the maximum number of individuals to move from a stage of contemplation to action. Furthermore, the best incentives will catalyze long-term lifestyle changes, so that when the rewards are removed the desired behaviors will continue due to intrinsic reinforcements. A key objective of employer-sponsored (or external) incentives is to motivate individuals to take action and maintain the new behaviors until their own internal reinforcements take over to sustain the positive changes.

Incentives can be thought of as either carrots (desirable rewards) or sticks (undesirable consequences). Incentive rewards can also be tangible or intangible. Tangible rewards include cash, merchandise, prizes, vacation days, reducing health care premiums and copays, and avoidance of costs (such as reduced health care premiums). Intangible rewards include recognition, personal challenges, group competition, and a sense of belonging, acceptance, and approval of peers. Incentive rewards are the most meaningful and effective when they are closely tied to the behaviors they intend to reinforce.

Rewards fall into two basic categories: activities and achievements. These options frame a fundamental question that employers must consider when designing an incentive program – should their program encourage and reward specific activities related to low-risk behaviors, or should it reward demonstrated measurable results? There are potential benefits and disadvantages to each approach, as outlined in Figure 2.

Figure 2
Pros and Cons of Activity-Based vs. Achievement-Based
Wellness Incentive Rewards

Activity-Based Rewards	Achievement-Based Rewards
Pro	Pro
<ul style="list-style-type: none"> - Motivate incremental action steps toward healthier lifestyles - Might be more readily achievable for all individuals - Effective at building health awareness by rewarding educational activities and seminars - Can be perceived as more "fair" because they reward effort rather than inherent health factors 	<ul style="list-style-type: none"> - Easy to measure - Focus on individual accountability for personal health management - Metrics quantify real risk reduction through incremental progress - Can measure how well low-risk individuals maintain their good health
Cons	Cons
<ul style="list-style-type: none"> - Performing specific activities is not necessarily enough to decrease health risks - Activity-based incentives are the easiest to "game" 	<ul style="list-style-type: none"> - Can put too much focus on specific measurement techniques, accuracy of specific tests, scoring methodology and metrics, and fairness across different demographic groups - Biometric testing involves additional costs - HIPAA requires that alternate standards be offered to some individuals

What are the practical limitations on incentive awards? For employers driven by ROI, it does not make sense to spend more on a health promotion program than it will return in savings. The reward amount should be commensurate with what the individual is being asked to do in return. For completing an online health assessment questionnaire, an incentive award might be in the \$10-\$25 range. A more extensive program including biometric testing (which involves drawing blood) and participation in a year-long program of targeted activities related to exercise, nutrition, and stress management might warrant an incentive in the \$200-\$600 range.

There are currently no hard and fast regulatory limitations on the magnitude of incentive awards that can be provided. However, the proposed HIPAA regulations that define a “bona fide wellness program” specify that the total reward that may be given to an individual for all wellness programs must not exceed a specified percentage of the cost of employee-only coverage under the plan. These regulations specify three alternative percentages: 10%, 15% and 20%, but a final regulation has not yet been issued. This percentage is to be applied to the total cost of employee-only coverage under the plan, which includes both employee and employer contributions. Employers implementing incentive-based wellness programs should familiarize themselves with these and other relevant HIPAA requirements. (Chicago Consulting Actuaries)

Tom's comments:

Approximately 70% of healthcare costs are attributable to preventable illness. I am sure one could find studies that would incrementally change that estimate, positively or negatively, but the fact remains that preventable illnesses have a major impact on healthcare costs. Employers need to seriously consider initiatives that encourage employee participation in wellness programs. These programs can positively impact short and long-term health. This is a classic win-win scenario for both the employee and the employer. As noted previously, no guarantee exists that proactive wellness initiatives will be successful, but it is better to evaluate these options than to be a victim of spiraling annual healthcare costs.

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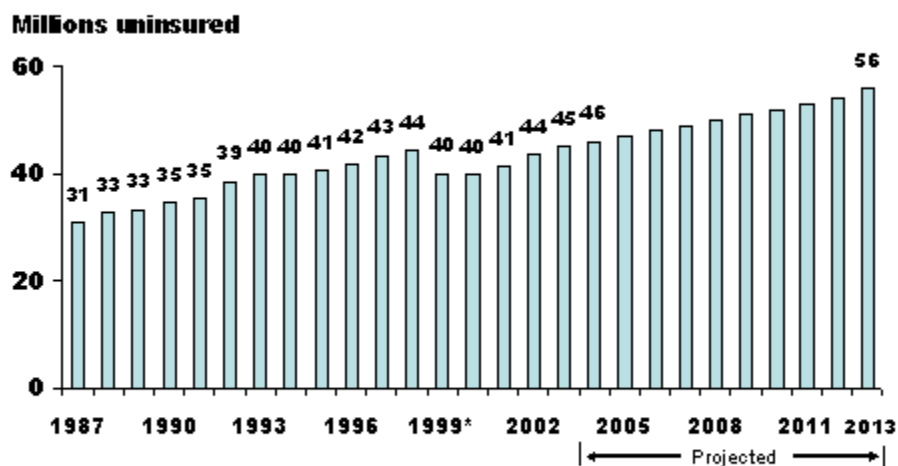
ACCESS TO CARE

Healthcare Reform: Less Talk and More Action!

Tom's Comments

Issues of cost of care, quality of care and access to care have plagued the U.S. since our existence. Every country in the world is struggling with these challenges. Countries outside of the U.S. have typically attempted to address these issues through government leadership and management. These countries have all achieved varying degrees of success or failure. In the U.S., we have a hybrid model, which is a combination of government programs directed at selected populations (egg. Medicare and Medicaid), and employer-paid insurance. As we all know millions of Americans fall outside of these healthcare safety nets. By last count there are 45.8 million uninsured Americans (U.S. Census Bureau), and some estimate an additional 16 million underinsured Americans (see July 2005 Quarterly Health Care Report). Projections indicate that the number of uninsured may exceed 50 million by the end of the decade.

Chart I-1. 46 Million Uninsured in 2004; Projected to Increase Substantially



* 1999–2003 estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.

Note: Projected estimates for 2005–2013 are for nonelderly uninsured based on T. Gilmer and R. Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs* Web Exclusive, April 5, 2005. Source: U.S. Census Bureau, March CPS Surveys 1988 to 2005.

There has been much discussion relating to various approaches to healthcare reform in the U.S. Various phrases and terms have become part of the everyday vocabulary of "health care reformers." Examples of such terminology include:

- Supply-side approach to health-care (Seattletimes and Relman)*
- market-based approach (FTC)*
- numerous proposals that focus on universal healthcare or one payer models (Uhcan).*

There are also many different, unique proposals that have been championed by healthcare experts like Harvard University's Michael E. Porter and University of Virginia's Elizabeth Olmsted Teisberg. Their writings which focus on redefining competition in healthcare are both fascinating and thought provoking. A different spin on this issue of competition can be found in an article by Alain Enthoven of Stanford University and Laura Tullen at the Kaiser Permanente Institute for Health Policy.

Employers are also taking a proactive role in addressing issues of cost, access and quality. Initiatives such as the Leapfrog Group, a consortium of Fortune 500 companies and other large private and public healthcare purchasers are leveraging their buying power to trigger a "giant leap forward" in safety, quality and affordable healthcare. An article by the CEO of Leapfrog further explains the role and mission of this group.(Delbanco)

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Enthoven, Alain C., and Tollen, Laura A., "Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency," Health Affairs. 7 Sept. 2005.

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What Is the Next Step for Real Healthcare Reform?

Tom's Comments

As noted previously, there has been much discussion and a few creative initiatives to attempt to address the issues of cost, access and quality of healthcare services. However, our nation has not made any significant progress in these areas.

"Despite the significant share of the economy consumed by healthcare, U.S. health outcomes continue to lag behind other industrialized nations," as noted by the Government Accounting Office Report released on February 16, 2005, "The United States now spends over 15% of its gross domestic product on health care – far more than other major industrialized nations. Yet relative to these nations, the United States performs below par in such measures as rates of infant mortality, life expectancy, and premature and preventable deaths."

I recognize that it is difficult to compare data across countries due to the number of dependent factors such as cultural issues. Even so, we find the data is consistent over time, sending a strong message that we still have a long way to go to address the real issues of cost, access and quality.

We in the U.S. have the opportunity to work with other countries to determine the best approaches to address the aforementioned healthcare issues. This does not mean that the result will be a "one size fits all approach" to the issues of cost, access and quality.

We also need to experiment (on a local, state, and national basis) more aggressively with approaches to address the issues of cost, access and quality.

Finally, we need to develop a national vision that quantifies our goals for cost, access and quality in healthcare. Can you imagine putting together a jigsaw puzzle without knowledge of the result? This is what we are doing in the world of healthcare. We go along day by day, year by year with no

real direction or goals. An analogy that is quite often used in healthcare today is the evolving issues of cost, quality and access will ultimately create the "Perfect Storm." Given history, this can only result in the "crisis management" mentality that creates more chaos.

We will continue to evaluate alternatives to healthcare reform in future issues of the Quarterly Health Care Report. We welcome articles, perspectives, etc. from our readers on these issues of cost, quality and access. Baldwin-Wallace College will also be sponsoring programs and talks that further explore these issues that impact us on a daily basis, along with ideas and initiatives to address them.

OHIO

Medicaid Managed Care

Pursuant to the requirements in Am. Sub. House Bill 66, the Department of Job and Family Services (ODJFS) will expand Medicaid managed care statewide for specific populations by December 2006. When expansion is complete, approximately 1.2 million Covered Families and Children (CF) and 125,000 Aged, Blind, and Disabled (ABD) Medicaid consumers will be placed in a managed care program which bases the delivery of health care services on a 'medical home' model that focuses on care coordination and preventive services. Medicaid consumers in the managed care program will have:

- A designated primary care physician;
- Access to a 24/7 nurse line for the medical advice and direction;
- A provider directory listing primary care physicians, hospitals, and specialists;
- Access to a member services call center dedicated to helping members access services appropriately; and
- Case management services, if qualified.

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Riley, Barbara. "Medicaid Managed Care Statewide Expansion". Ohio Job and Family Services," Memorandum to All Interested Parties. 30 Aug. 2005. <jfs.ohio.gov>

Toms Comments: Ohio's prior experience with Medicaid Managed Care was not too successful. A number of Medicaid HMOs declared bankruptcy and providers absorbed major financial losses. Medicaid HMOs were also not happy with the program due to the inability to make

a profit in the program. As a result of these financial concerns a number of Medicaid HMO withdrew from the program which resulted in a hardship to the recipients of the services. Hopefully this new generation of Medicaid managed care will be different. We will continue to monitor this initiative as we discuss Medicaid issues from a number of perspectives.

NORTHEAST OHIO

World Trade Center Cleveland International Business Events Calendar

To strengthen the regional economy, the World Trade Center Cleveland facilitates access to international business opportunity for small and mid-sized companies, advances the attraction of foreign companies to NE Ohio, and promotes the greater internationalization of the region.

To learn more about the programs offered by the World Trade Center Cleveland, visit their website: <http://www.wtccleveland.org/>

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**Spahr Chair Annual Lecture in Business Ethics:**

**A Panel Discussion on Sustainable Corporations and  
Communities**

**February 8, 2006**

**8 p.m.**

**Strosacker Student Union, Ballroom**

Panelists will be

- Steve Percy, retired CEO, BP America
- Pat Conway, president and owner of Great Lakes Brewing Company
- David Beach, executive director of EcoCity Cleveland.

Panelists will discuss why environmental sustainability has become an important imperative for successful corporations and communities. They will also offer examples and advice on how corporations and communities can effectively embark on this task.

This event is free and open to the public.

Call or email for more information:  
440-826-2392 or [graduate@bw.edu](mailto:graduate@bw.edu)

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