Includes Complete Results of the Employer Health Care Benefits Survey

10th Edition

2006

www.HCTrends.com

The Greater Milwaukee Annual Report on Health Care

In-Depth Health Care Coverage for Regional Businesses

Inside:

Underwritten By:

Aurora Health Care

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UnitedHealthcare
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BSG
The Benefit Services Group, Inc.
Best By Any Standard

"Committed to promoting informative discussions on health care issues."

The Greater Milwaukee Annual Report on Health Care

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September 2006

Dear Reader:

Welcome to the 10th Edition of The Greater Milwaukee Annual Report on Health Care. We noted in our inaugural issue that "until the mid-1980s, health care was a 'static' industry that was relatively easy to understand. Within the last 10 years all of that has changed." That statement is even more true today. Health care has become one of the most complex issues confronting businesses, communities and the nation; rapid change has become the norm.

Today, the big push is to measure health care quality as providers and purchasers seek to reduce costs by applying proven business practices to the health care industry. These efforts, however, are still in their infancy and many people do not know what data is available and what it means. In an effort to clear up some of the mystery, we offer a brief description of some of the quality measures now available (see "Measuring Quality" on page 20), and an interview with the president of the Wisconsin Healthcare Collaborative for Quality, which is at the forefront of the quality movement (see "Questions about Quality: Answers from a Leading Regional Quality Initiative" on page 45).

This year's Annual Report also includes extensive findings of our online Employer Health Care Benefits Survey (see page 24). The most comprehensive survey of its kind in southeastern Wisconsin, it provides a detailed look at how local employers are addressing their health care challenges.

We trust you will find the 10th Edition of *The Greater Milwaukee Annual Report on Health Care* and its companion Web site, HCTrends.com, to be valuable resources for health care information. Our objective is to ask questions, look for connections and pose potential solutions to promote a meaningful discussion about the health care challenges we face. We are deeply appreciative of the support of our sponsors, who understand the importance of an informed debate, even if they don't agree with everything we publish. We need your support, as well. The more people we have participating in this discussion, the better the outcome.

Dave Jensen
Editorial Director

PLEASE TELL US WHAT YOU THINK

Help us evaluate and improve *The Greater Milwaukee Annual Report on Health Care* by participating in our brief online readership survey at **www.HCTrends.com**. Your comments and insights will enhance our coverage of health care trends.

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THE BENEFIT SERVICES GROUP, INC.

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Integrated plan analysis and design, employee communication plans and contract consulting

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Time and again, BSG has demonstrated its ability to deliver the right balance between services and costs. But the element that differentiates BSG is creativity. BSG is well-known for finding solutions outside the box. In today's rapidly changing benefits industry, BSG's commitment to innovation, education and partnership helps it to earn the accolade "Best By Any Standard."

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UnitedHealthcare is focused on leading change to solve America's affordability crisis and our customers' challenges in providing affordable health benefits for their employees. Our experience in offering health care solutions that allow employers to lower administrative costs, while maintaining comprehensive, robust health care benefits for their employees is unsurpassed.

UnitedHealthcare offers a full spectrum of benefit solutions – from conventional plan designs to innovative, consumer-directed options – including medical, pharmacy, life, dental, vision and disability for employers of all sizes.

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- We provide members with tools and information to help them get the right care from the right care professional at the right time, including pro-active care programs and comprehensive wellness and activation tools

UnitedHealthcare helps more than 11 million Americans – including over 763,000 consumers in Wisconsin – achieve improved health and well-being. UnitedHealthcare arranges access to a national network of quality, affordable care professionals, including more than 500,000 physicians and care professionals and 4,600 hospitals across America.

UnitedHealthcare is one of the businesses of UnitedHealthGroup (NYSE: UNH), a diversified Fortune 50 health and well-being company.

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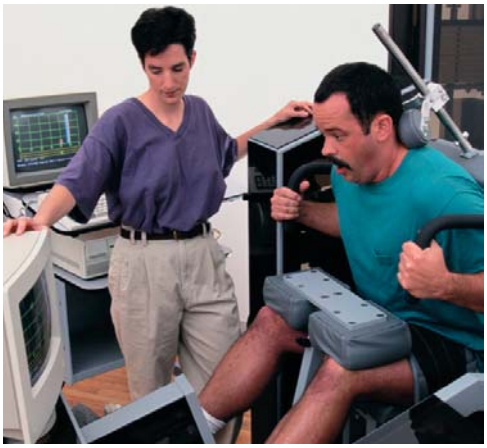
A community-owned, not-for-profit health care provider nationally recognized for its efforts to improve the quality of care.



A healthy bottom line starts with healthy people

We understand your challenge as an employer: hiring the right people and keeping them healthy and on the job are the keys to your success. We also understand the pain of rising health care costs. There is something we can do.

Our health care consultants will listen to you, learning all we can about your business and the health care needs of your employees. Working together, we will create programs for your company that will help keep your people healthy and on the job, which means higher productivity and lower health costs.

Aurora's unique approach to health care – a truly integrated system built on continuous quality improvement and care management principles – offers employers, insurers and networks the only meaningful, long-term solution to their health care cost challenges.

Aurora is continually seeking new ways to improve the health of the people it serves through prevention, early detection, proper diagnosis and appropriate treatment. The result is a health care delivery system unlike any other serving southeastern Wisconsin – a comprehensive, results-oriented solution that offers convenient access to quality, evidence-based care.

Keeping employees safe and healthy is the best way to minimize your health care costs. Our care management program, which is in place at all of our clinics, pharmacies and hospitals, ensures that your employees get the most appropriate, effective and cost-efficient care.

Aurora Health Care®

MILLIMAN

The changes to the evolving health care industry have been significant and the challenges you face are many. With mounting concerns about cost efficiency and quality, it's increasingly difficult to juggle multiple priorities – making reliable information, solid strategy and fresh ideas more important than ever. Milliman can help you navigate this shifting landscape and successfully manage your organization for today and tomorrow.

Milliman health care consultants bring to your organization in-depth knowledge, supported by the most current research and innovative proprietary tools. Our unique diversity of skills gives you the benefit of superb technical capabilities coupled with broad-based business expertise.

The suburban Milwaukee office of Milliman, founded in 1961, is the largest actuarial consulting operation in Wisconsin. With a staff of more than 160 consultants, actuaries and support personnel, some of the areas in which Milliman can help you include:

- Medicare Part D analyses
- Retiree health liability and projection
- Cost projections and plan designs
- Consumer-driven plan development
- Merger and acquisition support
- Captive feasibility analyses
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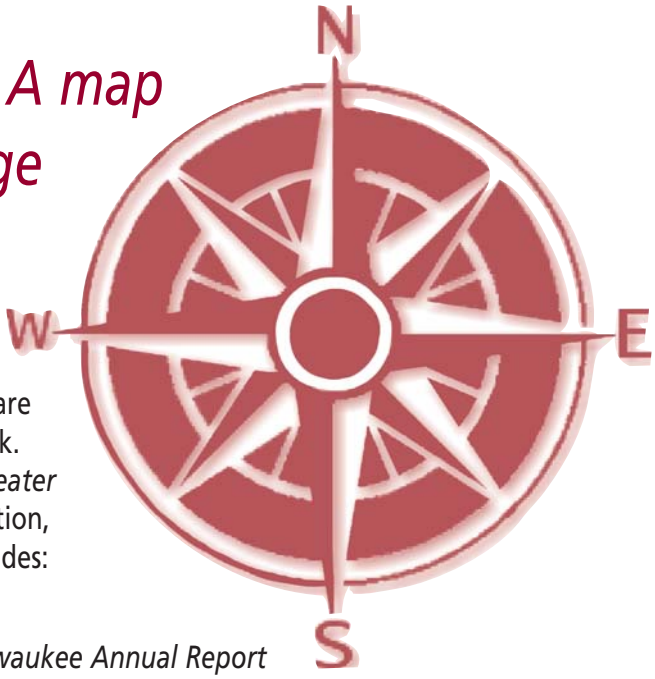
www.milliman.com

Delivering insight into the complexities and challenges of the continuously changing health care environment to employers and other industry clients.

A compass provides direction. A map highlights choices. Knowledge empowers the traveler who must choose a path.



When navigating through the constantly changing health care industry landscape, choosing the best path is a daunting task. Look to **HCTrends.com**, the companion Web site to *The Greater Milwaukee Annual Report on Health Care*, to offer information, highlight choices and provide direction. HCTrends.com provides:

- a request form for additional copies of *The Greater Milwaukee Annual Report on Health Care*
- full-text articles from current and past editions of the Annual Report
- background and support articles for topics covered in the Annual Report
- links to online publications and Web sites of interest
- an interactive, online survey concerning health coverage and other employee benefit issues; and
- e-mail links for your feedback

HCTrends.com

Profiling health care trends in the greater Milwaukee area – and beyond.

ANNUAL REPORT WHITE PAPER LIBRARY

Over the years, The Greater Milwaukee Annual Report on Health Care has published White Papers on a wide variety of topics related to health plan management, consumer-driven health care, productivity management, strategic tools, and health care strategies. These White Papers, as well as other articles, studies and survey results, are available for download at ***www.HCTrends.com***

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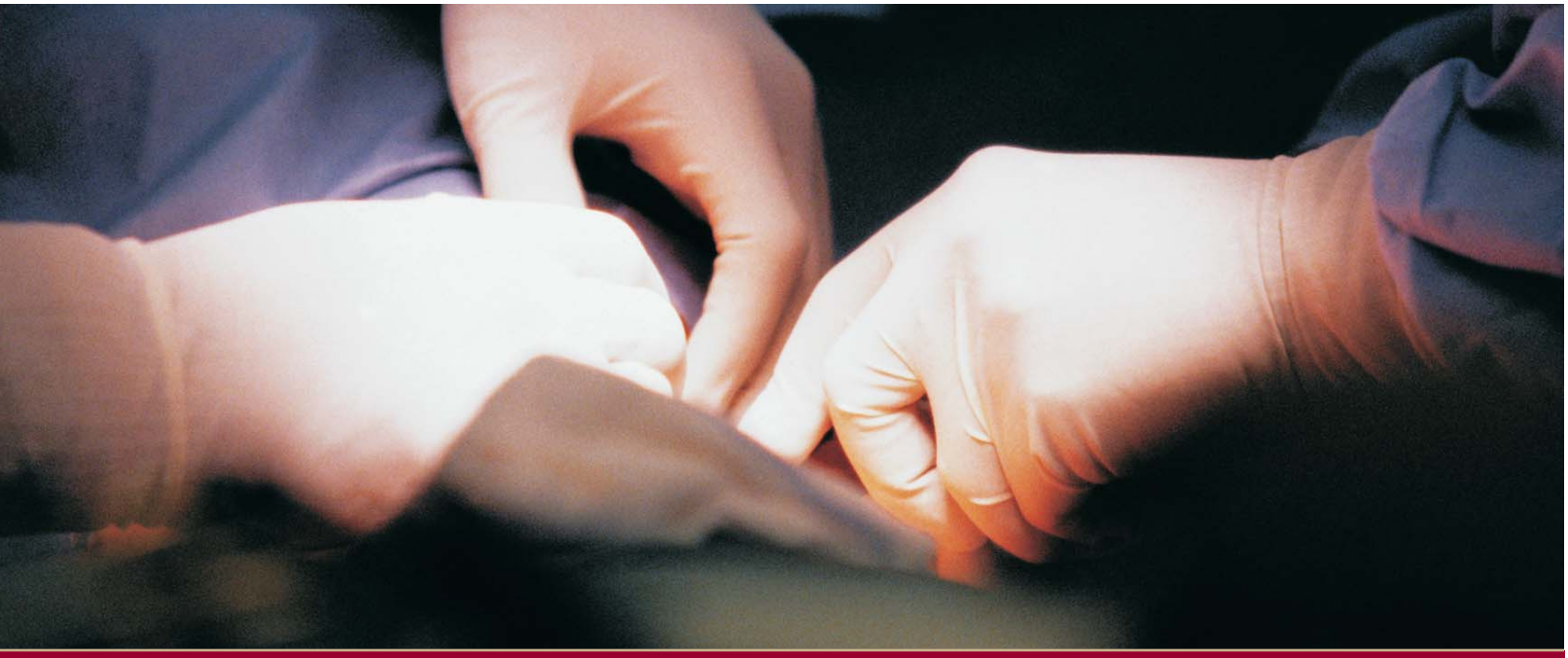


INDUSTRY UPDATE

The evolving health care industry continually presents new challenges and opportunities for providers, employers, employees and consumers. Understanding the local market – and its place in context with national and international trends – is critical.

In Part One:

Medical Community
Market Overview

Southeastern Wisconsin is served by six integrated health systems, three major health maintenance organizations and several large preferred provider organizations. In addition, it is the home of the Medical College of Wisconsin, a major medical college and research institution; Children's Hospital, the state's pediatric hospital; Froedtert Memorial Lutheran Hospital, the only Level 1 Trauma Center in the state; The Blood Center of Wisconsin, a leading research institution; and St. Luke's Medical Center, which is considered to be one of the top cardiac transplant centers in the country.

From a health plan perspective, approximately 75 percent of the population in southeastern Wisconsin is enrolled in broad-network preferred provider organizations (PPOs) or point-of-service (POS) plans. Although health maintenance organizations were dominant in the 1980s, they gave way to less-restrictive approaches to health care in the 1990s, as in much of the nation.

Provider Networks & Insurance Plans

There are many reasons why restrictive managed care products could not be maintained here. As a leading manufacturing center, Milwaukee employers offered generous benefits to attract and retain skilled workers. In addition, organized labor secured extensive health care coverage during contract negotiations. At the same time, the market demanded that every plan or network include virtually all providers in the area.

Today, approximately 375,000 people are enrolled in commercial HMO products, including Point of Service, with one health plan – UnitedHealthcare of Wisconsin – accounting for more than half of all HMO enrollment.

Reflecting the national trend away from managed care products, only 40 percent of the enrollees participate in traditional gatekeeper HMOs, while 60 percent participate in open access and point-of-service products. In addition to their commercial enrollment, the region's HMOs serve another 217,000 people enrolled in government-funded Medicare and Medicaid HMO products.

Milwaukee's PPO market is in a period of transition after years of rapid growth. The PPO market includes one dominant local network – HealthEOS, which consists of three smaller networks: the former AHC, HCN and

MultiPlan/Wisconsin Preferred Provider Network – plus networks operated by Anthem (formerly Blue Cross Blue Shield of Wisconsin), WPS Health Insurance, UnitedHealthcare and Humana. In addition, several new networks are being rolled out to address consumer-driven health plans. These include tiered networks that categorize providers by quality and/or price and exclusionary networks that include only some of the health systems and provider networks in the region.

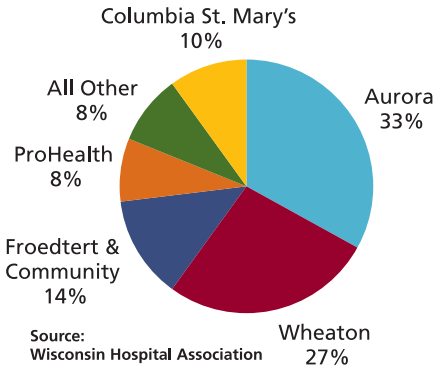
Health Care Providers

Southeastern Wisconsin is served by seven multi-hospital systems and a physician-owned system that has affiliated with area hospitals for inpatient services. Of the 26 acute-care hospitals in southeastern Wisconsin, only two are not part of a multi-hospital system – St. Joseph's Community Hospital in West Bend and the Clement J. Zablocki Veterans Affairs Medical Center.

Four hospital systems dominate the Milwaukee-area hospital market, each having more than a 10 percent share of the market. Together, they account for 75 percent of all hospital admissions in the seven-county area, based on figures compiled by the Wisconsin Hospital Association. Each system has its own unique "personality" based on the strategies employed to create it. Aurora Health Care, for example, has focused its efforts on developing a comprehensive spectrum of health care services in an expansive geographic network extending throughout eastern Wisconsin. Wheaton Franciscan Healthcare – formed this year with the merger of Covenant Healthcare and All Saints Healthcare – followed a similar, integrated approach, but focused on the metropolitan Milwaukee and Racine markets. Columbia St. Mary's and Froedtert & Community Health are smaller systems serving specific geographic areas: Columbia St. Mary's serves Milwaukee's east side and north shore; Froedtert & Community Health has hospitals west and northwest of Milwaukee. Froedtert also is aligned with the Medical College of Wisconsin, which provides faculty physicians at a number of hospitals throughout southeastern Wisconsin. The remaining hospital systems – ProHealth Care, Inc. in Waukesha County, Synergy in Washington County, United Hospital System in Kenosha and Children's Health System, which is based in Milwaukee – are smaller systems, but are dominant health care providers in their respective markets.

Following is an overview of the provider-owned integrated delivery systems currently serving the seven counties of southeastern Wisconsin.

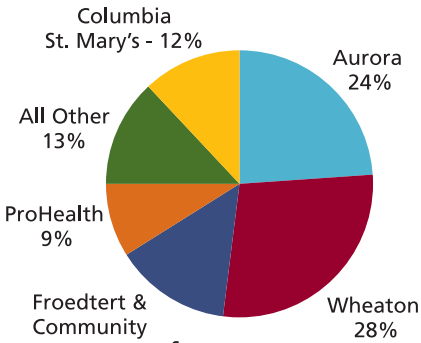
Market Share (Public Payers)



Source: Wisconsin Hospital Association

Health system market share varies depending on the type of payer. Aurora Health Care has one-third of the region's market share for Medicare and Medicaid patients (based on inpatient days), but only one-fourth of the more profitable commercial business segment. All of the other hospital systems have higher commercial market share than public market share, except Froedtert & Community Health, which has 14 percent of both markets.

Market Share (Commercial)



Source: Wisconsin Hospital Association

KEY HOSPITAL FINANCIAL CHARACTERISTICS

On the following pages, *The Greater Milwaukee Annual Report on Health Care* includes selected financial and utilization information for area hospitals (N/A indicates that information was not available).

- **Inpatient Days:** Calendar-year information from the Wisconsin Hospital Association's December 2001 and December 2005 Hospital Utilization Reports
- **ALOS:** Average length of stay information is year-end information from the Wisconsin Hospital Association's December 2001 and December 2005 Hospital Utilization Reports
- **Commercial % of Revenue:** Revenue from commercial payers as percent of total revenue. Fiscal Year 2004 data from the Wisconsin Health Care Data Report (2004)
- **Occupancy:** Fiscal year 2004 occupancy information from the Wisconsin Health Care Data Report (2004)

Advanced Healthcare

High Pointe Clinic – New Berlin
www.ah.com

Advanced Healthcare physicians have served the greater Milwaukee area for more than 40 years. It is the largest physician-owned, multi-specialty group practice in southeastern Wisconsin, with 250 physicians representing more than 30 medical and surgical specialties at 14 clinic sites in Milwaukee, Ozaukee, Waukesha and Washington counties. In addition to primary and subspecialty care, Advanced Healthcare also offers extensive diagnostic and procedural services (laboratory and imaging); walk-in/urgent care services; educational, wellness programs and electronic medical record capabilities. In 2005 Advanced Healthcare provided more than 1 million patient visits. In addition, many of its physicians conduct clinical research studies throughout the year.

Aurora Health Care

St. Luke's Medical Center – Milwaukee
www.aurorahealthcare.org

Aurora Health Care was the first organized system of care to form in Wisconsin and currently offers an array of health and social services in more than 90 communities throughout eastern Wisconsin. It includes 12 acute-care hospitals, a psychiatric hospital, more than 90 clinics and more than 120 retail pharmacies. More than 3,300 physicians are affiliated with Aurora Health Care, including 680 in the Aurora Medical Group. Aurora's Milwaukee County hospitals are Aurora St. Luke's Medical Center, St. Luke's South Shore, Aurora Sinai Medical Center, West Allis Memorial Hospital and Aurora Psychiatric Hospital. Other hospitals are Aurora Medical Center in Hartford, Aurora Medical Center in Kenosha, Memorial Hospital of Burlington, Aurora Lakeland Medical Center in Elkhorn, Aurora Medical Center in Two Rivers, Aurora Sheboygan Memorial Medical Center, Aurora BayCare Medical Center in Green Bay and Aurora Medical Center in Oshkosh.

Hospital Financial Characteristics

	Inpatient Admissions 2001	Inpatient Admissions 2005	Inpatient Admissions Change	ALOS 2005	ALOS Change 2001-2005	Commercial % of Revenue	Occupancy
Aurora Lakeland Medical Center	4,522	4,925	9%	3.46	0.3%	35%	65%
Aurora Medical Center – Kenosha	3,782	5,340	41%	3.34	2.3%	40%	77%
Aurora Medical Center – Washington Co.	2,008	2,543	27%	4.49	- 23.7%	41%	53%
Aurora St. Luke's Medical Center	37,032	38,436	4%	4.90	- 12.9%	29%	68%
Aurora Sinai Medical Center	13,673	9,858	- 28%	3.66	- 17.6%	19%	65%
Memorial Hospital of Burlington	3,413	3,207	- 6%	3.45	- 9.8%	40%	52%
West Allis Memorial Hospital	9,035	11,506	27%	4.08	- 22.9%	37%	62%

Aurora Visiting Nurse Association of Wisconsin offers home care and hospice services. Aurora Family Services and Village Adult Day Service offer family and social services, while Aurora Complementary Medicine offers services such as chiropractic and acupuncture. Aurora offers a full range of employer-directed services, including an integrated care management program with disease management, utilization management, health promotion, teleservices and eHealth, as well as Aurora Occupational Health Services and the Aurora Employee Assistance Program.

Children's Hospital and Health System

Children's Hospital of Wisconsin – Wauwatosa

www.chw.org

Children's Hospital and Health System is the region's only independent health care system dedicated solely to the health and well-being of children. Children's Hospital of Wisconsin, the flagship member of the health system, is one of the nation's top-rated pediatric hospitals. It is the only trauma center in the state devoted to children and is one of only 14 pediatric Level I Trauma Centers in the United States. Children's Hospital has also achieved Magnet Recognition – the highest level of nursing excellence – from the American Nurses Credentialing Center. Health system entities include Children's Hospital of Wisconsin – Fox Valley, Children's Hospital of Wisconsin - Kenosha, Children's Hospital and Health System Foundation, Children's Health Education Center, Children's Medical Group, Children's Service Society of Wisconsin, Children's Specialty Group, Surgicenter of Greater Milwaukee, Children's Research Institute, Seeger Health Resources, National Outcomes Center and Children's Community Health Plan. Children's Hospital serves children throughout Wisconsin, Michigan's Upper Peninsula and northern Illinois through more than 70 specialty clinics, including cardiology, cleft lip and palate, diabetes, ear, nose and throat, laser, oncology and plastic surgery.

Hospital Financial Characteristics

	Inpatient Admissions 2001	Inpatient Admissions 2005	Inpatient Admissions Change	ALOS 2005	ALOS Change 2001-2005	Commercial % of Revenue	Occupancy
Children's Hospital	19,031	21,643	14%	3.0	0.5%	58%	78%
Children's Hospital - Kenosha	1,050	900	- 14%	1.5	- 6.3%	64%	16%

Columbia St. Mary's

Ozaukee Campus – Mequon

www.columbia-stmarys.com

Columbia St. Mary's, Inc. includes four hospitals: Columbia St. Mary's Milwaukee Campus, Columbia St. Mary's Columbia Campus, Columbia St. Mary's Ozaukee Campus and Sacred Heart Rehabilitation Institute, as well as 26 primary care clinics, the Columbia College of Nursing and a partnership with the Orthopaedic Hospital of Wisconsin, Glendale. Columbia St. Mary's serves Milwaukee, Ozaukee and Washington counties with a combined history of more than 155 years. Its sponsor organizations are Ascension Health and Columbia Health

System. Columbia St. Mary's is building a new 513-bed hospital in Milwaukee that will replace the Milwaukee and Columbia campuses when it opens in 2010.

Hospital Financial Characteristics							
	Inpatient Admissions 2001	2005	Change	ALOS 2005	ALOS Change 2001-2005	Commercial % of Revenue	Occupancy
Columbia Campus	9,491	8,192	-14%	4.95	3.8%	48%	34%
Milwaukee Campus	9,577	9,927	4%	4.64	- 4.3%	50%	65%
Ozaukee Campus	5,681	6,578	16%	3.92	- 0.4%	54%	63%

Froedtert & Community Health

Froedtert & Community Health is a regional hospital system formed in 2001 by Froedtert Hospital and Community Memorial Hospital. Joining the capabilities of Community Memorial Hospital, a 196-bed community hospital, and Froedtert Hospital, a 434-bed academic medical center, Froedtert & Community Health delivers nationally recognized, cost-effective health care treatment and technologies from two hospitals, as well as multiple clinic and program sites throughout southeastern Wisconsin. Froedtert is also a major teaching hospital and the region's only Level 1 Trauma Center. In 2004, adult patient admissions for Froedtert & Community Health exceeded 31,000.

Froedtert Memorial Lutheran Hospital – Wauwatosa

www.froedtert.com

www.communitymemorial.com

Hospital Financial Characteristics							
	Inpatient Admissions 2001	2005	Change	ALOS 2005	ALOS Change 2001-2005	Commercial % of Revenue	Occupancy
Community Memorial Hospital	7,760	8,926	15%	4.16	- 1.9%	43%	56%
Froedtert Hospital	20,836	23,617	13%	5.26	- 8.2%	44%	76%

Medical Associates Health Centers

Medical Associates Health Centers is one of southeastern Wisconsin's largest independent, physician-owned, multi-specialty clinics with more than 100 independent physicians practicing in 27 different medical specialties and more than 800 employees providing more than 400,000 patient visits annually. Medical Associates serves families in Waukesha and Washington counties, with multi-specialty clinics in Menomonee Falls, Waukesha, Germantown, Sussex and Hartford. Behavioral Health Services are offered in Menomonee Falls, Waukesha, Hartford, Wauwatosa and West Bend. Rehabilitation Services are offered in Pewaukee, Menomonee Falls, Hartford and Germantown. Medical Associate's Eye Center, which provides comprehensive eye care, has locations in Menomonee Falls and Waukesha.

Medical Associates – Waukesha Clinic

www.ma-hc.org

ProHealth Care

ProHealth Care is a comprehensive, community-based health care system with nearly 100 years serving community needs. Its members include Waukesha Memorial Hospital and Oconomowoc Memorial Hospital, 15 primary care clinics, home health care and hospice services, assisted and independent living communities, corporate health services and the West Wood Health and Fitness Center. Approximately 900 physicians are affiliated with ProHealth Care, which is the largest employer in Waukesha County with 5,000 employees. ProHealth Care serves Waukesha County and surrounding areas.

Oconomowoc Memorial Hospital – Oconomowoc

www.prohealthcare.org

Hospital Financial Characteristics							
	Inpatient Admissions 2001	2005	Change	ALOS 2005	ALOS Change 2001-2005	Commercial % of Revenue	Occupancy
Oconomowoc Memorial	4,131	4,792	16%	3.16	- 6.2%	56%	53%
Waukesha Memorial	14,275	16,506	16%	4.43	- 6.0%	54%	65%

SynergyHealth

SynergyHealth is a regional health system serving the greater Washington County area. It opened a new 80-bed replacement hospital – St. Joseph's Hospital – on Hwy. 45 in the Town of Polk. Major services include advanced diagnostic services, emergency care, outpatient surgery and the New Life Center birthing center. SynergyHealth also includes the Alyce and Elmore Kraemer Cancer Care Center in West Bend and the West Bend Clinic, which offers primary and multi-specialty care with more than 70 physicians at locations in West Bend, Jackson, Hartford and Kewaskum, as well as ambulatory day surgery services at the West Bend Surgery Center.

West Bend Clinic – West Bend

www.synergyhealth.org

Hospital Financial Characteristics							
	Inpatient Admissions 2001	2005	Change	ALOS 2005	ALOS Change 2001-2005	Commercial % of Revenue	Occupancy
St. Joseph's Community Hospital	5,285	4,873	- 8%	4.51	2.3%	39%	47%

United Hospital System

United Hospital System, a member of the Wheaton Franciscan System, is a regional health care system that has served southeastern Wisconsin and northern Illinois for more than 100 years. It provides inpatient services at two locations – the Kenosha Medical Center Campus and the St. Catherine's Medical Center Campus – and operates several clinics. Over the years, United Hospital System has developed relationships with Froedtert, the Medical College of Wisconsin and Children's Hospital and Health System. One example of this collaboration is the

Children's Hospital of Wisconsin - Kenosha, a "hospital within a hospital" located on the sixth floor of the Kenosha Medical Center Campus.

Hospital Financial Characteristics							
	Inpatient Admissions 2001	2005	Change	ALOS 2005	ALOS Change 2001-2005	Commercial % of Revenue	Occupancy
Kenosha Medical Center	7,531	9,112	21%	4.46	3.2%	41%	54%

Wheaton Franciscan Healthcare

St. Joseph Regional Medical Center – Milwaukee
www.covhealth.org

Wheaton Franciscan Healthcare (WFH) is a Catholic, not-for-profit organization with more than 100 health and shelter organizations in Wisconsin, Iowa, Colorado and Illinois. In southeastern Wisconsin, WFH is co-sponsored by the Wheaton Franciscan and Felician Sisters and has more than 12,000 associates, making it the second-largest private employer in the area. Hospitals include All Saints in Racine, St. Joseph and St. Francis in Milwaukee, Elmbrook Memorial in Brookfield, and a joint venture affiliation with The Wisconsin Heart Hospital in Wauwatosa. The region also includes Wheaton Franciscan Medical Group with nearly 300 primary care and specialty physicians in 55 locations, a network of outpatient centers, four long-term care facilities, home health and hospice, two family medicine residency programs in collaboration with the Medical College of Wisconsin, retail pharmacies, and a full-service medical and pathology laboratory. Wheaton Franciscan Healthcare is also affiliated with Affinity Healthcare in the Fox Valley and United Hospital System in Kenosha. Started by the Wheaton Franciscan Sisters more than 125 years ago and formally incorporated in 1983, Wheaton Franciscan Healthcare has corporate services offices in Wheaton, Illinois, and Glendale, Wisconsin.

Hospital Financial Characteristics							
	Inpatient Admissions 2001	2005	Change	ALOS 2005	ALOS Change 2001-2005	Commercial % of Revenue	Occupancy
All Saints Medical Center	14,828	17,461	18%	4.42	- 15.5%	39%	60%
Elmbrook Memorial Hospital	5,815	6,201	7%	4.03	- 2.1%	58%	76%
St. Francis Hospital	9,547	9,007	- 6%	4.01	- 10.4%	44%	58%
St. Joseph Regional Medical Center	15,461	15,138	- 2%	4.59	- 13.5%	39%	76%
St. Michael Hospital (closed 2006)	8,022	5,050	- 37%	4.39	- 15.6%	25%	79%
The Wisconin Heart Hospital *Opened 2004	N/A*	1,993	N/A*	2.82	N/A*	39%	23%

Specialty Hospitals & Facilities

The Milwaukee area is also home to several specialty health care providers. Curative Care Network, one of the largest, most experienced and comprehensive rehabilitation and human service organizations in the nation, improves the function and quality of life for persons with disabilities or limiting conditions. Curative provides services to children, adults and seniors at community-based sites in Milwaukee and Waukesha counties. The Blood

Center of Wisconsin works with donors to meet patients' needs for blood and blood products at more than 50 local hospitals. In addition, the Blood Center is internationally renowned for its work in testing for, treatment of, and research on blood and blood-related diseases. Other specialty hospitals in the Milwaukee area include Aurora Psychiatric Hospital, an inpatient facility in Wauwatosa; Sacred Heart Rehabilitation Institute, an acute-care hospital located on the Columbia St. Mary's Columbia Campus; Columbia St. Mary's Regional Burn Center, which serves burn patients from Wisconsin, Michigan and northern Illinois; Kindred Hospital Milwaukee, a 63-bed, long-term, acute-care hospital that treats medically complex patients; and Rogers Memorial Hospital, a psychiatric-care provider for children, adolescents and adults with a 90-bed inpatient facility in Oconomowoc, a 70-bed facility in West Allis and treatment sites in Brown Deer and Kenosha.

Education

More than 5,000 people are enrolled in health-related educational programs at more than a dozen schools in southeastern Wisconsin. These include more than 1,000 students pursuing medical degrees in general medicine and dentistry, more than 900 students seeking health-related master's degrees, and nearly 800 students in residency training. In addition, several thousand people are enrolled in nursing programs throughout southeastern Wisconsin. The Medical College of Wisconsin is the primary medical teaching facility in the Milwaukee area. Nearly 1,400 students are enrolled at the college, including 500 graduate students. In addition, the Medical College faculty members supervise 800 physicians in residency training, primarily at its major teaching affiliates – Froedtert Hospital, Children's Hospital of Wisconsin and the VA Medical Center. The Medical College also partners with area health care systems to provide biomedical student and resident education. The University of Wisconsin Medical School operates a Milwaukee Clinical campus in conjunction with Aurora Health Care. The curriculum provides medical student and resident education in internal medicine, family medicine and obstetrics/gynecology programs. The Marquette University School of Dentistry has provided education, research and clinical services since 1894. The only dental school in the state, it offers graduate programs in dental surgery, endodontics, orthodontics, dental biomaterials and prosthodontics, as well as a gerontology certificate program.

HEALTH CARE PLANS

INSURER/NETWORK	HMO	PPO	POS	EPO	OA	ENROLLEES State	ENROLLEES Local*	ACCRED.	PHONE
Aetna		x	x	x	x	120,924	74,927	URAC	(800) 913-2386
Anthem BlueCross and BlueShield	x	x	x		x	296,630	142,086	NCQA	(414) 459-5000
Cigna HealthCare – Wisconsin		x	x	x	x	125,000	80,000		(414) 266-8025
Health EOS		x				1.3 million	500,000		(800) 279-9776
Humana	x	x	x	x	x	302,100	N/A	NCQA	(800) 825-9900
Interplan Health Network		x				96,300	43,000	URAC	(262) 754-4926
UnitedHealthcare of WI, Inc.	x	x	x	x	x	549,659	269,688	NCQA	(414) 443-4000
WPS Health Insurance		x		x		241,293	95,109	URAC	(800) 861-5442

Enrollment/participation figures as of Dec. 31, 2005

*Milwaukee, Waukesha, Washington, Ozaukee, Racine, Kenosha and Walworth counties

HMO – Health Maintenance Organization PPO – Preferred Provider Organization POS – Point of Service EPO – Exclusive Provider Organization OA – Open Access
Accred. - Accreditation NCQA – National Committee on Quality Assurance; URAC – American Accreditation Healthcare Commission

Local Trends in Health Care

A Sigh of Relief for Employers as Health Care Cost Increases Slow

Many Milwaukee-area employers are breathing a sigh of relief this fall, because it appears they will be able to limit their health care cost increases to 10 percent or less for the second year in a row. That's still higher than employers want, but it's significantly better than the 15 percent to 25 percent increases employers were reporting just a few short years ago.

That's not to say that benefits administrators and brokers won't have their work cut out for them during the fall renewal season. Many of the initial notices recently mailed out project increases of between 10 percent and 14 percent for the 2007 Plan Year, but those increases are likely to drop once employers tweak their plan design, according to *The Greater Milwaukee Annual Report on Health Care's* annual employer survey (see page 24). Last year, 71 percent of survey respondents initially expected double-digit cost increases; that dropped to 39 percent after changes were made.

The slowdown in cost increases is due to a number of factors. Employers are much more aggressive in their benefit designs, raising deductibles and other cost-shifting initiatives to increase employees' financial stake in the costs of the health care services they consume. There also has been a shift in the relationship between providers, insurers and health care purchasers. For several years, providers have been able to secure contracts based on negotiated discounts, which did little to limit the "retail" prices providers could charge.

Within the last year, however, the market has made a significant move toward fixed-fee pricing, in which purchasers and providers agree to set fees instead of discounts. Fixed-fee pricing is an integral component of the new contract

Noteworthy Events

- Aurora and UnitedHealthcare pact causes market realignment
- Covenant reorganizes, merging with All Saints to become Wheaton Franciscan Healthcare
- Purchasers demand transparency, but the outlook is cloudy

between Aurora Health Care and UnitedHealthcare. It also is a central component of the health plan developed by the Business Health Care Group of Southeast Wisconsin.

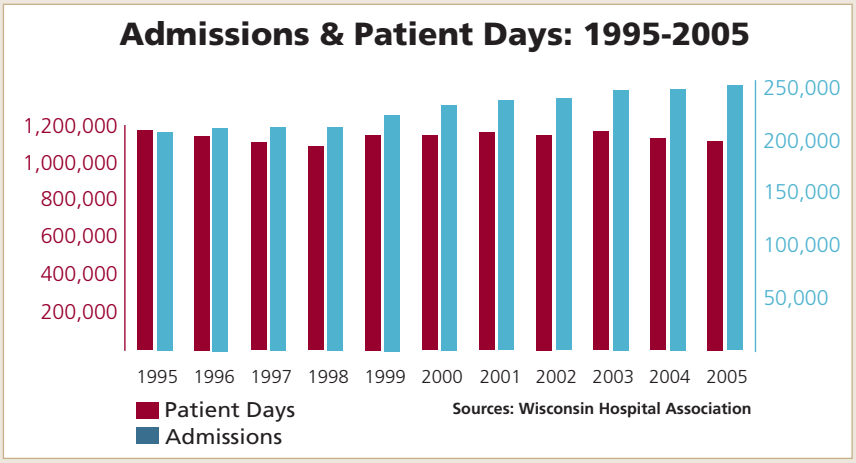
There also have been significant realignments within the marketplace, the most significant of which is Aurora's reunification with UnitedHealthcare. Aurora had been excluded from UnitedHealthcare's network for close to 10 years until the two market leaders reached a new 13-year agreement last fall. That deal has had a ripple effect throughout the provider community, impacting UnitedHealthcare's relationship with Froedtert Hospital, which used to handle the bulk of UnitedHealthcare's tertiary care services; and Wheaton Franciscan Healthcare (formerly Covenant Healthcare), Aurora's primary competitor in the Milwaukee region. Inpatient admissions at Wheaton's St. Francis Hospital (located just several blocks from Aurora's flagship hospital, St. Luke's Medical Center) dropped 10 percent between June 2005 and June 2006. UnitedHealthcare and Froedtert & Community Health had yet to settle on a new contract by Labor Day, throwing into question whether Froedtert and Community Memorial Hospital would be excluded from UnitedHealthcare's network this coming year.

Covenant Reorganizes, St. Michael Hospital Closes

Without question, one of the most significant provider changes within the last year has been the reorganization of Covenant Healthcare, the region's second-largest health system. Paul Dell Uomo, who had led the system for the last five years, retired in January after Covenant failed to secure inclusion in the new preferred provider network established by Business Health Care Group of Southeast Wisconsin. In July, Wheaton Franciscan Services, Covenant's parent organization, merged the Milwaukee-area health system with All Saints Healthcare, the Wheaton-owned system serving Racine and northern Kenosha counties. The new entity – Wheaton Franciscan Healthcare – consolidates the two systems' administrative functions and medical groups and is expected to save an estimated $15 million a year.

Wheaton also made several major facility announcements within the last year. It closed St. Michael Hospital, an

TEN YEARS LATER: CHANGES IN THE HEALTH CARE LANDSCAPE



The health care landscape has changed dramatically since the first edition of The Greater Milwaukee Annual Report on Health Care. Hospital admissions rose 21 percent between 1995 and 2005, while patient days dropped 5 percent (chart at right). As a result, the average time patients spend in the hospital has also dropped – from 5.6 days in 1995 to 4.4 days in 2005 – a decrease of 22 percent. One of the big stories in the first edition was the "break up" of Aurora Health Care and UnitedHealthcare over price and care management issues. It took the two organizations almost a decade to come to terms on a new contract, which was accomplished last year. Although the contract dispute caused considerable disruption among patients and providers, neither Aurora nor UnitedHealthcare was significantly harmed. After a slight dip in admissions and enrollment, both organizations quickly rebounded. Between 1995 and 2005, Aurora's inpatient admissions increased 32 percent, well ahead of the regional average, while UnitedHealthcare's enrollment increased 47 percent at a time when the region's overall enrollment in health maintenance organizations dropped by 10 percent, according to the Wisconsin Insurance Commissioner's Office.

inner-city facility that lost close to $100 million over the last five years. It also announced the construction of a new $80 million outpatient center in Franklin that it hopes will give it a solid foothold in the rapidly growing communities of southern Milwaukee and northern Racine counties.

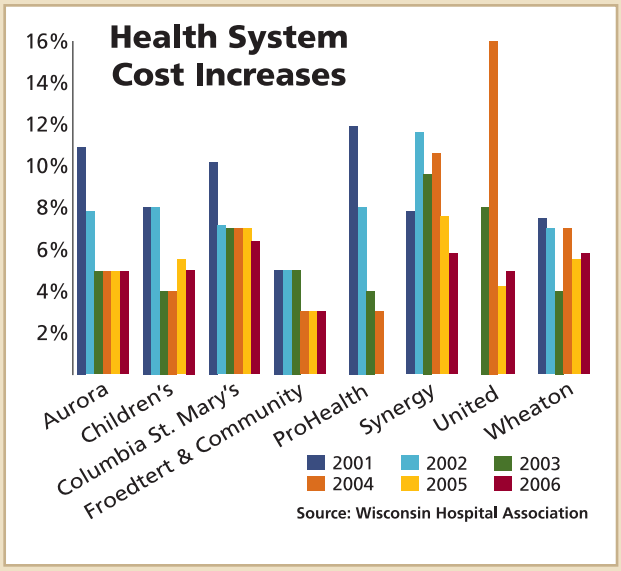
Aurora, too, has been successful in extending its reach beyond Milwaukee County. This summer, it finally received permission to build a new 88-bed hospital in western Waukesha County, an objective it has been pursuing for several years. The new facility will put pressure on nearby Oconomowoc Memorial Hospital, which is owned by ProHealth Care. ProHealth Care is also keeping an eye on Fort HealthCare of Fort Atkinson, which has stepped up advertising in the area after completing a $38 million expansion of its flagship hospital – Fort Atkinson Memorial. Fort Health's primary market is Jefferson County, but its service area reaches into western Waukesha County.

More provider changes are on the horizon. In addition to senior management turnover at what was Covenant, significant leadership change is occurring at Aurora, where G. Edwin Howe has announced his plans to retire as soon as a successor is found.

The Push for Quality and Transparency

Health care providers and insurers are also being pressured by employers, who have stepped up their efforts to apply the quality and cost improvement practices they developed for their businesses to the health care market. Chief financial officers and controllers are now overseeing health care decisions at many companies, replacing human resource professionals in this role.

Unfortunately, applying business practices to the health care model has proven to be daunting. Even the issue of transparency gets cloudy given the variations in care needed to treat patients with different levels of illness. It's relatively easy to compare prices for physician office visits, blood work, or X-rays; it gets increasingly difficult when you look at surgical procedures. For example, one provider may be able to perform bypass surgery less expensively than another provider, but may be performing bypasses when other providers would be performing less invasive (and less costly) procedures such as angioplasties.



Hospital cost increases have slowed dramatically since 2001, according to published data filed with the state. Hospitals must notify the public whenever an annualized price increase exceeds the federal government's consumer price index (CPI), which was 3.4 percent in 2006. Missing data above indicates the hospital's price increase was at or below the CPI. Between 2000 and 2006, Synergy had the greatest price jump, an increase of 60 percent, followed by Columbia St. Mary's at 55 percent. Froedtert had the lowest increase at 26 percent.

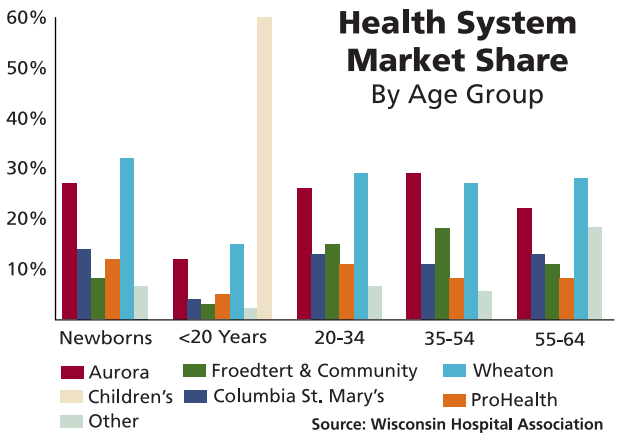
These types of issues will have to work themselves out as quality and transparency initiatives take root. Meanwhile, health plans continue to make significant strides in helping consumers understand health care costs. Most plans now have web-based tools that allow consumers to track their claims and out-of-pocket costs and to compare providers based on cost and/or quality.

Regional and national efforts are also under way. The Wisconsin Collaborative for Healthcare Quality, which includes most of the region's health systems and large physician groups, is one of six coalitions nationwide participating in a federal pilot project intended to develop a practical model for collecting and reporting clinical information from physician practices that would be useful for consumers and doctors. Another initiative, the Wisconsin Health Information Organization (WHIO), is assembling a statewide database to measure efficiency among health care

providers. The state's largest health insurers have agreed to pool their claims data, which would allow the WHIO to track patients over a period of time, giving a more accurate gauge of costs rather than looking at one hospital stay or office visit.

Taking Care of the Poor

Health systems are convinced they can do little to contain costs until they find a better way to treat Medicaid and uninsured patients. Many are awaiting the fallout from the closing of St. Michael Hospital, which promises to be the most significant change in indigent care since the closing of Milwaukee County's John L. Doyne Hospital in 1995. Wheaton has invested $3.8 million to renovate the emergency department at St. Joseph Regional Medical Center and accommodate 25,000 additional visits per year. Aurora's Sinai Medical Center and Columbia St. Mary's Milwaukee Campus have also been impacted.



Health system inpatient market share shows slight variations by age group, according to 2004 data from the Wisconsin Hospital Association. Aurora Health Care and Wheaton Franciscan Healthcare together control between 53 percent and 60 percent of the region's market share from all age groups but one: Children's Health System dominates the under 20 age group with 60 percent of the market share.

Meanwhile, the Medical Society of Milwaukee County is attempting to set up a network of volunteer physicians who would treat people without insurance, and executives from the area's largest health care systems have formed the Milwaukee Health Care Partnership to pursue government grants and raise funds to provide clinic and urgent care facilities in underserved areas.

Construction

Hospitals and clinics continue to be one of the hottest segments of the construction market. Even as Froedtert completes construction of a $120 million expansion of its cancer center, Columbia St. Mary's has broken ground for a new $417 million facility on Milwaukee's East Side. The 513-bed hospital will replace the system's existing St. Mary's and Columbia campuses when it opens in 2010. Columbia St. Mary's is also completing work on a $72 million expansion of its Ozaukee campus that will add 67 beds when completed next fall.

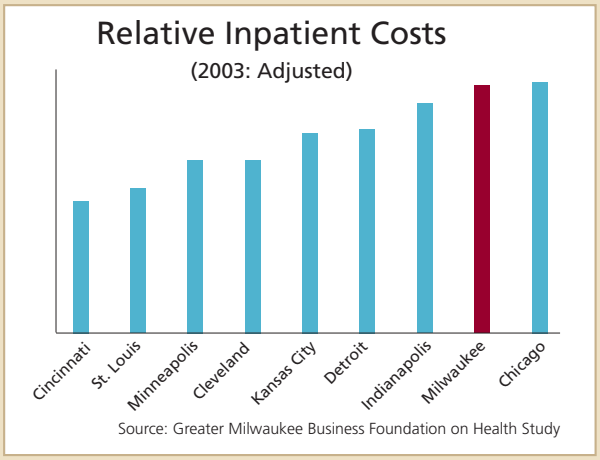
Other construction projects of note include:

- Children's Hospital has embarked on a $117 million, 12-story addition that will add 72 inpatient beds and expand the pediatric intensive care unit, surgical suites, and emergency department and trauma center when completed in 2009.
- ProHealth Care's Oconomowoc Memorial Hospital has started a three-year, $37 million expansion and renovation that will add 44,000 square feet of space and 20 beds. The plan also calls for a major renovation of the facility and an expansion of the emergency department.
- LifeCare Hospitals, a national hospital group that focuses on caring for long-term patients, is building a 60-bed, acute-care hospital in Pewaukee that will care for acutely ill and seriously injured patients when it opens in March 2007.
- Wheaton is building a 160,000-square-foot outpatient center in Sussex and a 233,000-square-foot outpatient center in Franklin.

ANOTHER YEAR, TWO MORE STUDIES

Federal, local studies conclude again that Milwaukee's health care costs are too high, but finally there are some ideas on the table for discussion

It is getting to be old news. Within the last year, two more studies have demonstrated that Milwaukee's health care costs are higher than those of other cities. The first was a follow-up study from the federal General Accounting Office, which compared Milwaukee's hospital, physician and total health care costs to metropolitan areas throughout the nation. The second was a follow-up study from The Greater Milwaukee Business Foundation on Health, which compared Milwaukee and eight other Midwestern cities. Of the two studies, the business foundation initiative was the most significant for two reasons – it did a better job of comparing apples to apples because it looked at cities of similar size in the same geographic region (the Midwest). It also offered, for the first time, some tangible solutions that community leaders, health care purchasers and providers could debate. Whether the recommendations are valid or achievable remains open to debate, but there are now some ideas on the table for discussion.



Milliman's analysis for the Greater Milwaukee Business Foundation on Health study found that Milwaukee's adjusted inpatient costs were the second-highest of nine Midwestern cities. For a copy of the complete study, go to: www.gmbfh.org.

Identifying the Market Dynamics That Drive Up Health Care Costs

The business foundation's analysis, which was conducted by Milliman, focused on inpatient costs. It concluded that no single factor was substantially responsible for Milwaukee's high inpatient costs. Instead, it identified the interaction of five factors that may be pushing prices upward:

1. Milwaukee insurers have smaller market shares than insurers in other cities, which reduces their negotiating leverage with providers
2. Hospital contracts in Milwaukee have been based on negotiated discounts, which give hospitals more freedom to raise rates. In other cities, contracts are more likely to include fixed charges based on specific procedures or diagnoses.
3. Per-unit hospital operating costs in Milwaukee are 14 to 26 percent higher (after adjusting for wage-rate differences) than the other cities analyzed
4. Milwaukee's health care systems are more geographically concentrated than in other cities, which makes it difficult for purchasers to exclude a hospital or health system without inconveniencing plan members
5. Two health systems – Aurora and Wheaton – bear a disproportionate share of the region's Medicare and Medicaid costs, but because they are the largest health care systems, they can use their market dominance to recoup some of the financial shortfall from commercial payers. Smaller systems can "shadow price" Aurora and Wheaton, even though they don't have the same Medicare/Medicaid burden, effectively establishing rates that are higher than would be found in a more balanced market. In other cities, the Medicare/Medicaid burden is more evenly distributed among health systems.

Since the release of the report this spring, the foundation has met with employers, payers, providers and governmental entities to find common ground on the changes it thinks are necessary to correct the upward price pressures. Some objectives are rather

straightforward. For example, the foundation wants area hospitals to commit to reducing their per-unit operating costs to the Midwest average within three years and to the lowest quartile of Midwest cities within five years. Other objectives will require cooperation and collaboration among traditional competitors. The foundation recommends that purchasers consolidate their purchasing power to secure better negotiating leverage with providers, but it is not clear who would control that process. And, what guarantees would there be that a dominant purchaser would pass along any savings? The foundation also recommends that Wheaton and Aurora be allowed to open non-tertiary hospitals in suburban communities to help them offset their cost-shifting burden, but that idea is not going to get much support from existing hospitals already serving those suburban markets.

Whether the foundation can achieve its objective to bring purchasers, providers and the government together to implement a regional solution to high health care costs remains to be seen. It will be difficult enough to get competing providers and insurers to agree to a definition of the "common good," let alone getting them to commit to implementing it.

Fortunately, market forces may already be correcting some of the issues outlined in the foundation's report, which is based on data that is several years old. For example, many of the newly negotiated hospital contracts are based on set fees instead of negotiated discounts, which should slow the increase in unit prices. In addition, several of the region's health care systems are working together to establish inner-city clinics for Medicaid and uninsured patients in the hope that these facilities will ease the non-urgent care hospitals are now providing in their emergency rooms. Both Aurora and Wheaton are building medical facilities in the suburbs, which should help them offset the losses they incur in Milwaukee. The effects of market forces and the foundation initiatives won't be known for several years. And, even if successful, they aren't likely to lower health care costs. Probably the best that can be expected is a reduction in the rate of increase, which will allow the rest of the nation to catch up.

The GAO Study: A First Attempt at Nationwide Comparisons

Last fall, the General Accounting Office (GAO) released the results of its analysis of claims for millions of federal employees in more than 331 urban areas nationwide. It found that health care costs varied by as much as 100 percent among urban areas. The study also found that Milwaukee's adjusted hospital costs were 58 percent higher than the national average, its physician costs were 22 percent higher than the national average and its overall health care costs were 20 percent above the national average. Ironically, this occurred even though Milwaukee is considered a competitive market by GAO standards. The GAO study found that two hospitals or health systems controlled 75 percent of the market share in more than half of the cities analyzed. Aurora and Wheaton, by comparison, have a combined market share of 48 percent, which is just slightly above the 44-percent threshold that GAO uses to define the "most competitive" urban areas.

The GAO study is significant in that it marks the first attempt to compare health care costs among cities nationwide, but its results may be distorted by the relatively small sample size it relied on in many markets (see chart at right). The study also did not address variances in the rates paid by networks within each market. In one city, federal employees may be part of a network that has the highest costs for that market; in another city, federal employees may be enrolled in that market's most cost-effective plan. The study can be downloaded at: www.gao.gov.

Metro Area	Population	Sample Size*	Percent of Total
Least Expensive Cities			
Grand Rapids, MI	1.1 million	8,312	0.78%
Honolulu	884,956	50,494	5.71%
Buffalo, NY	1.2 million	21,916	1.90%
Boston, MA	3.3 million	36,916	1.12%
Johnstown, PA	236,001	3,287	1.39%
Most Expensive Cities			
Biloxi/Gulfport, MS	356,665	18,256	5.12%
Myrtle Beach, SC	181,343	2,004	1.10%
Monroe, LA	149,390	1,291	0.90%
Hattiesburg, MS	112,810	1,984	1.76%
Parkersburg-Marietta, WV-OH	150,830	5,073	3.36%
Milwaukee	**1.5 million**	**22,541**	**1.54%**

* Includes federal employees and their dependents (based on a family size of 2.2 people)

In many of the markets that GAO analyzed, federal employees represented less than 3 percent of the region's total population, which may have distorted some of the data. Above are comparisons of sample sizes in the least expensive and most expensive cities according to the GAO report.

MEASURING QUALITY

Assessing How Hospitals Compare

There's no shortage of efforts to measure provider quality, but many of the initiatives are not well known by employers and consumers. On the following pages, we have listed some of the quality measures for local hospitals as compiled by leading local, state and national coalitions. Information from the Wisconsin Collaborative for Health Care Quality is not included because its hospital comparisons are based on CheckPoint and Centers for Medicare and Medicaid Services' data, which is provided. Much of the Wisconsin collaborative's efforts are focused on physician measures and can be viewed at the collaborative's web site: www.wchq.org.

Following is a brief description of the organizations whose data we have included:

CheckPoint

Sponsored by the Wisconsin Hospital Association, CheckPoint provides data on 14 hospital interventions for the treatment of heart attacks, heart failure and pneumonia; eight surgical services measures; and five error-prevention goals. The 128 hospitals reporting to CheckPoint provide care to more than 99 percent of the state's patient population. The medical and surgical services measures are based on data collected over four calendar quarters. The reports are updated each quarter to include more current quarters.

Hospital Compare

A joint effort of the Centers for Medicare & Medicaid Services and the Hospital Quality Alliance (HQA), Hospital Compare reports the frequency with which hospitals provide recommended care. The HQA is a public-private collaboration that includes the American Hospital Association (AHA), Federation of American Hospitals (FAH) and Association of American Medical Colleges (AAMC).

The Leapfrog Group

Formed in 1998, The Leapfrog Group is a consortium of large employers seeking to improve the quality and affordability of health care. Funded by the Business Roundtable, The Robert Wood Johnson Foundation and member organizations, the group has identified four quality and safety practices that are the focus of its hospital performance comparisons: computerized physician-order entry; evidence-based hospital referral; intensive care unit (ICU) staffing by physicians experienced in critical care medicine; and The Leapfrog Safe Practices Score, which is based on National Quality Foundation-endorsed safe practices.

HealthGrades

HealthGrades, Inc. is a publicly traded health care ratings, information, and advisory services company that provides quality ratings and profiles of hospitals, nursing homes and physicians to consumers, corporations, health plans and hospitals. Its health-management tools are used by 3 million consumers, 125 of the nation's largest employers and health plans, and more than 250 hospitals.

Quality Comparisons by Hospital

	CheckPoint			Centers for Medicare & Medicaid Services				
	Mark Site	Check Process	Elim Abbrev	Aspirin Arrival	Beta Blocker	LVF Assess	Oxygen Assess	Blood Culture
Average	**97%**	**98%**	**96%**	**91%**	**87%**	**80%**	**99%**	**82%**
Benchmark (Top 10%)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**93%**
Aurora - Lakeland	100%	100%	98%	N/R	N/R	N/R	N/R	N/R
Aurora - Kenosha	98%	99%	95%	N/R	N/R	N/R	N/R	N/R
Aurora - Sinai	N/R	N/R	N/R	97%	94%	99%	99%	81%
Aurora - Washington County	94%	96%	98%	94%	86%	90%	100%	83%
Children's	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
Children's - Kenosha	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
CSM - Columbia	94%	97%	97%	96%	94%	88%	100%	86%
CSM - Milwaukee	96%	98%	100%	99%	90%	97%	100%	86%
CSM - Ozaukee	99%	100%	98%	98%	92%	88%	100%	91%
Community Memorial	95%	99%	99%	94%	89%	90%	100%	92%
Elmbrook Memorial	N/R	N/R	N/R	100%	86%	96%	100%	94%
Froedtert Memorial	83%	98%	99%	99%	98%	96%	100%	83%
Kenosha Medical Center	97%	96%	98%	N/R	N/R	N/R	N/R	N/R
Memorial - Burlington	100%	100%	98%	N/R	N/R	N/R	N/R	N/R
Oconomowoc Memorial	99%	99%	92%	98%	97%	93%	100%	77%
St. Catherine's	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
St. Francis	86%	95%	99%	97%	84%	86%	100%	84%
St. Joseph Community	N/R	N/R	N/R	77%	70%	88%	100%	91%
St. Joseph Reg Medical Center	92%	94%	93%	98%	94%	93%	100%	80%
St. Luke's Medical Center	100%	96%	97%	95%	93%	94%	100%	94%
St. Michael (Closed 2006)	N/R	N/R	N/R	91%	89%	92%	100%	89%
Waukesha Memorial	99%	99%	98%	95%	92%	95%	100%	84%
West Allis Memorial	97%	96%	98%	88%	80%	95%	100%	94%
Wheaton - All Saints	91%	92%	98%	N/R	N/R	N/R	N/R	N/R
Wisconsin Heart Hospital	100%	100%	100%	100%	93%	95%	100%	100%

Wisconsin Hospital Association CheckPoint www.wicheckpoint.org

Mark Site: Composite score (100=perfect) measuring the marking of the site on the patient for a procedure or surgery

Check Process: Composite score (100=perfect) measuring the confirmation of right patient, right procedure and right site

Eliminate Abbreviations: Composite score (100=perfect) indicating progress toward elimination of nine confusing medical abbreviations

Centers for Medicare & Medicaid Services www.hospitalcompare.hhs.gov

Aspirin at Arrival: Percentage of cardiac patients given aspirin upon arrival

Beta Blocker: Percentage of heart patients given Beta blocker at discharge

LVF Assessment: Percentage of congestive heart failure patients given an assessment of left ventricular function

Oxygen Assessment: Percentage of pneumonia patients given an oxygenation assessment

Blood Culture: Percentage of pneumonia patients having a blood culture performed before receiving first antibiotic

Quality Comparisons by Hospital

	Leapfrog					HealthGrades			
	CPOE	ICU	Bypass	Angio	Delivery	Safety	Back	Maternity	Knee
Aurora - Lakeland	1	1	N/R	N/R	N/R	4	N/R	3	3
Aurora - Kenosha	1	2	N/R	N/R	N/R	3	N/R	3	3
Aurora - Sinai	1	3	2	4	4	4	N/R	3	3
Aurora - Washington County	1	1	N/R	N/R	N/R	4	N/R	5	3
Children's	4	4	N/R	N/R	4	4	N/R	N/R	N/R
Children's - Kenosha	1	N/R	N/R	N/R	N/R	4	N/R	N/R	N/R
CSM - Columbia	1	1	3	2	2	3	1	3	3
CSM - Milwaukee	1	1	3	3	2	3	N/R	3	3
CSM - Ozaukee	1	1	N/R	N/R	N/R	3	3	3	3
Community Memorial	1	1	3	1	1	3	3	3	3
Elmbrook Memorial	1	1	N/R	N/R	N/R	4	3	3	3
Froedtert Memorial	1	3	2	1	3	3	3	3	3
Kenosha Medical Center	N/R	N/R	N/R	N/R	N/R	N/R	3	3	5
Memorial - Burlington	1	1	N/R	N/R	N/R	4	N/R	3	3
Oconomowoc	1	1	N/R	3	N/R	4	N/R	3	1
St. Catherine's	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
St. Francis	1	1	2	4	N/R	4	3	3	3
St. Joseph Community	N/R	N/R	N/R	N/R	N/R	N/R	N/R	1	5
St. Joseph Reg Medical Center	1	3	3	4	4	4	3	3	3
St. Luke's Medical Center	1	3	3	3	4	4	1	1	3
St. Michael (Closed 2006)	1	1	2	3	N/R	4	N/R	3	N/R
Waukesha Memorial	1	1	3	4	2	4	3	5	5
West Allis Memorial	1	1	N/R	N/R	2	4	3	3	5
Wheaton - All Saints	1	1	1	2	1	1	3	3	5
Wisconsin Heart Hospital	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R

Leapfrog

1. Willing to report; does not meet early-stage criteria
2. Good early-stage effort
3. Good progress at fully implementing standard
4. Fully implemented the standard

N/R Did not report

HealthGrades

1. Ranks poorly compared to similar hospitals
2. Ranks between poorly and "as expected"
3. Ranked "as expected"
4. Ranked between as expected and the best
5. Ranked among the best hospitals

Leapfrog www.leapfroggroup.com

CPOE: Computerized Physician Order Entry: 75% of physicians use CPOE with error-prevention software to prescribe medications
ICU: Intensive Care Units are staffed by intensivists who must be able to respond to pages within five minutes 95 percent of the time
Bypass: Performs at least 450 coronary artery bypass graft surgeries per year
Angio: Performs at least 400 percutaneous coronary interventions (angioplasties) per year
Delivery: Operates a neonatal ICU unit with an average daily census of at least 15 patients

HealthGrades www.healthgrades.com

Safety: Based on hospital's performance on more than a dozen patient safety indicators
Back: Proprietary performance measure related to back and neck surgery (except spinal fusion)
Maternity: Proprietary performance measure related to maternity services
Knee: Proprietary performance measure related to total knee replacement surgery

BATTLE OF THE ZIP CODES

Consumer-driven health care is based on the premise that people will shop around for providers based on quality and efficiency; however, proximity continues to be the primary factor consumers use to select providers. An analysis of 2004 Medicare data indicates that around 60 percent of hospital admissions come from the three closest Zip codes (the notable exceptions being St. Luke's Medical Center and Froedtert Hospital). Significant competition existed in only 11 of the 101 Zip codes analyzed as shown in the chart above (the system with the largest market share in each Zip code is highlighted in red). The most competitive Zip codes were just west and northwest of Milwaukee.

THE MOST COMPETITIVE COMMUNITIES

ZIP	Community	Aurora	CSM	Froedtert & Community	ProHealth	Wheaton
53151	New Berlin	25%	-	-	16%	15%
53205	Milwaukee	33%	10%	-	-	-
53206	Milwaukee	21%	12%	17%	-	26%
53208	Milwaukee	19%	-	17%	-	21%
53209	Milwaukee	-	31%	10%	-	33%
53212	Milwaukee	17%	31%	-	-	11%
53214	West Milwaukee	35%	-	15%	-	-
53216	Milwaukee	11%	12%	16%	-	38%
53223	Brown Deer	-	31%	-	-	18%
53225	Milwaukee	-	11%	16%	-	34%
53226	Wauwatosa	-	-	33%	-	33%

"OWNED" COMMUNITIES: WHERE SYSTEMS DOMINATE

AURORA HEALTH CARE

ZIP	Community	Share	Competitor
53220	Greenfield	73%	(Wheaton - 10%)
53110	Cudahy	72%	(Wheaton - 15%)
53219	Milwaukee	72%	(None)
53172	South Milwaukee	66%	(Wheaton - 19%)
53132	Franklin	65%	(Wheaton - 13%)
53154	Oak Creek	64%	(Wheaton - 16%)
53221	Milwaukee	63%	(Wheaton - 18%)

COLUMBIA ST. MARY'S

ZIP	Community	Share	Competitor
53074	Port Washington	68%	(None)
53211	Milwaukee	66%	(None)
53024	Grafton	65%	(Froedtert/Community - 17%)
53012	Cedarburg	64%	(None)
53092	Thiensville	60%	(None)

FROEDTERT & COMMUNITY HEALTH

ZIP	Community	Share	Competitor
53051	Menomonee Falls	73%	(None)
53022	Germantown	68%	(None)
53017	Colgate	64%	(None)
53033	Hubertus	64%	(None)
53089	Sussex	60%	(None)

PROHEALTH CARE

ZIP	Community	Share	Competitor
53188	Waukesha	76%	(None)
53189	Waukesha	76%	(None)
53149	Mukwonago	75%	(None)
53186	Waukesha	69%	(Wheaton - 10%)
53029	Hartland	61%	(None)

SYNERGY

ZIP	Community	Share	Competitor
53040	Kewaskum	64%	(None)

UNITED HEALTH SYSTEM

ZIP	Community	Share	Competitor
53143	Kenosha	64%	(Aurora - 16%)
53140	Kenosha	62%	(Aurora - 14%)

WHEATON FRANCISCAN HEALTHCARE

ZIP	Community	Share	Competitor
53404	Racine	85%	(None)
53403	Racine	82%	(None)
53406	Racine	81%	(None)
53506	Racine	81%	(None)
53402	North Bay	77%	(None)

In 30 of the 101 Zip codes analyzed, one health system had a dominant market share, controlling at least 60 percent of all Medicare admissions. In addition, there were only 10 Zip codes in which the dominant health system had a competitor that had more than 10 percent market share.

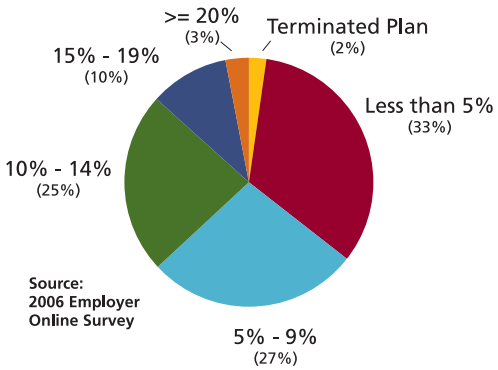
Annual Employer Health Care Benefits Survey

Most Employers Achieve Single-Digit Increases

Sixty-one percent of Milwaukee-area employers achieved single-digit health care cost increases in 2006, significantly better than the 46 percent and 36 percent who achieved the same in 2005 and 2004, respectively, according to *The Greater Milwaukee Annual Report on Health Care's* annual employer benefits survey. More than 250 companies responded to the online survey, which was completed this summer.

Only 3 percent of survey respondents reported a final increase greater than 20 percent. This was down significantly from the 12 percent of respondents who made the same claim in 2005 and the 14 percent who reported 20 percent or more increases in 2004. Two percent of respondents said they terminated their health plan in 2006, down from 5 percent in 2005.

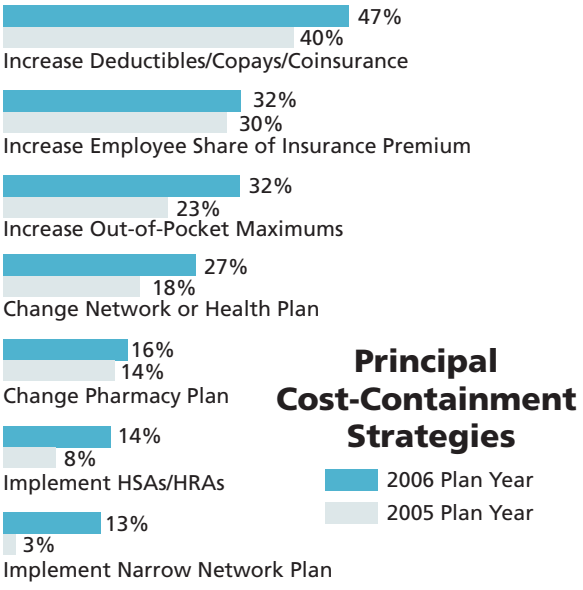
2006 Final Plan Cost Increase



The median premium or premium-equivalent rate (employer and employee share combined) was between $4,250-$4,499 for single coverage, although 40 percent of respondents reported a premium of $4,750 or more. Twenty-three percent reported single-coverage premiums of less than $3,250. The median family premium or premium equivalent was $12,000-$12,499, with 39 percent of respondents reporting an annual premium of $13,000 or more. Twenty-two percent reported family premiums of less than $10,000.

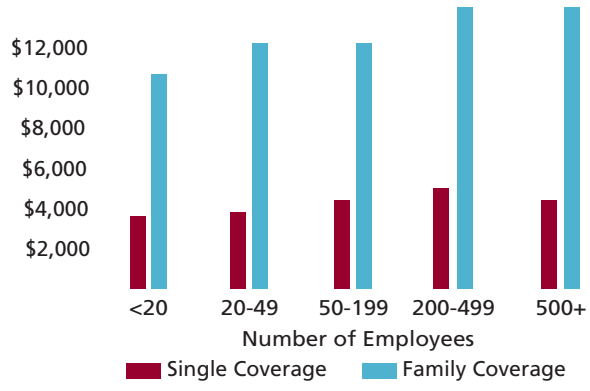
Forty-five percent of respondents expected 2007 initial renewal notices to be less than 10 percent and 37 percent expected increases to be in the 10 percent to 14 percent range.

Principal Cost-Containment Strategies



Employers were more likely to increase employees' out-of-pocket costs than payroll deductions. Forty-seven percent of respondents increased deductibles, copays and/or coinsurance; one-third increased the employee share of the premium. Twenty-seven percent of respondents changed networks or health plans for the 2006 plan year, up significantly from 18 percent in 2005.

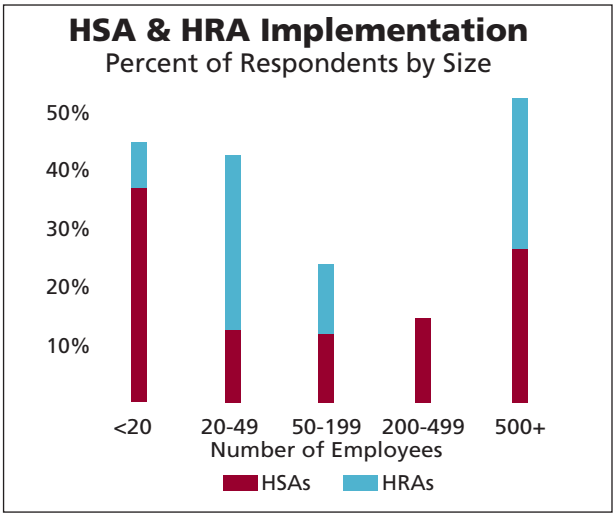
Average Annual COBRA Premiums



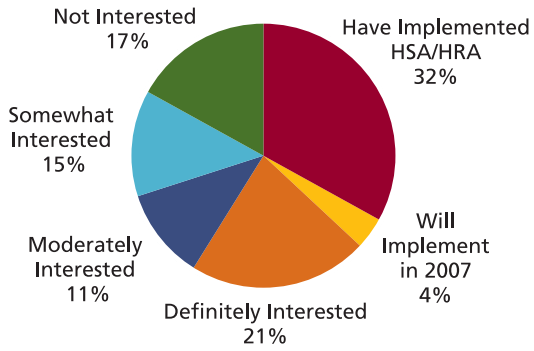
Generally speaking, total premium costs (employer and employee share combined) increased with the size of the employer. Small employers had annual premium costs of $3,500-$3,749 for single coverage and $10,500-$10,999 for family coverage. Companies with more than 200 employees had annual premium costs in excess of $4,750 for single coverage and $13,000 for family coverage.

HSAs and HRAs

Almost one-third of employers responding to the survey have implemented either a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) for their employees and another 25 percent showed strong interest. The popularity of the two consumer-driven approaches was evenly split: 18 percent implemented HSAs and 14 percent implemented HRAs, with smaller companies preferring HSAs and larger companies selecting HRAs. Forty percent of employers made their contribution contingent on specific employee activities, including yearly physicals (25 percent), health-risk assessments (12 percent) and participation in wellness programs (12 percent). Employers with HSA and HRA arrangements enjoyed significantly lower premium costs than other benefit plan approaches.



Employer Interest in HSAs and HRAs



Median Annual COBRA Premium

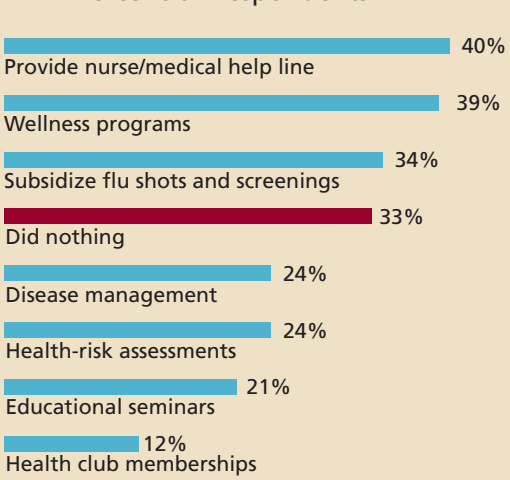
Type of Plan	Single	Family
HSA	$3,750-$3,999	$11,000-$11,499
HRA	$3,750-$3,999	$11,500-$11,999
Neither	$4,500-$4,749	$12,500-$12,999

Typical HSA & HRA Characteristics

Account Funding (Employer Share)	Single	Family
	$500-$749	**$1,000-$1,249**
Deductible for Qualifying Plan	Single	Family
	$1,500-$1,749	**$3,000-$3,499**
Percent of Employees Enrolled in HSA/HRA		**>45%**

PREVENTION & WELLNESS INITIATIVES

Employers were slightly more aggressive in implementing prevention and wellness strategies for 2006 than they were in 2005. Two-thirds of employers had at least one program in place, up from 59 percent last year. Interest in wellness/prevention activities depended on employer size. Ninety-six percent of companies with more than 500 employees offered a prevention or wellness program, compared to less than a third of companies with less than 20 employees. For all employers, the use of nurse/medical help lines was the most popular approach. Health-risk assessments and disease management programs showed the greatest increase in popularity, both jumping from 14 percent of respondents in 2005 to 24 percent in 2006. Large companies (more than 500 employees) were most likely to utilize health-risk assessments and disease management programs (74 percent and 63 percent of respondents, respectively). Fewer than 5 percent of small businesses (less than 50 employees) used health-risk assessments and fewer than 15 percent used disease management programs.



Plan Characteristics by Type of Company

There was no significant difference in plan designs and costs between the various types of private-sector employers, but there were several notable distinctions between public-sector and private-sector employers. Government and schools reported the lowest median copay ($5), the lowest deductibles (less than $300 for single and less than $750 for families) and the lowest annual out-of-pocket expenses (less than $500 for individuals and less than $2,000 for families). In addition, they had the most generous co-insurance: 100 percent for in-network providers and 80 percent for out-of-network providers.

Not surprisingly, they also had the highest median premium costs as well. All of the government and education respondents indicated their premium costs this year were at least $4,750 for single coverage and $13,000 for families, the highest bracket in the survey. They also had little interest in HSAs or HRAs: none of the respondents offered the consumer-driven plans.

Median Annual COBRA Premium

Type of Company	Single	Family
Service	$3,750-$3,999	$11,500-$11,999
Manufacturing	$4,000-$4,249	$11,500-$11,999
Government/Education	$4,750+	$13,000+
Other	$4,500-$4,749	$13,000+

Typical Plan Characteristics

Type of Company	% Paid by Employer		Deductible		Physician Copay	Co-Insurance		Out-of-Pocket Maximums	
	Single	Family	Single	Family		Network	Out	Single	Family
Service	75%-79%	75%-79%	$500-$599	$750-$1,499	$20	80%	70%	$2,000-$2,499	$4,000-$4,999
Manufacturing	85%-89%	80%-84%	$500-$599	$1,500-$1,749	$20	85%	65%	$2,000-$2,499	$4,000-$4,999
Government/Education	95%-99%	90%-99%	<$300	<$750	$5	100%	80%	<$500	<$2,000
Other	80%-84%	75%-79%	$500-$599	$1,500-$1,749	$20	80%	70%	$1,500-$1,999	$4,000-$4,999

Median 2005 Premium Costs

Total premium cost (COBRA rate – employer and employee share combined)

Single Coverage: **$3,500-$3,749**

Family Coverage: **$10,500-$10,999**

Expected Increase 2007: **5% - 9%**

Typical Plan Characteristics

Percent Paid by Employer	Single	Family	
	90%-94%	**85%-89%**	
Deductible	Single	Family	
	$500-$599	**$1,500-$1,749**	
Out-of-Pocket Maximums	Single	Family	
	$1,500-$1,999	**$3,000-$3,999**	
Physician Office Copay		**$20**	
Prescription Plan Copays	Tier 1	Tier 2	Tier 3
	$5	**$25**	**$40**

Fewer than 20 Employees

Fifty-five percent of respondents achieved single-digit cost increases in 2006; 12 percent reported an increase greater than 15 percent. Primary cost-containment strategies implemented this year included:

- increasing deductibles and copays (49 percent of respondents)
- increasing out-of-pocket maximums (37 percent of respondents)
- implementing HSAs (23 percent of respondents)

Thirty-seven percent of employers offer health savings accounts (HSAs) to their employees, the highest percentage of employer groups. Another 23 percent say they will implement HSAs in 2007 or are "definitely interested" in the idea. Only one-third of respondents said they had implemented any pro-active wellness or disease-prevention strategies.

2006 Total Premium or Health Plan Costs (Employer and Employee Share Combined)

Single Coverage	<$3,250	$3,250-$3,499	$3,500-$3,749	$3,750-$3,999	$4,000-$4,249	$4,250-$4,499	$4,500-$4,749	$4,750+
% of Respondents	**38%**	**0%**	**16%**	**3%**	**0%**	**6%**	**3%**	**34%**
Family Coverage	<$10,000	$10,000-$10,499	$10,500-$10,999	$11,000-$11,499	$11,500-$11,999	$12,000-$12,499	$12,500-$12,999	$13,000+
% of Respondents	**32%**	**7%**	**11%**	**0%**	**0%**	**14%**	**4%**	**32%**

Median 2005 Premium Costs

Total premium cost (COBRA rate – employer and employee share combined)

Single Coverage: **$3,750-$3,999**

Family Coverage: **$12,000-$12,499**

Expected Increase 2007: **10% - 14%**

Typical Plan Characteristics			
Percent Paid by Employer	Single	Family	
	80%-84%	**75%-79%**	
Deductible	Single	Family	
	$800+	**$1,500-$1,749**	
Out-of-Pocket Maximums	Single	Family	
	$1,500-$1,999	**$3,000-$3,999**	
Physician Office Copay		**$25**	
Prescription Plan Copays	Tier 1	Tier 2	Tier 3
	$10	**$25**	**$50**

20-49 Employees

Fifty-two percent of respondents achieved single-digit cost increases in 2006; 17 percent reported an increase greater than 15 percent. The most common cost-containment strategies were:

- increasing employees' share of the premium or equivalent (39 percent of respondents)
- increasing deductibles, coinsurance and copays (36 percent)
- changing health plans or networks (21 percent)

Forty-three percent of respondents said they had implemented HSA or HRA programs, with HRAs twice as popular as HSAs. This group had the highest median copay and the highest median deductible of all the groups. Employers of this size showed little interest in pro-active disease-prevention programs. Twenty-eight percent said they offered nurse/med lines and 21 percent offered wellness programs, but 39 percent of respondents said they offered nothing.

2006 Total Premium or Health Plan Costs (Employer and Employee Share Combined)								
Single Coverage	<$3,250	$3,250-$3,499	$3,500-$3,749	$3,750-$3,999	$4,000-$4,249	$4,250-$4,499	$4,500-$4,749	$4,750+
% of Respondents	**30%**	**4%**	**4%**	**12%**	**4%**	**8%**	**8%**	**30%**
Family Coverage	<$10,000	$10,000-$10,499	$10,500-$10,999	$11,000-$11,499	$11,500-$11,999	$12,000-$12,499	$12,500-$12,999	$13,000+
% of Respondents	**19%**	**0%**	**4%**	**4%**	**12%**	**19%**	**12%**	**30%**

50-199 Employees

Almost 70 percent of respondents achieved single-digit cost increases in 2006, the highest of all employer groups; 12 percent reported increases greater than 15 percent. The most common cost-containment strategies were:

- increasing deductibles, coinsurance and copays (48 percent)
- increasing employees' share of the premium or equivalent (34 percent)
- increasing out-of-pocket maximums (34 percent)

This segment made employees pay the greatest share of premium costs but had the least interest in consumer-driven plans. Less than 25 percent of respondents said they had implemented either an HSA or HRA, and another 65 percent said they had little or no interest in doing so. Seventy-four percent have some type of pro-active disease-prevention program. Nurse/med lines were the most common, followed by flu shots and wellness programs.

Median 2005 Premium Costs

Total premium cost (COBRA rate – employer and employee share combined)

Single Coverage: **$4,250-$4,499**

Family Coverage: **$12,000-$12,499**

Expected Increase 2007: **5% - 9%**

Typical Plan Characteristics			
Percent Paid by Employer	Single	Family	
	80%-84%	**75%-79%**	
Deductible	Single	Family	
	$500-$599	**$750-$1,499**	
Out-of-Pocket Maximums	Single	Family	
	$1,500-$1,999	**$4,000-$4,999**	
Physician Office Copay		**$20**	
Prescription Plan Copays	Tier 1	Tier 2	Tier 3
	$10	**$25**	**$50**

2006 Total Premium or Health Plan Costs (Employer and Employee Share Combined)								
Single Coverage	<$3,250	$3,250-$3,499	$3,500-$3,749	$3,750-$3,999	$4,000-$4,249	$4,250-$4,499	$4,500-$4,749	$4,750+
% of Respondents	**22%**	**2%**	**6%**	**10%**	**6%**	**8%**	**12%**	**34%**
Family Coverage	<$10,000	$10,000-$10,499	$10,500-$10,999	$11,000-$11,499	$11,500-$11,999	$12,000-$12,499	$12,500-$12,999	$13,000+
% of Respondents	**22%**	**8%**	**6%**	**6%**	**6%**	**12%**	**10%**	**30%**

200-499 Employees

Seventy percent of respondents in this group achieved single-digit cost increases in 2006 and none of the respondents had increases that were greater than 15 percent. Nonetheless, this group had the highest premiums of all the employer groups. At least 60 percent of respondents selected the survey's highest bracket ($4,750+ for single coverage; $13,000+ for family coverage).

The most common cost-containment strategies were:

- increasing employees' share of the premium or equivalent (43 percent of respondents)
- increasing deductibles, coinsurance and copays (43 percent)
- increasing out-of-pocket maximums (33 percent)

Fifty-two percent of respondents have wellness programs, 43 percent have nurse/med lines and 33 percent utilize health-risk assessments or subsidize flu shots.

Median 2005 Premium Costs

Total premium cost (COBRA rate – employer and employee share combined)

Single Coverage: **$4,750+**

Family Coverage: **$13,000+**

Expected Increase 2007: **10% - 14%**

Typical Plan Characteristics			
Percent Paid by Employer	Single	Family	
	80%-84%	**75%-79%**	
Deductible	Single	Family	
	$500-$599	**$750-$1,499**	
Out-of-Pocket Maximums	Single	Family	
	$1,500-$1,999	**$3,000-$3,999**	
Physician Office Copay		**$15**	
Prescription Plan Copays	Tier 1	Tier 2	Tier 3
	$10	**$25**	**$45**

2006 Total Premium or Health Plan Costs (Employer and Employee Share Combined)								
Single Coverage	<$3,250	$3,250-$3,499	$3,500-$3,749	$3,750-$3,999	$4,000-$4,249	$4,250-$4,499	$4,500-$4,749	$4,750+
% of Respondents	**15%**	**0%**	**0%**	**0%**	**5%**	**5%**	**15%**	**60%**
Family Coverage	<$10,000	$10,000-$10,499	$10,500-$10,999	$11,000-$11,499	$11,500-$11,999	$12,000-$12,499	$12,500-$12,999	$13,000+
% of Respondents	**25%**	**0%**	**0%**	**0%**	**10%**	**0%**	**0%**	**65%**

500+ Employees

Sixty-nine percent of respondents achieved single-digit cost increases in 2006 but 19 percent reported an increase greater than 15 percent. The most common cost-containment strategies were:

- changing network or plan (42 percent of respondents)
- increasing employees' share of the premium or equivalent (42 percent of respondents)
- increasing deductibles, coinsurance and copays (42 percent)
- increasing out-of-pocket maximums (42 percent)

Fifty-two percent of respondents offered HSAs or HRAs and another 20 percent said they were "definitely interested" in the concept. Employers in this segment were also very active in disease prevention. Eighty-one percent of respondents have wellness programs, 74 percent have disease management programs and 70 percent have nurse/med lines.

Median 2005 Premium Costs

Total premium cost (COBRA rate – employer and employee share combined)

Single Coverage: **$4,250-$4,499**

Family Coverage: **$12,000-$12,499**

Expected Increase 2007: **5% - 9%**

Typical Plan Characteristics			
Percent Paid by Employer	Single	Family	
	80%-84%	**80%-84%**	
Deductible	Single	Family	
	$300-$399	**<$750**	
Out-of-Pocket Maximums	Single	Family	
	$2,500-$2,499	**$4,000-$4,999**	
Physician Office Copay		**$25**	
Prescription Plan Copays	Tier 1	Tier 2	Tier 3
	$10	**$25**	**$50**

2006 Total Premium or Health Plan Costs (Employer and Employee Share Combined)								
Single Coverage	<$3,250	$3,250-$3,499	$3,500-$3,749	$3,750-$3,999	$4,000-$4,249	$4,250-$4,499	$4,500-$4,749	$4,750+
% of Respondents	**9%**	**0%**	**9%**	**17%**	**13%**	**13%**	**9%**	**30%**
Family Coverage	<$10,000	$10,000-$10,499	$10,500-$10,999	$11,000-$11,499	$11,500-$11,999	$12,000-$12,499	$12,500-$12,999	$13,000+
% of Respondents	**11%**	**4%**	**4%**	**8%**	**11%**	**8%**	**11%**	**43%**

National Trends in Health Care

A New Push (And a New Look) for Universal Coverage

Universal health care coverage is back on the front burner, but it has a somewhat new look and feel as states attempt to devise plans that will ensure coverage for all of their citizens but won't be seen as single-payer, government programs. Earlier this year, Massachusetts enacted bipartisan legislation that requires every person in the state to purchase health insurance or face financial penalties. The law requires the policies cover all of the state's 40 mandated coverages, including in-vitro fertilization, and mandates first-dollar coverage for primary care. It also requires employers with 11 or more employees to pay a $295 annual fine for any employee that doesn't have health insurance and to cover all health care costs above $50,000 per year for any uninsured workers they employ. A statewide risk pool, called the "Connector," simplifies the purchase of individual policies and provides subsidies to make policies affordable for low-income workers. Actuaries contracted by the state estimate the cost of coverage through the Connector would be about $200 a month, but there is concern the estimates are unrealistically low and will quickly lead to higher taxes and assessments on individuals and employers.

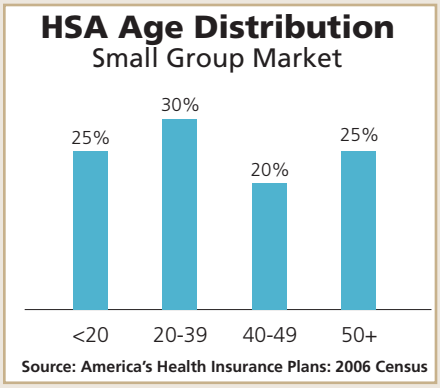
Maine and Vermont have also enacted legislation designed to ensure universal coverage, and several other states are considering the concept to reduce the costs of their programs for the underinsured and Medicaid recipients. In Wisconsin, lawmakers are pondering legislation that would assess employers up to 12 percent of payroll and would assess individual employees 2 percent of their salary to fund a voucher program that individuals would use to purchase insurance from competing vendors.

Earlier this year, the American Medical Association joined the American Hospital Association in support of a federal universal health care coverage requirement. The AMA proposal would require all Americans to purchase catastrophic and preventive health insurance. Individuals earning more than 500 percent of the federal poverty level (which equates to $100,000 for a family of four in 2006) would face tax penalties if they failed to comply. Those earning less would be eligible for subsidies or tax credits to help them pay for coverage.

The universal health care debate is expected to ratchet up this fall when the Citizens' Health Care Working Group submits its final recommendations to the president and Congress. Created as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the 14-member group held public hearings around the country to let the public debate the "services they want cov-

HSAs & HRAs GAIN TRACTION

After a slow start, the number of companies offering HSA-qualified plans is doubling annually. Growth appears to be particularly strong in the large group market, which includes companies with more than 10,000 employees; the number of firms offering the coverage jumped from 1 percent in 2004 to 8 percent in 2005. The appeal of consumer-driven plans appears to be broad-based, allaying fears voiced about the plans when they were first introduced. Although many were concerned that young people would be the primary users of HSA-qualified plans, age distribution appears to be fairly uniform. Fifty-five percent of enrollees are under age 40, while 45 percent are between 40 and 65, according to a report from America's Health Insurance Plans, a trade group representing insurers. There also appears to be no discernible difference between a person's perceived health status and plan selection. Seventy-seven percent of respondents with HSA-qualified plans reported their health status as "good" or "very good," which was identical to the responses of people enrolled in other plans. Eleven percent reported their status as "fair" or "poor," which was slightly less than the 12 percent reported by enrollees in other health plans.



Source: America's Health Insurance Plans: 2006 Census

ered, what health care coverage they want and how they are willing to pay for coverage." The public comment period ended this summer and the final report is due out at the end of September (for more information, go to: www.citizenshealthcare.gov), but the group's key recommendations include:

- All Americans should be guaranteed affordable health care coverage by law
- Coverage should include a legally defined set of benefits that guarantee financial protection against very high health care costs
- The core benefits/services should be selected through an independent, transparent and scientific process that gives priority to the consumer-provider relationship
- Consumers should be allowed to purchase additional coverage for services beyond the core package
- The government should use its federally funded health programs to promote quality, efficiency and cost containment

The building momentum for universal coverage doesn't mean the nation is lurching toward Canadian-style health care. Almost all of the ideas under serious consideration would use market forces, not a government program, to ensure universal coverage. In many cases, the basic plan would be an HSA-qualified, high-deductible plan for catastrophic coverage coupled with some preventive services.

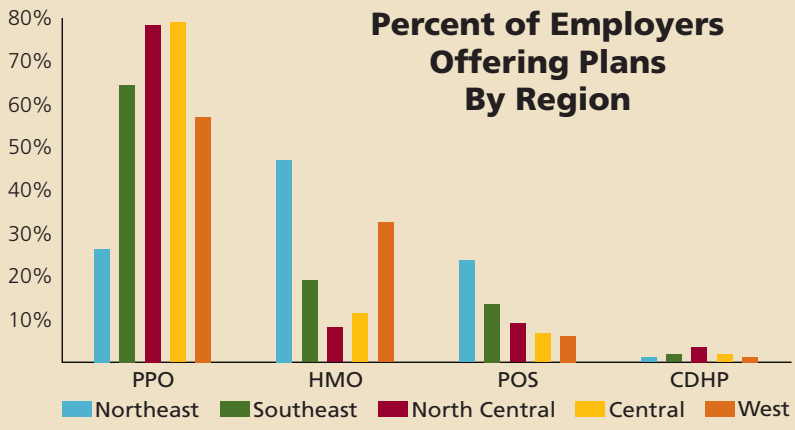
Would Universal Health Care Coverage Matter Anyway?

Even if everyone ends up with insurance, it doesn't mean they would get any healthier. That's the conclusion of a new Rand Corporation study, which shows that virtually every person in the United States is at risk of failing to receive needed care regardless of their race, gender, income or insurance status. The study, which assessed preventive services and care for 30 conditions that are among the leading causes of death and disability, concluded that participants received recommended care only 55 percent of the time even though the recommended treatments are widely known and accepted.

(Continued on page 32)

REGIONAL VARIATIONS IN HEALTH PLANS & COSTS

Benefit plan designs vary significantly by region, demonstrating the different approaches employers have taken in specific geographic areas. This was demonstrated in the 2005 UBA/Ingenix Survey, the most comprehensive nationwide employer benefits survey undertaken. The North Central region, which includes Wisconsin, has a clear preference for Preferred Provider Organizations (PPOs) and shies away from Health Maintenance Organizations (HMOs). The North Central region also has proven to be an early leader in the adoption of consumer-driven health plans (CDHP). Though the percentage of North Central employers offering CDHPs in 2005 was small (3.7 percent), it was almost double the percentage posted in other regions. The survey also showed that North Central employers were more even-handed in their approach to premiums for single and family coverage. The typical employer paid 83 percent of single coverage and 75 percent of family coverage. In other regions, it was common for employers to make employees pay a greater share of the premium burden for family coverage. Employees in the Southeast and Central regions pay 57 percent of family premiums, in the West they must pick up 62 percent of the tab.

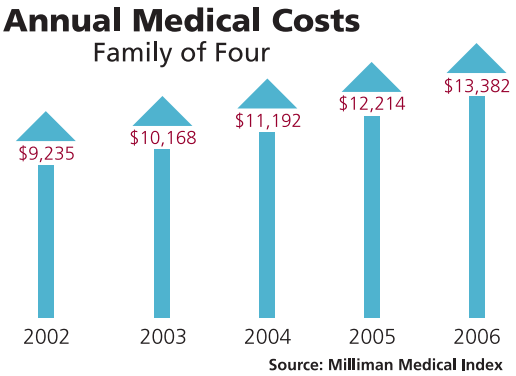


Source: 2005 UBA/Ingenix Health Plan Survey

THE RISING COST OF CARE

The Milliman Medical Index shows a 9.6 percent climb in health care costs for family of four in 2006

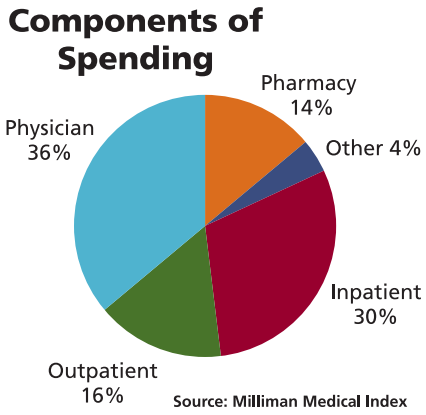
Average annual medical costs for a family of four will be $13,382 in 2006, an increase of 9.6 percent from 2005, according to the 2006 Milliman Medical Index. That is greater than the 9.1 percent increase reported in 2005, but less than the 10.1 percent increases reported for 2003 and 2004. And despite growing employee concerns about bearing a greater financial burden for their health care costs, the average family is paying a smaller portion of its medical costs now than it was three years ago. Employees will pay 38 percent of their total medical costs this year, down from 40 percent in 2003, according to the Milliman Medical Index. During the same time, the employer's share has increased from 58 percent to 60 percent.



The annual medical costs for a "typical" family of four increased 9.6 percent to $13,382 in 2006, according to the Milliman Medical Index. Outpatient costs rose the fastest (12.6 percent). Pharmacy costs, which rose 12.8 percent in 2005, slowed to a growth rate of 8.3 percent in 2006.

The Milliman Medical Index measures the average spending for a "typical" family of four covered by an employer-sponsored PPO program. It is based on an analysis of claims costs nationwide using estimated average provider payment rates and Milliman's analysis of historical claims data and trends in provider contracting. According to the index, the average family will pay approximately $5,020 for its health care this year. This includes $2,810 in premium costs and $2,210 in deductibles, copays and other out-of-pocket expenses. Inpatient and outpatient hospital services will account for 46 percent of total medical costs in 2006, followed by physician services (36 percent), prescription drugs (14 percent) and other miscellaneous services (4 percent).

Outpatient costs will increase the most this year – 12.6 percent – followed by inpatient costs (9.3 percent), pharmacy (8.3 percent) and physician costs (5.9 percent). The increase in pharmacy costs is significantly lower than the 11 percent to 13 percent increases reported in 2003, 2004 and 2005, which Milliman attributes to the increased use of three-tier and four-tier pharmacy plans and to the end of patent protection for several significant brand-name drugs.



Physician costs represent the largest portion of health care spending, accounting for 36 percent of total costs, followed by inpatient and outpatient costs.

According to the Milliman Medical Index, the average family of four will spend $810 in out-of-pocket costs for physician office visits this year, $575 for inpatient care, $285 for outpatient care and $465 for prescription drugs. Utilization and costs for a particular family varies significantly depending on family members' ages and health status. It also varies according to region; for example, average medical costs in Chicago are 13 percent higher than in Dallas but 4 percent lower than New York, according to Milliman's analysis of six selected cities.

The complete Milliman Medical Index can be downloaded at www.hctrends.com or www.milliman.com.

(Continued from page 30)

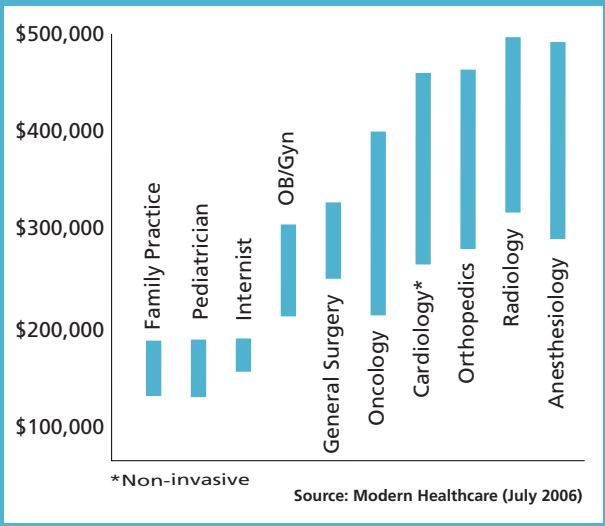
The Rand study found that:

- People with annual family incomes greater than $50,000 had quality scores that were just 3.5 percentage points higher than those whose families had incomes less than $15,000
- Women were more likely to receive recommended care than men (57 percent vs. 52 percent)
- Women were more likely to receive preventive services (58 percent vs. 50 percent) and recommended chronic care (58 percent vs. 55 percent)
- Women were less likely to receive recommended acute care (52 percent vs. 58 percent)
- Younger participants were more likely to be screened, but were less likely to receive follow-up care than older participants
- Adults under age 31 were significantly more likely to receive preventive care
- People aged 31 to 64 received significantly better chronic care than those under age 31.

The study also included some surprising conclusions. African-Americans fared better than whites in several important areas. They were more likely to receive recommended chronic care than whites (61 percent vs. 55 percent), and more likely to receive the recommended treatments (64 percent vs. 56 percent). Whites also fared worse than Hispanics when it came to recommended screenings: 56 percent of Hispanics received recommended screenings, compared to 52 percent for whites.

Nearly 7,000 adults in 12 metropolitan areas participated in the study, which evaluated performance on 439 indicators of quality for a variety of conditions, including urinary tract infections, diabetes, asthma, high blood pressure and heart disease.

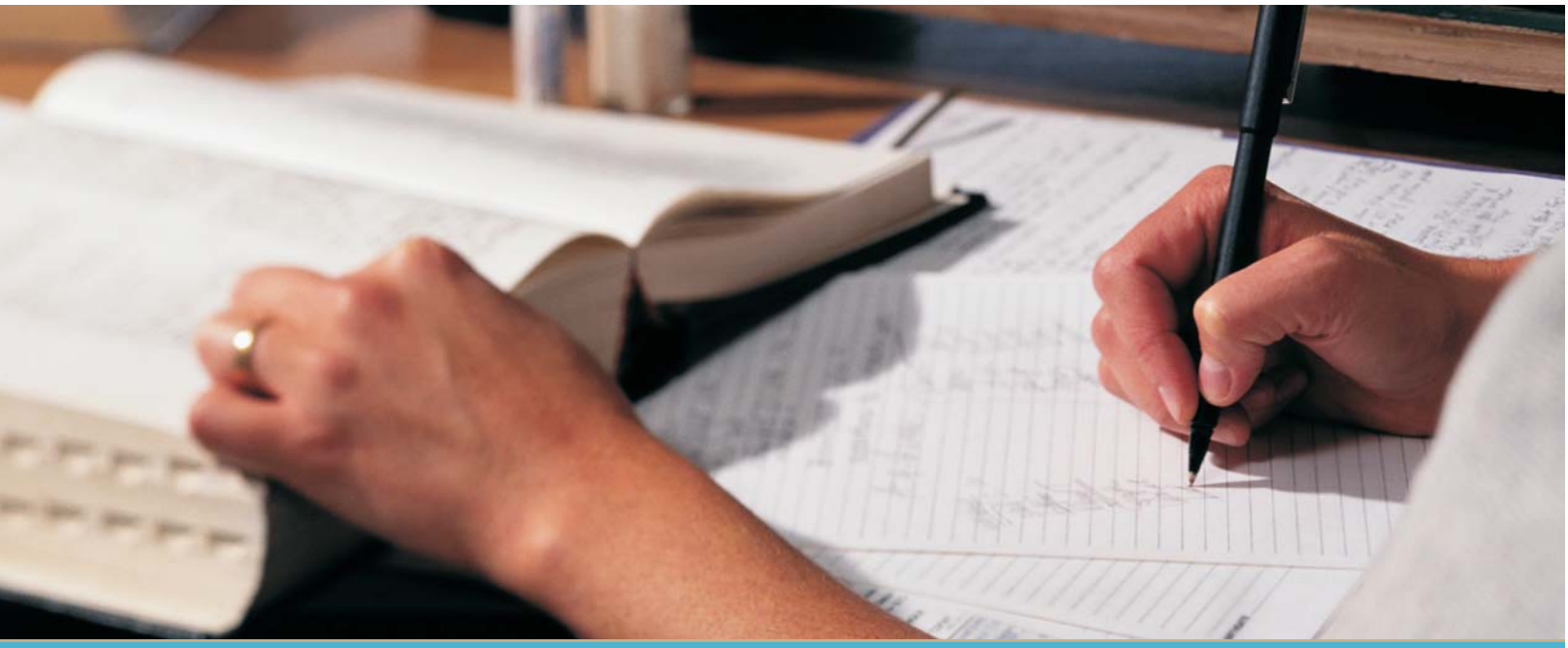
VARIATIONS IN PHYSICIAN PAY



Primary care physicians continue to earn much less than specialists nationwide. According to Modern Healthcare's annual physician salary survey, which is based on information from 15 trade groups and physician recruitment firms, family practice physicians were the lowest-paid physicians in 2006, earning between $142,000 and $190,000 per year. By comparison, radiologists earned between $325,000 and $475,000, while anesthesiologists earned between $284,000 and $453,000.

Not Much Help From the Patients

Even though a staggering 72 percent of Americans are overweight – and 39 percent are considered obese – weight loss is a low priority for most Americans, according to the 2005 Yankelovich Preventative Healthcare Study. Only 30 percent of respondents said they were actively trying to lose weight. More surprising were the responses people gave when asked the best approaches to shedding pounds. At the top of the list was "maintaining personal hygiene and cleanliness," which was reported by 64 percent of respondents; "maintaining a positive attitude," cited by 58 percent of respondents; and "maintaining/cultivating good family relationships," which was selected 53 percent of the time. Diet and exercise, long considered the most effective clinical approaches to losing weight, placed 13th and 17th in the survey, respectively. The survey, which included 6,000 U.S. adults, also found that only 30 percent of individuals considered health and wellness a priority. Fifty-nine percent of respondents either had a superficial concern about their health risks or took their health status for granted, foregoing screenings and preventive care.



WHITE PAPERS

The Annual Report on Health Care's White Papers provide an in-depth look at important issues in health care. Previously published White Papers are available at HCTrends.com

Medicare Part D for Plan Sponsors: What Have We Learned & Where Do We Go From Here?

By Troy Filipek, Milliman

Many plan sponsors of retiree prescription drug coverage are reconsidering their options for 2007. Early indications are that the so-called "route of least resistance" under Medicare Part D, the Retiree Drug Subsidy (RDS), is losing traction as plan sponsors learn more about other options, according to several national surveys, as well as a survey of Wisconsin Plan sponsors conducted by Milliman.[1]

For 2006, plan sponsors had four main options under Medicare Part D:

- Keep existing prescription drug coverage and apply for the RDS (this was the option selected by 59 percent of plan sponsors nationally and 23 percent of plan sponsors in Wisconsin)
- Make individual Part D the primary prescription drug coverage and offer a wraparound plan (11 percent nationally; 3 percent in Wisconsin)
- Purchase group coverage directly through a Medicare Advantage (MA-PD) or Prescription Drug Plan (PDP) under an Employer Group Waiver Plan (EGWP) (5 percent nationally; 7 percent in Wisconsin)
- Drop prescription drug coverage (6 percent nationally; 11 percent in Wisconsin)

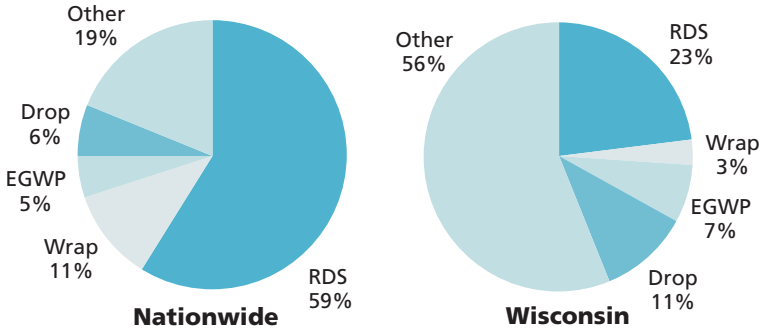
The majority of the remaining plans maintained coverage without applying for the RDS, including a particularly high percentage of plan sponsors in Wisconsin. Many of these plan sponsors had a small covered population (fewer than 50 or so lives) or had benefit levels below those required for the RDS (please see page 36 for a description of the options).

What Have We Learned After One Year of Medicare Part D?

As with any new government program, there have been growing pains as plan sponsors and health plans gain familiarity with Part D. Lessons learned along the way include:

- **All plan sponsors must do something.** Many plan sponsors assumed they could ignore Part D if they did not offer retiree prescription drug coverage. However, if any Medicare-eligible individuals, spouses or dependents are covered under the active plan, plan sponsors must issue a creditable-coverage certification to help members avoid late-enrollment penalties in the future.

Popularity of 2006 Options



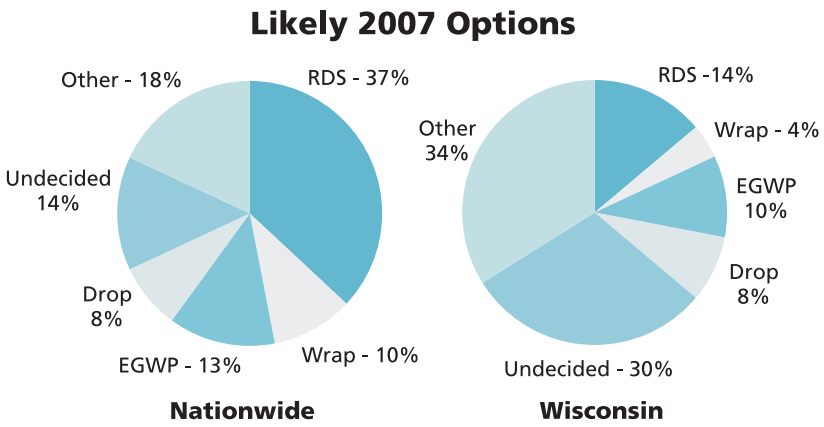
Source: Milliman Analysis of Employer Surveys

1. The surveys included: Deloitte Consulting, "Employer Response to Medicare Part D Prescription Drugs – 2005 Survey" (January 2005); Mercer Human Resource Consulting, "Retiree Medical Plan Sponsors Anticipate Cost Relief from New Medicare Drug Benefit" (July 1, 2005); Milliman, Inc., "Wisconsin Plan Sponsors' Approaches to Medicare – Eligible Prescription Drug Benefits" (Summer 2006); The Segal Company, "Results of the Segal Medicare Part D Survey of Public Sector Plans" (Summer 2006); Towers Perrin and the International Society of Certified Employee Benefit Specialists, "Plan Sponsors With Retiree Drug Benefits Charting Different Courses for 2007" (March 2006).

- **Communication is crucial.** Late last year, many plan sponsors were scrambling to chart their course for prescription drug benefits, handle the necessary implementation and reporting challenges, and communicate the plan and any changes to covered retirees. Communication was often the most neglected of these tasks, leaving many retirees frustrated and confused. To avoid this problem, plan sponsors should consider the following:
    - Communicate early and often through multiple communication vehicles
    - Understand that retirees require extra hand-holding and prefer traditional forms of communication, such as printed materials and brochures
    - Ensure Medicare-eligible actives receive creditable-coverage notices and alert them to the financial penalties they face for late enrollment
    - Understand that dual-eligible members (people who are both Medicare- and Medicaid-eligible) may require special attention
- **No option is without some hassle.** Many plan sponsors who initially viewed the RDS as the "route of least resistance," found the process costly, cumbersome and not worth the effort
- **There is not a one-size-fits-all solution.** It is crucial for plan sponsors to consider all Part D options in order to make an educated decision on the optimal approach. Many plan sponsors opted for the RDS because it seemed to be the "easy thing" to do, but left money on the table as a result. For example, the RDS is less attractive to tax-exempt organizations (due to their inability to make use of the tax incentive) and to sponsors with relatively few Medicare-eligible members (due to the costs of reporting, administration and actuarial attestation). It is important to perform a quantitative analysis, weigh the potential savings for each option and overlay this comparison with the qualitative factors before making a decision.

Where Do We Go From Here?

The RDS option is clearly losing popularity, as only 37 percent of plan sponsors nationally and 14 percent of Wisconsin plan sponsors surveyed were certain they were going this route in 2007, compared with 59 percent and 23 percent, respectively, for 2006. This trend is expected to continue into 2008 and beyond.



Source: Milliman Analysis of Employer Surveys

Several things may impact 2007 Part D strategies, including:

- More interest in and availability of options other than the RDS. There is significantly more interest in pursuing non-RDS options, in particular the EGWP option. For 2007, 13 percent of plan sponsors nationally and 11 percent in Wisconsin have decided on this route, compared with 5 percent and 7 percent in 2006, respectively.
- Medicare private fee-for-service (PFFS). These plans are garnering more interest from national plan sponsors because Medicare-eligible retirees can receive medical services from any physician or hospital willing to accept Medicare payment terms from the carrier. In addition, these plans can be easily paired with prescription drug benefits from EGWPs, which simplifies benefits administration for nationwide plans. Aetna, for example, announced in July that it would pair its Medicare Open PFFS plan with its nationwide EGWP drug coverage.

MEDICARE PART D OPTIONS

OPTION	ADVANTAGES	REQUIREMENTS	COMMENTS
Drug Subsidy Option (RDS)	■ Maintains the current benefit plan(s) ■ Can use the same administrator, insurer, and/or pharmacy benefit manager ■ Allows plan sponsor to realize fairly predictable savings while assessing other, potentially more complex approaches	■ Qualified actuary must certify that plan sponsor coverage is at least as rich as the Medicare Part D benefit and that sponsor contributes a sufficient premium contribution to be eligible for 28 percent tax-free RDS on allowable retiree costs between $250 and $5,000 (2006 values, indexed annually).	■ Will likely remain, at least for the immediate future, the preferred option for offering retiree prescription drug coverage ■ Due to the tax incentives, for-profit plan sponsors gain the most benefit from the RDS ■ Large plan sponsors (1000+ retirees) used this approach more frequently in 2006, probably because they offered richer benefit designs that met the RDS standards for coverage
Wraparound Supplemental Plan	■ Provides a benefit equivalent to current coverage at a lower cost ■ Easy to communicate the benefit structure to retirees because of its similarities to Medicare Part A and B wraparound plans	■ Must coordinate benefits between primary and secondary plan sponsors	■ Plan sponsors offer secondary coverage conditioned on the retiree's enrollment in individual Part D. The secondary coverage could fill in Medicare's coverage gap and/or reduce retiree cost-sharing ■ Attractive to tax-exempt organizations because of the ability to achieve greater cost savings than the RDS ■ Major stumbling point in 2006 was the uncertainty of coordinating benefits between the primary and secondary coverage. Some pharmacy benefit managers were unable to provide this capability in 2006. CMS has created a clearinghouse for coordination of coverage that should increase the popularity of this option.
Employer Group Waiver Plans (EGWPs)	■ Largely maintains the current benefit plan(s) ■ Eliminates coordination of coverage issues by using a single pharmacy administrator ■ Retains control over the benefit plan through formulary and medical management, if becoming own EGWP	■ Must add federal catastrophic benefit ■ Must have deductible less than the standard Part D deductible ■ Must have total coverage greater than or equal to standard Medicare Part D coverage	■ Plan sponsors can use CMS waiver provisions to maintain group prescription drug coverage by implementing their own EGWP or purchasing an EGWP from a vendor ■ Many plan sponsors used vendors for this option in 2006 ■ Attractive to tax-exempt organizations because of the ability to achieve greater cost savings than the RDS ■ Also attractive to plans that don't qualify for RDS because their retiree premium contributions are too high ■ This option should gain popularity going forward as more carriers begin to offer EGWPs ■ Timing an issue because final pricing decisions cannot be made until August (at the earliest) when CMS releases its Part D national average bid and premium amounts
Dropping Coverage	■ Inexpensive approach that protects retirees from catastrophic prescription drug costs (if contributing toward their individual Part D premium)	■ Employers must remain in compliance with existing labor contracts	■ Plan sponsors eliminate their current retiree drug coverage and can pay none, some, or all of their retirees' Part D premiums ■ The average monthly individual Part D premium for 2006 was roughly $24 per retiree ■ Most plan sponsors opted against this approach (some due to collective bargaining agreements) in 2006

- Reporting changes. Both public and private plan sponsors are likely to be impacted by potential accounting changes. On the public side, the Governmental Accounting Standards Board (GASB) issued guidance in early June that expected retiree health care liability cannot be reduced by the amount of the RDS, which has generated strong objections from plan sponsors and their advisors. On the private side, the Financial Accounting Standards Board (FASB) began a project last November to address the accounting treatment of pensions and other post-retirement benefits, which could require reporting of additional balance sheet liability. Both of these issues could prompt plan sponsors to take a fresh look at all of their retiree coverage offerings.

Plan sponsors are just beginning to understand the variety of alternatives to reduce costs associated with prescription drug coverage they offer retirees beyond the RDS option.

Plan sponsors are just beginning to understand the variety of alternatives to reduce costs associated with the prescription drug coverage they offer retirees beyond the RDS option. In order to select the option best suited to their needs, plan sponsors should:

- Review their current retiree coverage offerings
- Analyze all Part D options from a financial and administrative standpoint
- Assess Part D options in light of present and future company goals
- Plan and follow through on implementation and communication strategies

If you haven't already made 2007 decisions, now is the time to take action. Time is running out to capitalize on the savings available under the various options.

Note: This article reflects information released through July 1, 2006. For additional information, contact Troy Filipek at 262-796-3402 or your Milliman consultant.

Changing the Rules: New Medicare DRGs May Create Financial Turmoil

This fall, the Centers for Medicare & Medicaid Services (CMS) will begin the most significant revision of its DRG-based payment system since it was implemented in 1983. The changes will have a substantial impact on the way hospitals are reimbursed by Medicare, which, in turn, could impact the fees employers, insurers and other private-sector purchasers pay for health care services.

Hospitals and medical device manufacturers are breathing a collective sigh of relief as the new rules take effect. They successfully launched a lobbying blitz that convinced CMS to modify its initial proposal, which could have been financially devastating to urban hospitals. Under the initial proposal, cardiac care would be especially hard hit, with many estimates projecting a 20 percent to 50 percent reduction in various reimbursement rates. That was significant, because cardiac care is a major revenue center for many urban hospitals, providing them with high operating margins they can use to offset the losses they incur providing other types of inpatient care.

Complaints from hospitals, medical device manufacturers and congressmen prompted CMS to revise their methodology. Under the final rule, approved in August, CMS claims that no DRG will see a reimbursement reduction of greater than 5.6 percent. In addition, CMS is phasing the new reimbursement system in over a longer period to help providers adapt to the transition.

The changes will have a substantial impact on the way hospitals are reimbursed by Medicare, which, in turn, could impact the fees employers, insurers and other private-sector purchasers pay for health care services.

DRGs, or diagnosis-related groups, were implemented by Medicare in 1983 to streamline the payment process for inpatient care. They help Medicare establish a uniform rate for various types of inpatient care and the procedures performed. They eliminate the need for Medicare to negotiate with thousands of hospitals nationwide for all of the services provided during every inpatient stay.

Because they are based on hospital charges, instead of costs, DRG payments are skewed due to the way different hospitals mark up their ancillary services. DRGs also do not take into account the health of the patient being treated. This can be significant because patients with multiple complications require more care and consume more hospital resources than other patients. Medicare has developed payment adjustments to account for these differences over the years, but this year's proposed changes are the first wholesale attempt to correct structural deficiencies.

Basing DRGs on Average Costs Instead of Charges

The new DRGs will be based on hospital costs, not charges. In addition, they will be expanded – from 526 DRGs to up to 861 DRGs – to better capture the difference in the relative illness of each patient treated. Incorporating the All Patients Refined (APR-DRGs) system developed by 3-M Health Information Systems (see "Apples & Oranges: How Severity Adjusting Makes Comparisons More Meaningful" in the 2005 Edition of the Annual Report), the new codes will allow four levels of severity to be attached to each patient. The levels of severity are determined by the patient's underlying conditions and the risk of mortality. For example, a patient who undergoes an uncomplicated heart-bypass graft would be considered a Level 1 severity, while a diabetic patient would be considered Level 2 and a patient with congestive heart failure would be Level 3. The sickest patients – those most at risk of dying – would be Level 4.

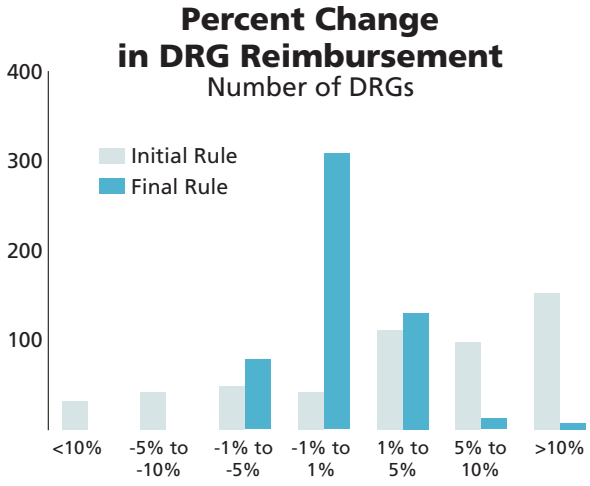
The changes are intended to be revenue-neutral nationwide, but will have varying impacts on reimbursement lev-

els at individual hospitals. The changes will result in modest increases for the vast majority of hospitals (1 percent to 5 percent) and no hospitals are expected to see a net reduction due to the DRG changes. (Under its initial proposal, CMS estimated there would be a decrease in reimbursements to more than 350 hospitals).

Also significant in the final rule was CMS's decision to change its weighting methodology to ensure the new payment method would not negatively impact the development of new medical technology and the use of advanced procedures that rely on that technology. Medical device manufacturers were especially concerned about the effects of "charge compression" in the methodology CMS uses to determine hospital costs. Instead of determining actual costs for every item used by a hospital, CMS established 10 broad cost-center categories and then applied national rather than hospital-specific cost-to-charge ratios.

While simpler to administer, this approach "rewards" items with high mark-ups and penalizes high-priced technology that doesn't have a significant mark-up. It is also based on DRG weights that are three to five years old, which is out of synch with the 18-24 month life cycle for technology.

CMS adjusted its weighting methodology to further minimize the impact of charge compression and has hired a consultant to explore the issue further. For now, the changes should have minimal impact on technology-dependent costs. Medtronic, a leading manufacturer of medical devices, estimates the final rule will decrease reimbursements for implantable cardioverter defibrillators (ICDs) by 2.6 percent but will increase reimbursements for pacemakers by 1.6 percent.



Source: Centers for Medicare & Medicaid Services

Initially, CMS targeted about 30 percent of DRGs for reimbursement increases of greater than 10 percent. However, concerns about severe cuts in reimbursement rates for DRGs dependent on medical technology (stents, pacemakers and implantable defibrillators) and the need to keep the collective DRG changes "revenue neutral" prompted CMS to significantly change reimbursement rates for most DRGs. Now, only 1 percent of DRGs will see a reimbursement increase greater than 10 percent; almost 60 percent will see virtually no change compared to current reimbursements.

The ultimate impact of these changes on providers and commercial payers remains to be seen. Depending on how the changes balance themselves out, some hospitals may find themselves with a new revenue squeeze.

A New Prescription:
Companies Ramping Up Intensity of Wellness Plans

Companies are writing a new, much more aggressive prescription for corporate wellness. They are increasing financial pressure on employees to encourage participation, incorporating sophisticated modeling and tracking tools to minimize the potential for large claims, working with providers to create effective treatment programs for chronic conditions and integrating their health care, wellness and disability programs under the umbrella of "productivity management." In short, many companies are coming to realize that absenteeism, productivity, wellness and health care are different facets of the same challenge.

There's no longer much doubt that, if done properly, wellness initiatives are effective. A recent study that analyzed 32 different studies of corporate wellness programs found that wellness initiatives reduced hospital admissions by 62 percent, claim costs by 28 percent and physician office visits by 16 percent. Disability costs dropped by more than one-third. The new wellness initiatives are based on a comprehensive strategy designed to improve the health status of the entire employee group. This multi-pronged approach:

- implements wellness initiatives designed to modify lifestyle practices (smoking, excessive drinking, poor exercise habits, etc.) prevalent in a given employee group
- identifies and triages at-risk employees before they incur expensive hospital and procedure costs
- provides intensive, coordinated care for patients with chronic or complex conditions

Wellness programs can't succeed without participation. Leading-edge companies are moving beyond T-shirts and bonus dollars to motivate employees. These traditional approaches tend to attract people who are healthy or are already focused on healthy lifestyle choices. They did little to improve the lives at greatest risk of generating significant health care claims.

Some companies are making it financially unbearable for employees to choose not to participate. They offer significant discounts – 40 percent or more – in the employee's share of the health care premium if he or she participates in wellness initiatives. The most aggressive companies have gone a step farther, requiring employees to pay 100 percent of the health premium costs if they don't participate or fail to meet the program's requirements. These incentives can dramatically improve participation. In employee groups where no significant incentive is offered, participation in wellness initiatives seldom exceeds 20 percent. When a significant penalty or incentive is added, participation typically jumps to 90 percent or more.

In employee groups where no significant incentive is offered, participation in wellness initiatives seldom exceeds 20 percent. When a significant penalty or incentive is added, participation typically jumps to 90 percent or more.

Companies are also becoming more aggressive with their disease management programs. They no longer rely on the voluntary participation of chronically ill patients. New, provider-directed approaches address this challenge by getting physicians to identify, to reach out and to treat their chronically ill patients. Incentives can also be used to ensure chronically ill patients comply with their treatment plans. For example, placing drugs commonly prescribed for chronic conditions in the least-expensive tier of the pharmacy benefit plan encourages disease maintenance while reducing the potential for emergency room and inpatient utilization.

Health-Risk Assessments

The tools used to implement wellness initiatives have become increasingly sophisticated. Health-risk assessments, which started as self-reporting surveys, now typically include blood pressure, height/weight ratios, cholesterol levels, hearing and other biometric tests that can be objectively measured and benchmarked.

Health-risk assessments are sometimes used to generate customized lists of diagnostic tests that should be performed in addition to basic tests to address that patient's risk factors. The results of these customized screenings can then be benchmarked and tracked to monitor the patient's progress in reducing their risks. For example, patients who are genetically predisposed for heart disease can be tested for the C-reactive protein, which is a strong predictor of future cardiac events. Subjective measurements have also proven to be a good indicator of potential claims. Some health-risk assessments now gauge how people "feel" about their health. This is based on research that people who tend to have a low opinion of their health – regardless of any objective measures otherwise – are significantly higher utilizers of physician services. Finally, employees are being held to task for their health-risk assessment scores. In addition to rewarding employees who are healthy, companies are providing financial incentives to people who improve their scores from one year to the next.

Predictive Modeling

Predictive modeling, which uses historical claims data to project potential outcomes, is used to identify common conditions that can result in high-cost care, including low-back pain, high-risk pregnancy and irritable bowel conditions. It can also be used, in conjunction with health-risk assessments, to focus wellness initiatives on the specific needs of an employee group. Increasingly sophisticated predictive modeling software is being used to analyze data and identify people who are most likely to seek high-cost health care services within the next six to 12 months. Medical and pharmacy claims data can be supplemented with demographic data and ZIP code information. As predictive modeling and disease management programs evolve, they are providing a wealth of information about the progression of chronic diseases from both a clinical and claims perspective, which will enhance the effectiveness of future generations of predictive modeling software.

Increasingly sophisticated predictive modeling software is being used to analyze data and identify people who are most likely to seek high-cost health care services within the next six to 12 months.

Another critical change in wellness initiatives is the use of one-on-one health coaching. Many companies require all wellness participants, regardless of their health status, to meet with a health coach at least once a year to review their health-risk assessments. Patients with risk factors or chronic conditions are required to meet with a health coach more frequently. Health coaches allow participants to analyze their lifestyle in a judgment-free environment, so they can better understand the choices they make. This approach also helps participants achieve buy-in to the wellness concept. In some cases predictive modeling can be used to help the health coach or disease management team find the most effective motivator based on the individual's demographic characteristics and their interaction with web sites and telephonic programs.

Integrating Health Care, Wellness, Disease Management and Disability

Arguably the most significant change in wellness initiatives is the realization that health care costs, disability claims and employee productivity are intertwined. Just as companies have learned that a large share of their health care dollars are spent on employees with chronic illnesses, they are finding there is a significant correlation between the number of employees filing disability claims and a company's overall health care costs. A recent UnumProvident study, for example, found that more than two-thirds of all medical, disability and workers' compensation costs combined are generated by the 10 percent of the workforce who file either occupational or non-occupational disability claims. The average annual medical cost for these claimants was $8,908 – more than 10 times that of employees who experienced no disability during the same period. Annual health-care costs jumped to $18,000 per year for employees with long-term disability claims.

The Problem with Presenteeism

Companies are also beginning to zero in on the broader issue of productivity. Studies conducted by the Integrated Benefits Institute indicate that lost productivity costs employers up to three times more than the money they spend on their group health and disability programs combined.

Much of this is in the form of "presenteeism," which is defined as a loss of productivity caused by employees who show up to work but are distracted because of allergies, illness or emotional issues. Assessing the impact of presenteeism is difficult, but some studies indicate it may be many times the drain on productivity as absenteeism. In its 1999 analysis of 17 diseases, the Employers Health Coalition of Tampa, Fla., determined that lost productivity from presenteeism was 7.5 times greater than the loss of productivity from absenteeism. For some health issues, including allergies, arthritis, heart disease and hypertension, lost productivity from presenteeism was 15 times greater than absenteeism.

Anxiety and depression disorders have the most significant impact on employees' ability to do their jobs, but allergies and asthma are also significant concerns.

Addressing presenteeism requires new strategies for companies. Disease management and wellness initiatives typically focus on reducing the risk of claims from chronic conditions such as heart disease, diabetes and smoking-related diseases. Studies indicate that the bulk of "presenteeism" costs are associated with musculoskeletal, gastrointestinal and respiratory problems. Not surprisingly, anxiety and depression disorders have the most significant impact on employees' ability to do their jobs, but allergies and asthma are also significant concerns.

Among the challenges inherent in presenteeism is accurately measuring the loss of productivity and defining what is meant by a fully productive employee. Benchmarking productivity is relatively easy for jobs that involve repetitive tasks, such as assembly-line work, clerical duties and call centers. But it is much more difficult to gauge output declines in "knowledge" workers, such as lawyers, accountants, managers and other professionals.

Still Seeking Ways to Effectively Measure ROI

In addition, establishing meaningful return-on-investment standards continues to be difficult due to the sometimes murky analysis of "avoided" health care costs. In addition, integrated programs have not been around long enough to provide trend data. The advent of a formal definition of disease management, plus newly established disease management accreditation initiatives by the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Committee (URAC), are creating an objective standard that can be used to evaluate and compare programs. Trend data will also become available as these comprehensive, integrated programs take root.

Some companies have already developed their own internal evaluation tools. Some package shipping companies, for example, keep detailed, employee-specific information on the number of packages delivered, the number of packages lost and the number of motor-vehicle accidents. They have combined this information with medical claims data and employee health surveys to pinpoint diseases or conditions that reduce efficiency or increase the risk of accidents. They also have been able to use the data to measure the success of their initiatives designed to reduce these risks.

There also is a major initiative under way to develop tools to objectively evaluate health and productivity management programs for all businesses. Under a project funded by the U.S. Centers for Disease Control and Prevention, the Midwest Business Group on Health has partnered with Harvard Medical School and the Georgia Health Care Leadership Council to create the Atlanta-Chicago Health and Work Performance Initiative. The alliance is using the World Health Organization's Health and Work Performance Questionnaire to survey employees. Preliminary findings from the project are expected to be released this fall.

Long-Term Care: Why Employers Should Consider This Benefit Option

By Milliman's Milwaukee LTC Consulting Group

As working "Baby Boomers" age, they've begun to realize that the nursing costs associated with a debilitating illness or accident could wipe out their retirement savings. That has prompted them to take a close look at group long-term care insurance which, until recently, was sold primarily as individual policies. Over the past several years, however, the growth of the group long-term care market has outpaced the growth of the individual market as employers realize group long-term care allows them to offer a valuable employee benefit that doesn't have to cost anything other than administrative effort. Because group long-term care is usually paid entirely by employees or retirees, employers are not at risk for premium costs or claims. The coverage is also fully portable; employees can continue coverage if they quit or retire. The employer's role is typically limited to choosing an insurance carrier and handling the communication and administration.

GROUP COVERAGE ADVANTAGES

- Typically less expensive than individually purchased long-term care because:
  - there is little or no commission
  - the employer facilitates enrollment and billing (through payroll deduction)
  - the underwriting is usually streamlined or simplified for active at-work employees
- Tax-qualified long-term care plans can be tax deductible (as a medical expense) to the employee
- Employees' spouses, parents, in-laws and grandparents are often eligible to apply through the employer's group long-term care insurance, although they are subject to the carrier's regular underwriting rules

Some employers are offering LTC as an employee benefit because:

- It can be a competitive advantage for recruiting talent, especially as employees become more aware of long-term care and as more employers offer the benefit
- Long-term care can help protect employees from financial devastation – much like pensions and life insurance policies do – insulating employers from morale and image problems that can occur when their employees or retirees become destitute
- Allowing employees to provide coverage to spouses and parents can maintain employee productivity by reducing the potential for financial and emotional stress for employees who are responsible for providing care to an older or disabled person
- Employer contributions to a qualified long-term care plan are tax deductible and excluded from the taxable income of the employee

What Benefits Should You Consider?

Coverage is typically available for nursing home, home health and assisted-living facilities. Most plans are tax-qualified, which means that premiums are tax deductible (as a medical expense) and benefits received are not considered taxable income. Benefits for a tax-qualified plan are typically based on cognitive impairment or the inability to perform two of six activities of daily living (bathing, continence, dressing, eating, toileting and mobility). Long-term care is sold with various combinations of elimination periods, benefit periods and indemnity amounts per day or service. The most common combination is a 90-day elimination period and a three- or five-year benefit period. The elimination period is the period of care during which the individual is responsible for long-term care expenses. The benefit period can be stated in terms of a pool of money available for benefits. For example, a benefit period of five years with a $100 daily benefit would be $182,500 ($100 x 365 x 5). Premium

KEY ISSUES FOR EVALUATION

- Seek assistance in selecting the appropriate long-term carriers to approach
- Review long-term benefits options to determine if benefit packages have reasonable premium differences
- Evaluate proposals from long-term care carriers to determine a finalist to offer to employees

rates are unisex, even though actual claim costs are generally higher for females than males. Significant premium discounts – ranging from 10 percent to 40 percent – are offered for married applicants, because they tend to have much lower claim costs due to the presence of a caregiver, the spouse, in the home.

Because nursing home costs vary significantly throughout the country, employees need to know the current cost-per-day in their area to determine an appropriate daily benefit. A daily benefit amount may be uniform for all services (nursing home, home health and assisted living facility) or the home health benefit may be a percentage (50 percent, for example) of the daily nursing home benefit. In addition, employees do not have to purchase coverage equal to the full current daily nursing home cost if they are willing to assume some risk.

Group long-term care typically comes with two types of inflation protection – guaranteed purchase options and automatic benefit inflation (ABI). Guaranteed purchase options give applicants the ability to purchase additional coverage at later attained age rates without further medical underwriting. Some carriers stipulate that guaranteed purchase options expire if the insured declines to exercise a specified purchase. These options are often limited to 5 percent benefit increases each year and are typically offered every two or three years. With ABI, daily benefits automatically increase, typically at a rate of 5 percent per year. The premium is built into the original premium the employee pays at issue and does not increase with age. A plan with an ABI benefit may cost three to four times greater than a guaranteed purchase plan at younger ages, but eventually, the guaranteed purchase option premiums may be greater than those for the ABI plan.

Many carriers typically offer a waiver-of-premium option that waives premiums whenever benefits are being received. This option typically costs more and extends the elimination period. Some carriers also offer a limited non-forfeiture benefit, which means there is some benefit available even if an employee lapses the policy after a certain time period.

The Future of Group Long-Term Care

Currently, participation rates of 10 percent to 15 percent are considered quite successful for group long-term care, which is significantly lower than the typical participation rates of 401k plans and other voluntary employee benefits. In order to increase participation, employers may have to begin paying a portion of the premium expense, perhaps with vesting and waiting periods. It also may be effective to offer a "core" employer-paid plan with employee-paid "buy-up" options.

Group long-term care as an employee benefit is likely to gain traction when issues surrounding the entire long-term care market are resolved, including a lack of education and information, Medicaid loopholes and the need for a public policy that creates a "personal responsibility" mentality. Establishing a group program on proven strategies now could give employers a competitive edge by properly preparing themselves for the expected evolution of this employee benefit.

For additional information, please contact a Milliman LTC Consultant at 262.784.2250 or email: milw.client.services@milliman.com.

KEY ISSUES FOR PARTICIPATION

- **Quality Insurer:** The long-term care insurer should be financially strong, experienced, and have a reputation for service and commitment.
- **Program Support:** It must be clear that the employer is behind the offering, perhaps by using its name and logo in marketing and communication materials.
- **Marketing Communications:** The marketing lead period should be long enough to properly expose employees and other eligible members to the concept of long-term care.
- **Benefit Features:** There should be a careful review of the options offered to ensure the best possible match of benefit options with the potential insureds. A limited number of benefit options should be promoted, including a lower cost option.

Questions About Quality:
Answers From a Leading Regional Quality Initiative

The Wisconsin Collaborative for Healthcare Quality (www.wchq.org) is a nonprofit organization established in 2003 to promote health care quality improvement by developing and publicly reporting comparative measures of health care performance. Based in Madison, it currently has 25 members, representing most of the state's largest health care systems, physician groups and health plans. The Greater Milwaukee Annual Report on Health Care sat down with Chris Queram, the collaborative's president/CEO, to discuss its progress.

What is the Wisconsin Collaborative for Healthcare Quality focusing on right now?

One of our major priorities is the introduction of three new measures – for colorectal, breast and cervical cancer screening. They will increase our total number of ambulatory measures to eight.

We are also launching a project with the support of the Greater Milwaukee Business Foundation on Health to test the scalability of our measurement methodology for small primary care practices. Our membership represents primarily medium and large specialty practices. We are interested in evaluating the degree to which we can work with a 15-physician clinic or single family practitioner to get them information they can use to benchmark their performance and to find ways to improve. The pilot will help us determine whether or not there is enough data in these small practices to be meaningful for comparison purposes, and the degree of difficulty in collecting the data, given that many small practices have not yet implemented electronic health records.

A third initiative is to empirically evaluate the degree to which our public reporting efforts have improved quality. The literature is still pretty immature on the link between the public reporting of quality data and quality improvement, and especially with regard to ambulatory care. It is critically important to show the practicing physician there is a reason to be invested in the process and that there is a real benefit to publishing comparative data.

How many similar initiatives are there around the country? How does your quality collaborative compare?

There are a handful of regional quality coalitions around the country and they are all relatively new. Ours is almost four years old. By comparison, the Massachusetts coalition started in the late 1990s while the one in Minnesota began in 2004. We are all pretty young from the standpoint of organizational lifecycle, but multi-stakeholder, not-for-profit regional quality coalitions represent the emerging infrastructure for measuring, improving and reporting health care performance.

One of the things that sets our collaborative apart from the other initiatives is that its vision and leadership come from physicians. They saw the movement to publicly report hospital performance and realized physician measurement would soon follow. Their philosophy was, if transparency is inevitable, let's do it right by designing a model that gives us actionable information to drive improvements. Our measures emphasize a "population-based" approach, reporting measures for all patients who fit the criteria for a specific measure. This is a significant feature, and it would not have been possible without the physician leadership needed to commit the resources to work through the very difficult

"One of the things that sets our collaborative apart from the other initiatives is that its vision and leadership comes from physicians."

– Chris Queram
Wisconsin Collaborative for Healthcare Quality

issues of what we are going to measure and how we are going to collect, refine and report it.
By contrast, the leadership in some of the other regional coalitions – the ones in Massachusetts, California and Minnesota – comes from the health plans. There is a tension between health plans and providers. Having our leadership come from the provider community leads to a different level of engagement and commitment.

"Reporting on a population level allows us to localize practice variations as well. Groups that have five or six practice locations can get comparative information for each location. They can drill even deeper to get to individual practice units – a group of internists or family practitioners."

Health plans only have a portion of the data needed to measure performance. As big as HealthPartners is in Minnesota, they only represent 30 percent of the market. This necessitates the use of a sampling methodology to estimate the percent of patients receiving the recommended treatment. We report measures at a population level, which has led to a very high degree of credibility within the physician community. One of the first questions providers ask is "can that data be right?" Because our methodology includes all patients, we have been able to convince providers that our numbers are accurate and representative.

Reporting on a population level allows us to localize practice variations as well. Groups that have five or six practice locations can get comparative information for each location. They can drill even deeper to get to individual practice units – a group of internists or family practitioners. We haven't yet reported publicly at the physician level yet; while there is interest in getting to this level of reporting, there are many methodological issues to be worked through before we take this step.

How far are we away from being able to compare quality measures between cities or regions?

When you read a balance sheet for Johnson Controls or Pacific Gas and Electric, there are common definitions and a standard way information is portrayed. That is still one of the most critical things missing in health care – reporting information in a way that allows us to compare information across regions. We are there in Wisconsin because everyone is working on the same measurement platform, but we are not there as a nation.

Performance measurement, for all of the current interest in it, is still very much in its infancy. The initial public comparative report on hospital performance in Wisconsin was issued in 2001. While five years may seem like a long time, it's really not when you are trying to build an infrastructure to collect and report data in the same way.

The progress that has been made in the last three years has been hugely significant. We are getting calls from physician organizations in South Dakota, Omaha and Missouri. They realize the transparency initiative is coming and want to know if there is a way to replicate what we are doing in their markets. As a result of that progress I think that it is possible you may see a pretty robust set of measures and a pretty well-established infrastructure nationally by 2010.

What has been the most significant challenge(s) in identifying, gathering, tabulating and reporting on the various quality measures?

Aligning priorities within the organization; getting everybody to agree on where we are going to invest their time and resources. There is also the challenge of establishing measure specifications. It may come as a surprise to the lay person that we don't have consistent ways to measure something like diabetes or hypertension. We are working hard to find the ways to efficiently and effectively collect the information in an industry that is still transitioning from manual chart abstraction to electronic retrieval.

Even electronic medical records, for all of their promise, have not yet significantly changed the efficiency with which we gather data. Their effectiveness depends on where each organization is in the implementation process.

Many organizations are not yet to the point where they have embedded the measure specifications into their electronic systems.

Some variables can be abstracted very quickly. You can go through electronically and pull out patients with a primary or secondary diagnosis of diabetes, for example, but then you have to go through a more detailed screening to see if they met the precise measurement specifications. Asking derivative questions to see if patients meet certain criteria and then specifically including or excluding patients based on those criteria is very painstaking and detail-oriented.

What prevents a provider from "gaming" the system; that is, focusing its resources to look good on the targeted measurements without a real top-down commitment to quality?

You can only shine a light on so many things at any point in time. What we want to do is concentrate our measurement work in areas that represent highest cost or burden to consumers and society. We're hoping there will be a Hawthorne Effect: if you focus on a few areas, it will elevate the priority that is placed on continuous improvement activities and result in a cultural transformation within the organization.

In order to ensure the integrity of the data we collect and report, we have developed a sophisticated auditing process similar to what you would have with a publicly traded company. Our web-based data submission tool allows for a fairly detailed review of whether the inclusion and exclusion criteria were applied consistently. And, we have a field auditor solely dedicated to working with member organizations on spot checks and data audits.

Given that many patients don't have a regular physician, don't comply with physician treatment recommendations or choose hospital systems or specialists based solely on physician recommendations, is the cost associated with these quality initiatives justified?

The clinical and administrative leaders from our member organizations have consistently stated that the cost of belonging to the collaborative – both in terms of what they pay to support our activities and the costs they incur to collect and utilize the data – is worth the investment. If you look at the trend data on our web site, quality is improving. It may be happening for a lot of different reasons, but it is happening.

One of the themes you hear is that there is a burden associated with collecting and reporting data on multiple quality measures, and there is legitimacy to this perspective. It will be interesting to see how this plays out over time. I would hope that we will see the costs diminish significantly as we realize the benefits of information technology, establish and report on standardized measures and, as has happened in many other industries, achieve lower costs by improving quality.

"I would hope that we will see the costs diminish significantly as we realize the benefits of information technology, establish and report on standardized measures and, as we have seen happen in many other industries, achieve lower health care costs by improving quality."

Will quality measures ever become consumer tools? Or, is their real importance to providers who can use them as benchmarks and to purchasers who can use them in negotiations?

Here again, this is an evolutionary process. We know that most of the visits to our web site are from members. The reality is that the nation is in the early stage of adopting a consumer-oriented model for health care. We have not reached a tipping point where there is a significant amount of people demanding ways to identify high-value providers.

One of the reasons we are introducing the cancer screening measures is because people pay attention to these indicators as they reach a point in their lives where the screenings become relevant to their personal experience. As they become eligible for these screenings they will be more interested in knowing how providers compare.

Another important area is measures that relate to patients' experience with care: did your physician listen to you, did he/she give you the information you needed to effectively manage your care? There is a belief that when this information is made available publicly, it will lead people to increase their use of all of the data being reported.

Purchasers are also becoming more interested in quality information. As public- and private-sector purchasers learn more and more about the gaps between what we should be doing and what we are doing, many are likely to begin to tie reimbursement to performance.

"There is no denying that health care professionals want to be the best at what they do. They honestly believe they are doing the right thing, but until they have hard data to look at they just don't know for sure."

Can you quantitatively demonstrate that the collaborative's efforts have positively impacted the quality of care being delivered in the region?

This is one of our key priorities – to empirically assess the link between public reporting and improvement – but it won't be easy. We are working with a group of health services researchers from within our membership to develop a study design that will answer this question. Finding a control group and designing the study will be a methodological challenge.

Anecdotally, I can tell you that physician leaders say that the formation of WCHQ has positively impacted the conversation about quality within their organizations. Making credible data public catalyzes a different type of discussion. One of our physician leaders said he had never received so many calls from his cardiologists as he did when the cardiac numbers for diabetes were reported. There is no denying that health care professionals – whether you are a physician, nurse or physician assistant – want to be the best at what they do. They honestly believe they are doing the right thing, but, until they have hard data to look at, they just don't know for sure.

Tell us a little about the collaborative's participation in the federal pilot project on ambulatory care, which will combine public and private information to measure physician practices and identify high quality providers.

We are one of six regional coalitions participating in the Ambulatory Quality Alliance pilot. We are currently finalizing the scope of our work, which is designed to significantly expand the number of ambulatory measures being reported and to experiment with methods of reporting that meaningfully engage both providers and consumers in the use of the information. Right now we are learning the strengths and limitations of the different methods used by the various quality initiatives. The diversity in the models and approaches being used in different parts of the country will help in developing a national strategy for comprehensive performance reporting.

What are the major challenges facing the collaborative?

Any time you have a fledgling organization, it is vitally important to define and deliver a value proposition that can be sustained across time. Our challenge is to build a sustainable business model and to demonstrate that there is a reason for doing this, which gets back to our initiative to empirically assess the link between public reporting and quality improvement. As we grow and develop, it is important that we sustain our guiding philosophy of collaboration and shared learning based on the use of comparative information. It is not unusual for a group of founding organizations to share a common philosophy and vision; it can be a challenge to sustain this shared commitment as an organization adds new members. Yet, we are confident that we can successfully manage this evolution given the clarity of our mission and Wisconsin's tradition of collaboration within and across communities.

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