Deloitte.

Issue Brief:

The Physician Workforce: *Opportunities and challenges post-health care reform*

In 1969, ABC began a seven-year, 172-episode run of "Marcus Welby, M.D." and changed the landscape for medicine notably. Robert Young, the white-haired actor previously known as "Father Knows Best" provided sage advice; Consuelo Lopez (Elena Verdugo) welcomed every patient as family to the peaceful quiet of the office sans computers and waiting room, and hard-around-the-edges Dr. Steven Kiley (James Brolin) provided a shadowy contrast, allowing Welby to shine as mentor, spiritual counselor and life coach to patients – and occasionally treat disease or medical problems.

In many ways, consumers still want Marcus Welby. They seek caring people, skillful professionalism and undaunted adherence to the evidence of "what works best for people like me." Older consumers do not understand electronic health records – why the fuss? – and regard the judgment of "their" physician as sacrosanct. But for younger adults, it's different. They want verifiable quality via metrics and data; access via electronic scheduling and e-mail exchanges; control of their medical record and absolute assurance of privacy. They understand teams work better than solo acts, and imagine science that will allow them to control their own health destiny.

The new normal maps to the needs and expectations of Millennials and Gen X who grew up with video games, YouTube, and text messaging. Health reform is about lowering cost and managing care per the evidence, while imposing performance-based payments to physicians as a means of aligning their economic incentives with long-term goals.

For many physicians, it's sobering, perplexing, frustrating, and perilous. For some, it's an opportunity – to align in winning teams, to leverage technology to diagnose more accurately and treat more effectively, to improve outcomes and stay abreast of science, and to maintain peer and patient esteem.

For some, a difficult transition to new normal; for others, changes in the right direction.

Paul H. Keckley, Ph.D.
Executive Director
Deloitte Center for Health Solutions

Produced by the Deloitte Center for Health Solutions

The physician workforce

While the nation's economic recovery is slower than expected and overall unemployment is 9.6 percent, the health care industry is experiencing job growth. Data from the Bureau of Labor Statistics (BLS) indicate that job losses since the downturn (12/07) total 8.4 million; in the same period, health care employment increased 732,000.

Of the 14.3 million health care workforce, 40 percent are in hospitals; 21 percent in nursing and residential care facilities; 16 percent are in physician offices. As the population ages and demand for health services increases, at least three million new jobs in health care will be required in the next decade. The industry is both labor and capital intensive – technology, facilities, infrastructure. To be competitive or survive, innovation in both is a strategic imperative.

In the BLS's 2010-2011 Occupational Handbook, the following "significant points" introduce its chapter about physicians and surgeons:

- Many physicians and surgeons work long, irregular hours.
- Acceptance to medical school is highly competitive.
- Formal education and training requirements – typically four years of undergraduate school, four years of medical school, and three to eight years of internship and residency – are among the most demanding of any occupation, but earnings are among the highest.
- Job opportunities should be very good, particularly in rural and low-income areas.

Add requirements to adopt electronic medical records by 2015, the specter of payment cuts by Medicare, increased transparency via report cards, expanded scope of practice for nurse professionals and pharmacists, and burgeoning competition from retailers and technology companies – the "new normal" is unsettling to many clinicians.

Physicians influence almost every dollar spent in the U.S. $2.5 trillion health care industry. Their orders are directly responsible for 80 percent of spending; only one in ten consumers feels somewhat confident challenging a physician's judgment. The voice of medicine is prominent in advocacy: the American Medical Association (AMA) spent $6.2 million lobbying health reform in 2010 through July (Center for Responsive Politics) and most of its affiliated societies invested in advertising and lobbying efforts alongside AMA.

Given health reform and emergent trends, the "new normal" is a major shift for physicians from old rules that dominated the profession in the Modern Era to new realities for the profession (Figure 1).

Figure 1: The Effects of Emergent Trends and Health Reform on Physician Workforce

Factors	Old Rules	New Normal
Training and resources	Expectations, core competencies set by the profession within specialties, subspecialties Overseen by trade organizations: AMA, Association of American Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education (ACGME), Accreditation Council for Continuing Medical Education (ACCME) State licensing, peer review, Continuing Medical Education (CME) critical quality control factors Learning by journal clubs and reflective learning	Adapted to evidence-based standards of care via the Patient Centered Outcome Research Institute (PCORI), Comparative Effectiveness Peer review secondary to demonstrated, quantifiable performance (report cards) Augments trade and professional structures already in place adding complexity, standardization per evidence-based practices Leveraged by widespread use of clinical and administrative information technologies to assist in decision-making and patient directives (learning by review of real-time data augmented by reflective learning)
Incentives and professional appeal	Volume (visits, tests, procedures) Individual rewards: "it's what I do" "Quality" perceived Trust by patients based on relationships Peer esteem: The industry self-policies	Performance (safety, outcomes, satisfaction, efficiency) Individual and team-based rewards blended: "It's what we do" Quality of care transparent based on severity adjusted data
Practice Settings	Primarily independent smaller physician organizations that reward physician autonomy and productivity (volume) Predominantly independent of exclusive relationships with plans/hospitals unless a faculty member or staff model health maintenance organization (HMO) Information systems used for billing, credit and collections Local focus	Primarily large medical groups aligned with a health system or health plan (exclusively/semi-exclusively OR a mega-group that operates hospitals/a plan) Information systems for patient medical management and administration Regional focus
Reputation	Individual "brand" based on patient word of mouth, peer referrals Hospital affiliation secondary	"System" affiliation important to performance-based results Affiliation with health plan/hospital/academic medical center important dimension of brand
Income potential	Productivity based (visits, tests, procedures) Specialists 2-5 times more than primary care clinicians Technical skills paid more than cognitive Significant opportunities to invest in ancillaries to which patients are referred Commercial health plans a major source of income potential; Medicare secondary; Medicaid last	Value-based: Outcomes, costs and satisfaction Limits on self-referrals and passive income from ancillary investments Cognitive skills balanced with technical Independent Medicare Payment Board will create global budgets that limit physician income growth PPACA and related self-referral legislation limit income from investments in physician-owned ancillaries and services Commercial and Medicare rates the same; in primary care, Medicaid attractive

PPACA and physicians: A strategic perspective

Major elements of the Patient Protection and Affordable Care Act (PPACA) will likely alter the physician workforce: Medical liability reform and a permanent fix to the physician pay formula are not in the legislation though sought by the AMA in its lobbying effort. A review of the bill through the lens of physicians indicate **positives** and **cautionary** elements (Figure 2).

Figure 2: Sections of PPACA that Affect the Physician Workforce

PPACA Section	Focus	Impact on Physicians
1001, 1201	Immediate insurance industry reforms – require coverage without pre-existing conditions, expansion of dependent coverage, elimination of annual and lifetime limits, etc.	**Increases access to commercially insured patients; increases practice revenue, especially for primary care physicians (PCPs)**
1104	Required implementation of administrative simplification	**Reduces costs of billing, credit and collections with insurance plans; reduced costs for answering patients questions about insurance coverage**
1416	Authorizes study of geographic variation in coverage; care provided	**Possible spotlight on overuse of services (diagnostics, surgery, prescribing patterns) might prompt increased attention to variability and non-evidence-based practice patterns of physicians**
1501	Individual mandate expected to expand commercial insurance coverage for 16 million who are currently uninsured	**Increases commercial market for physicians, but rate might be closer to Medicare than commercial**
2001-2004, 2301-2303, 2401-2403, 10202, 2601-2602	Expansion and federal funding for Medicaid and Children's Health Insurance programs (CHIP); expanded coverage for community-based care, hospice care; expansion of pilots for dual eligibles	**Expanded funding opportunities for primary care providers (physicians, nurses); additional funding via pilots for dual eligibles**
2702-2706	Pilot funding for accountable care organizations (ACOs) medical homes and avoidable readmissions programs	**Encourages alignment of physicians and hospitals and clinical integration across specialties (accountable care models do not require hospital affiliation)**
2951-2954, 4101-4108	Funding for maternal child health; patient education; preventive health; expansion of preventive health services under oversight of the U.S. Department of Health and Human Services (HHS) via school based clinics, annual wellness visits for Medicare enrollees, etc.	**Additional funding for primary care services targeted to underserved populations, especially services for women and children**
3002, 3003-3007, 10327, 10331	Increased transparency of physician performance	**More visibility about physician performance: Safety, outcomes, efficiency, patient satisfaction**

■ Positives ■ Cautionary

continues on next page

continued from previous page

Figure 2: Sections of PPACA that Affect the Physician Workforce

PPACA Section	Focus	Impact on Physicians
3011-3015	Development of national quality strategy by HHS	Potential changes to role, scope of physician practice; challenge to physician autonomy
3134-3135	Increased reporting requirements for imaging facilities, etc.	Increased focus on physician self-referrals, inappropriate overuse
3403	Creation of Independent Payment Advisory Board	Sets physician pay per a formula starting 2014
5501-5508, 120502-10504	Increased supply of PCPs via residency programs, etc.; study of health care workforce, implications for training programs	Attractive to PCPs considering medical career
6001-6005	Increased transparency requirements for physician self-referrals, prohibitions for physician-owned hospitals, etc.	Challenges physician ownership of diagnostics/ ancillaries; limits autonomy of physicians in related business interests
6301-6302	PCORI	Potential erosion of medical society control of guidelines and standards of care
6402-6409	Increased coding and fraud oversight; Medicare self-referral protocols	Increased scrutiny of business office practices
9008-9009	Excise taxes on drugs and devices	Increased costs for medical supplies and equipment
9010	Tax on health insurance plans	Increased pressure from plans for lower costs, tougher negotiations

Positives Cautionary

A possible scenario

Primary care: The increased demand for primary care services will require expanded scope of practice for nurse practitioners (NPs) and advanced practice nurses coupled with innovation in the use of bio-monitoring technologies and payment mechanisms to encourage group visits, medical adherence and lifestyle modification. Primary care workforce supply will be defined more broadly to include retail clinics and expanded roles for pharmacists, and eventually inclusion of prophylactic dental and vision care. Employers that decide to maintain health insurance coverage for employees will integrate on-site primary care in the workplace serving as a default medical home, or otherwise contract with primary care providers capable of accepting risk for cost containment and population-based outcomes. As PPACA is implemented, the "medical home" will be a centerpiece but the model will evolve as care management technologies are fully deployed and performance-based payments become the norm. Net investment in primary care will increase disproportionately to acute care and specialty medicine.

Specialty medicine: PPACA portends two threats to specialists, especially surgical specialists: Appropriate use procedures and tests will be in the spotlight, and team-based care management models and the medical home will require specialists to collaborate with peers in shared risk arrangements.

Medical education: Virtually absent in the bill. Advocate for medical education will need to consider curricular innovations that align with technology-enabled care management, team-based care models and core competences built around life-long learning that's measurable and transparent. The new normal changes the method, funding and expectations for training of future physicians.

PPACA changes physician expectations substantially. Instead of "eminence-based practice", it's evidence-based performance that matters. "M.D.eity" will give way to "Team Delivery" and patient trust will be augmented by metrics of performance. Sobering to all, threatening to some, but certain.

Physicians in context of developed systems of care: Global comparisons

The U.S. has fewer physicians than many developed countries (Figure 3); income for the physician workforce is significantly higher in comparison to average wages than others.

Figure 3: Overview of Global Physician Workforce

	U.S.	Canada	France	Germany	Switzerland	U.K.
Physicians/1,000 (2008)	2.4	2.2	3.4	3.4	3.8	2.4
Average physician income to average non-physician income (2007) professional appeal	5.5	3.2	1.9	3.4	2.1	1.4
Percent of adults that grade their system A/B grade (2010)	20 percent	42 percent	54 percent	18 percent	54 percent	30 percent
Average per capita expenditure (2008)	$7,538	$4,079	$3,698	$3,737	$4,210	$3,129

Sources: OECD 2010 and *2010 Global Survey of Health Care Consumers,* Deloitte Center for Health Solutions (May 2010)

The Sustainable Growth Rate (SGR) model for physician compensation: What's ahead?

The Medicare Sustainable Growth Rate (SGR) is the target growth rate for aggregate allowed expenditures on physician services. Since April 1996, the Centers for Medicare and Medicaid Services (CMS) have updated the fee schedule comparing cumulative actual costs of the physician services to cumulative target spending ("allowed expenditures"). For 2011, the update will reflect the cumulative actual to cumulative target expenditures from April 1, 1996 through December 31, 2010. If expenditures exceed the target costs, the fee schedule update is reduced. If expenditures are less than the target, the update is increased.

In 2002 for the first time, the formula required a 4.8 percent reduction in physician fees. Every subsequent year since 2002, the SGR has called for a reduction in physician reimbursements. And every year since 2002, Congress passed legislation that temporarily avoided cuts. In June 2010, Congress approved its latest – a temporary fix delaying a scheduled 21 percent cut while increasing reimbursements by 2.2 percent from June 1, 2010 through November 30, 2010. Looking ahead, without another temporary fix, physicians face a 23.5 percent reduction in Medicare reimbursements on December 1, 2010.

PPACA does not address the SGR. However, the Congressional Budget Office (CBO) analysis of PPACA (March 2010) predicting a surplus of $138 billion assumed the SGR scheduled cut 21 percent cut dating back to October 1, 2009. The CBO forecast included projections that the Independent Payment Advisory Board will reduce overall health costs from 6.4 percent compound annual growth rate (CAGR) to 5.3 percent including scheduled SGR cuts to physician payments in its calculus. Similarly, the most recent Medicare Actuary projections (August 2010) assume that the short-term SGR fix passed by Congress expiring on November 30, 2010 will be followed by a 23 percent cut in Medicare payments. Therefore, the CBO estimates of a surplus and slower spending are largely predicated on lower payments to physicians.

Pay cuts are a major concern to physicians. Recent reports indicate physicians are considering closing their practices or limiting access to Medicare and Medicaid enrollees unless payments are adequate:

- **The American Academy of Family Physicians (AAFP)** – 13 percent of respondents didn't participate in Medicare last year, up from 8 percent in 2008 and 6 percent in 2004.
- **The American Osteopathic Association (AOA)** – 15 percent of its members don't participate in Medicare and 19 percent don't accept new Medicare patients. If the 23 percent cut is not reversed, it says, the numbers will double.
- **The AMA** – 17 percent of more than 9,000 doctors surveyed restrict the number of Medicare patients in their practice. Among PCPs, the rate is 31 percent.
- **In Illinois** – 18 percent of doctors restrict the number of Medicare patients in their practice, according to a medical society survey.
- **In North Carolina** – 117 doctors have opted out of Medicare since January, the state's medical society says.
- **In New York** – about 1,100 doctors have left Medicare. Even the medical society president isn't taking new Medicare patients.

The fiscal problem: Per the CBO (April 2010), fixing the SGR model would require Congress to take a $267 billion charge to make the treasury whole for overpayments dating back to 2004. The current proposal, a six-month extension, will be the ninth temporary fix passed since 2004 and the fourth in 2010. The charge would add to the FY10 deficit of $1.5 trillion and is therefore politically sensitive. No one likes the SGR model; solutions are hard to find and accrued deficits are mounting. MedPAC went on record last June advocating a permanent fix to the SGR model:

> "…we remind readers that the Commission is not satisfied with the current physician payment update mechanism. It does not provide incentives for individual physicians to control volume growth, and it is inequitable to those physicians who do not increase volume unnecessarily. And it continues to call for substantial negative updates through at least 2016. Such reductions in physician payment rates, if they take place, would threaten beneficiaries' access to physician services."

Potential scenario: Congress may approve another temporary fix in November, possibly with modest increases for physician payments overall with targeted cuts to technical components of practice and practice expense components of the SGR formula. A two-year fix (through FY13) would allow the Independent Payment Advisory Board to pick up responsibility for physician payments starting January 2014, and force the Treasury to take a charge for the accrued overpayments since 2004.

Medical education

There are 133 medical schools and 400 teaching hospitals in the U.S., but the operations of the two are quite dissimilar (Figure 4).

Figure 4: Comparing Academic Medical Centers and Teaching Hospitals

	Academic Medical Centers	Teaching Hospitals
Primary model	Three-in-one: Teaching, research and patient care Faculty plan augmented by community-based physician relationships	Patient care with selective residency and research foci Medical staff model with increased complement of employed physicians
Physician compensation	Blend of research, productivity and administrative responsibilities; varied dependence on patient care productivity depending on departmental governance, institutional policies Shared ownership of intellectual property	Patient care productivity primary; administrative responsibilities for targeted clinicians Often augmented by directorships for specialty clinical programs or oversight of residency programs
Access to capital	Tax exempt bonds, debt and select joint ventures with strategic partners; state/federal appropriations University – AMC capital budgeting process Gifts: Restricted and unrestricted – major focus	Tax exempt bonds, debt and select joint ventures with strategic partners ; state/federal appropriations (public equity for FP systems with residency programs) Gifts/development: supplemental focus
Profitability and sustainability	Research, teaching programs not profitable; patient care and indirect medical education funding key sources Dependence on non-operating income	Direct and indirect medical education funding, patient care revenues key sources Dependence on operating income
Managed care posture	Seek preferred tier status; resist deep discounting and carve outs	Seek preferential tier positioning

For the 2009-2010 entering class, U.S. medical schools received 562,694 applications from 42,269 applicants, an average of 13 per applicant. There were also 31,063 first-time applicants – up slightly from 31,019 in 2008-09. The all-time high was 46,965 (1996-1997) but reflects an upward trend since a recent low of 33,625 (2002-2003). Fifty-two percent of applicants were males. *(Source: AMA Data Warehouse)*

In 2008-09, women received 8,035 (48.8 percent) of the 16,468 M.D.s awarded. *(Source: AAMC)*

Ninety-six percent of all medical students graduate within ten years with an M.D. compared to 62 percent graduation rates to other post-baccalaureate programs. *(Source: National Center for Education Statistics)*

Medical school tuition and fees for a first-year medical student for 2009-2010: Public schools $11,638-$75,238; private schools $17,215-$54,244. *(Source: AAMC)*

Debt: The average 2009 medical graduate has total debt of $156,456: 79 percent at least $100,000, 58 percent at least $150,000 and 87 percent carry outstanding loans. *(Source: AAMC 2009 Graduation Questionnaire)*

"Supply sensitive care" points to differences in practice patterns by physicians

Comparing Medicare costs, utilization and outcomes across 300-plus communities, three factors explain differences: Oversupply of specialists and hospitals, ineffective use of primary care and over-use of diagnostic and surgical treatments not associated with evidence. *(Source: The Dartmouth Atlas of Health Care)* As much as 30 percent of health costs could be reduced without compromising outcomes per the Institute. In Congressional hearings as PPACA was being debated, Dartmouth data was frequently cited. Testimony about physician practice variation was a consistent theme as advocates on all sides called attention to "supply sensitive care".

Retail clinics: Disruptive innovation challenging traditional primary care

The nation's 1,200 retail clinics provide basic health care services for a dozen non-complicated conditions through same-day appointments that average $59 for a visit including prescription drug cost *(Source: Retail Clinics: Update and Implications, Deloitte Center for Health Solutions, November 2009)*. NPs staff retail clinics; a medical director sets clinical standards, reviews charts and handles patients with complicated symptoms or risk factors. Sixty-seven percent of retail clinic visits are covered by commercial insurance compared to 90 percent of PCP visits.

Forty-five percent of uninsured consumers reported that they would use a retail clinic compared to 32 percent of insured consumers. *(Source: 2010 Survey of Health Care Consumers, Deloitte Center for Health Solutions, May 2010)*. Sixteen percent of adults used a retail clinic one or more times in the past two years – 70 percent of these had an existing primary care relationship. Convenience and cost savings were reasons for use; safety and quality issues were not a concern. The appeal of retail clinics is highest among younger consumers topped by 79 percent of millenials (born 1982-1993) vs. seniors at 46 percent.

Note: Retail clinics are in three settings primarily: retail drugstores, discount retailers and grocery stores/ supermarkets. They are usually adjacent to a prescription drug store facilitating dispensing, and often optometry and dental care enhancing diagnostics. A visit costs $55 less than a physician's office visit and $279 less than an emergency department visit *(Source: Convenient Care Association 2010)*. Consumers who have used retail clinics are satisfied and 90 percent of the current sites adhere to third party accreditation of ten safety and quality standards. We project 5,000 retail clinics in operation within five years, likely serving growing numbers of the newly insured via PPACA subsidies.

The AMA: Scope and reach

In the recent health reform debate, the AMA board of delegates endorsed the bill though it did not include a fix to the physician pay formula and liability reforms – two of its major lobbying goals. In its history dating back to the 1930s, the AMA has been a major player in health advocacy:

- In the 1930s, the AMA sought to limit its members' participation in early stage HMOs citing HMOs as a violation of the Sherman Antitrust Act.
- In the 1950s and 1960s, AMA campaigned against Medicare via its Operation Coffee Cup campaign.
- In 1994, it was part of a coalition against reforms proposed by the Clinton Administration.
- And in 2009, it opposed House Resolution 676 that created a single payer system.

The AMA traces its roots to 1844 when it operated at the Medical Society of the State of New York. Not including residents/fellows/students in its membership, AMA membership is 135,000 practitioners – less than 20 percent of physicians that provide patient care. It is affiliated with 110 other medical specialty societies and has affiliate organizations in each state.

Scope of practice: Current status

The scope of practice that define the boundaries for NPs, advanced practice nurses and related health professionals are set by state licensing boards in each state. These regulations vary widely. For retail clinics, scope issues involve permit requirements, ratios of overseeing physicians to NPs, and the conditions and age groups that can be treated. For NPs and physician assistants (PAs) practicing in hospitals and clinics, regulations tend to focus on standards of physician oversight/approval, prescribing authority, ratios of physicians to practitioners and risk-associated with patient chart reviews. Eleven states allow NPs and PAs to practice independent of a physician, but most states limit their ability to prescribe medications. The states with the most latitude in scope of practice for mid-levels are Washington, Tennessee, New Hampshire, Maine, Idaho, Arkansas and Alaska – notably states where primary care supply is low in rural areas and the medical society more accepting of scope expansion.

Fact file

- 661,400 physicians and surgeons are licensed in the U.S. (2008): 19 percent are employed in hospitals; 53 percent in group practices, 12 percent are solo practitioners and 16 percent work in research/educational roles in larger organizations. *(Source: AMA)*
- Of those in patient-care settings, 32 percent practice in primary care; 68 percent in specialties. *(Sources: AMA, U.S. Bureau of Labor Statistics)*
- 75 percent practice in urban areas; 25 percent in rural. *(Sources: AMA, U.S. Department of Commerce)*
- Between 2008 and 2018, the physician workforce will increase 22 percent to 805,500. *(Source: U.S. Department of Labor)*
- Median income for PCPs in 2008: $186,044; for specialists $339,738. *(Source: Medical Group Management Association)* Note: Does not include income from ownership of ancillaries/hospitals.
- Annual membership costs for AMA: physician-$420; resident/fellow-$45; retired physician-$84; medical student-$20. *(Source: AMA)*
- Revenue production per employed physician and salary for select specialties: *(Source: Merritt-Hawkins' 2010 Inpatient-Outpatient Survey)*
  - Neurosurgery: $2,815,650 revenue; $571,000 salary
  - Cardiology (invasive): $2,240,366 revenue; $475,000 salary
  - Orthopedic surgery: $2,117,764 revenue; $481,000 salary
  - General surgery: $2,112,492 revenue; $321,000 salary
  - Internal medicine: $1,678,341 revenue; $186,000 salary
  - Family practice: $1,622,832 revenue; $173,000 salary
  - Hematology/Oncology: $1,485,627 revenue; $335,000 salary
  - Gastroenterology: $1,450,540 revenue; $393,000 salary
  - Urology: $1,382,704 revenue; $401,000 salary
  - OB/GYN: $1,364,131 revenue; $266,000 salary
  - Cardiology (non-invasive): $1,319,658 revenue; $419,000 salary
  - Psychiatry: $1,290,104 revenue; $200,000 salary
  - Pulmonology: $1,204,919 revenue; $293,000 salary
  - Neurology: $907,317 revenue; $258,000 salary
  - Pediatrics: $856,154 revenue; $171,000 salary
  - Ophthalmology: $842,711 revenue; $282,000 salary
  - Nephrology: $696,888 revenue; $240,000 salary
- Physician demand: AAMC projects a shortage of 46,000 PCPs, 41,000 surgeons and 8,000 specialists by 2025. *(Source: Association of American Medical Colleges)*
- In 2008, health care employed 14.3 million wage and salaried workers. Ten of the 20 fastest growing occupations are health care related: Between 2008 and 2018, the industry will generate 3.2 million new wage and salary jobs, more than any other industry. *(Source: U.S. Bureau of Labor Statistics. Career Guide to Industries, 2010-11 Edition, Healthcare. February 2010)*
- Following a similar trend in prior months, July employment decreased by 54,000; unemployment is 9.5 percent. *(Source: U.S. Department of Labor Report, September 3, 2010)*
- Employer health insurance costs increased three percent last year while employee contribution increased 14 percent – $482 per household. Since 2005, employer contributions increased 27 percent employee contributions increased 47 percent, wages increased 18 percent and inflation increased 12 percent. Employees covered under $1,000 or higher deductible health insurance plans increased from 6 percent to 17 percent in the same period. Workers pay 30 percent of health benefits costs – up from 26 percent in 2005. Average premiums for 2010: families plans $13,770 (up three percent from 2009) and $5,049 for individual plans (up five percent from 2009). *(Source: "2010 Employer Health Benefits Survey" Kaiser Family Foundation and the Health Research and Educational Trust (HRET), released 9/2/10)*
- Demand for PAs will increase 39 percent in the decade. *(Source: U.S. Department of Labor)*

Author

Paul H. Keckley, Ph.D.
Executive Director
Deloitte Center for Health Solutions
pkeckley@deloitte.com

Contributors

John Bigalke
U.S. Industry Leader
Health Sciences and Government
Deloitte LLP
jbigalke@deloitte.com

Bill Copeland
National Leader
Health Reform
Deloitte Consulting LLP
bcopeland@deloitte.com

Andrew Vaz
National Managing Director
Life Sciences and Health Care
Deloitte Consulting LLP
anvaz@deloitte.com

Steve Kraus
Principal
Human Capital
Deloitte Consulting LLP
stkraus@deloitte.com

Acknowledgements

We wish to thank Wally Gregory, Catherine Amble, Jennifer Bohn, Kerry Iseman, Ellen Rice, Cynthia Vasquez and the many others who contributed to this project.

Note: This Issue Brief was originally published as part of the Deloitte Center for Health Solutions' Health Reform Update on September 7, 2010.

Contact information

To learn more about the Deloitte Center for Health Solutions, its projects and events, please visit: www.deloitte.com/centerforhealthsolutions.

Deloitte Center for Health Solutions
555 12th Street N.W.
Washington, DC 20004
Phone 202-220-2177
Fax 202-220-2178
Toll free 888-233-6169
Email healthsolutions@deloitte.com
Web http://www.deloitte.com/centerforhealthsolutions

Deloitte.
Center for Health Solutions

About the Center

The Deloitte Center for Health Solutions (DCHS) is the health services research arm of Deloitte LLP. Our goal is to inform all stakeholders in the health care system about emerging trends, challenges and opportunities using rigorous research. Through our research, roundtables and other forms of engagement, we seek to be a trusted source for relevant, timely and reliable insights.

To learn more about the DCHS, its research projects and events, please visit: www.deloitte.com/centerforhealthsolutions

Copyright © 2010 Deloitte Development LLC. All rights reserved.

Member of Deloitte Touche Tohmatsu Limited

These materials and the information contained herein are provided by Deloitte LLP and are intended to provide general information on a particular subject or subjects and are not an exhaustive treatment of such subject(s). Accordingly, the information in these materials is not intended to constitute accounting, tax, legal, investment, consulting or other professional advice or services. Before making any decision or taking any action that might affect your personal finances or business, you should consult a qualified professional advisor.

These materials and the information contained therein are provided as is, and Deloitte LLP makes no express or implied representations or warranties regarding these materials or the information contained therein. Without limiting the foregoing, Deloitte LLP does not warrant that the materials or information contained therein will be error-free or will meet any particular criteria of performance or quality. Deloitte LLP expressly declaims all implied warranties, including, without limitation, warranties of merchantability, title, fitness for a particular purpose, non-infringement, compatibility, security and accuracy.

Your use of these materials and information contained therein is at your own risk, and you assume full responsibility and risk of loss resulting from the use thereof. Deloitte LLP will not be liable for any special, indirect, incidental, consequential, or punitive damages or any other damages whatsoever, whether in an action of contract, statute, tort (including, without limitation, negligence), or otherwise, relating to the use of these materials or the information contained therein.

If any of the foregoing is not fully enforceable for any reason, the remainder shall nonetheless continue to apply.

About Deloitte

Deloitte refers to one or more of Deloitte Touche Tohmatsu Limited, a UK private company limited by guarantee, and its network of member firms, each of which is a legally separate and independent entity. Please see www.deloitte.com/about for a detailed description of the legal structure of Deloitte Touche Tohmatsu Limited and its member firms. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries.

Copyright © Deloitte Development LLC. All rights reserved