



College of Professional Studies



CENTERGY

Central WI Alliance for Economic Development



A part of BMO Financial Group

Central Wisconsin Economic Research Bureau

Second Quarter 2011 Economic Indicators Centergy Region

Presented

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NATIONAL ECONOMIC CONDITIONS

Due to gains in productivity and international sales, the national economy is growing as measured by Gross Domestic Product. For eight consecutive quarters, the nation's output of goods and services has expanded. However, for the last two quarters growth in Real GDP was just 0.4 percent and 1.0 percent respectively. This means that the economy is perilously close to falling into another recession. Another measure of output is industrial production. Our nation's factories increased their output by a meager 0.4 percent in second quarter. Consumer prices as measured by the overall CPI grew by 3.8 percent from August 2010 to August 2011. If energy and food are excluded the Core CPI measure rose by 2.1.

However, it is employment growth or the lack thereof that truly defines the nature of this economy. The official unemployment rate was 9.1 percent in August. As a matter of record the unemployment rate has been over 9.0 percent for over two years. If discouraged workers and part time workers are taken into account, the real unemployment rate is above 16 percent. With non-farm payrolls growing by only 1.0 percent over the past year in the US, it could take until the end of this decade before total employment reaches pre-recession levels. In addition to the poor job market, households are also hurting from the loss of wealth associated with falling real estate prices and stock market values.

The majority of past recessions in this country did not emanate from a crisis in the nation's financial system. There are few people left who remember the last economy wide financial bubble of the 1930s. From a historic perspective recessions caused by wide spread financial excess are unusually deep and their recoveries are painfully slow. Why? Most people are aware that a huge number of households are currently underwater with their mortgages or behind in their monthly house payments and other types of debt. Moreover, a huge number of important financial institutions suffered large mortgage related losses. This means the balance sheets of households and financial institutions are in great need of repair. This will take a long time to accomplish and it will not happen overnight. Until then, do not expect households or financial institutions to provide the spending and lending needed to propel the economy forward. Ben Bernanke, chairman of the Federal Reserve, has indicated repeatedly that the economic recovery will be tempered by "hard-to-get credit for consumers and businesses, and by households saving more, spending less and trimming their debt." To underscore the difficulty that households are having, consider Wisconsin. The U.S. Census Bureau reports the real inflation adjusted median household income in Wisconsin has dropped from \$57,316 in 2000 to \$49,993 in 2009, a decline of 14.5 percent! It's no wonder why the recovery has been almost non-existent. Aggravating the slow job recovery has been the growing intensity of international competition and the loss of jobs to overseas competitors.

The Federal Reserve and the vast majority of economists are revising their forecasts in a downward direction for this year and next with the probability of a double dip recession being at least 50 percent. Some economists, who are more bearish about the economy, put the probability at over 60 percent for 2012. Adding to the air of pessimism is the seeming

ineffectiveness of monetary policy to stimulate the economy. With real interest rates near zero and the economy awash in liquidity, it is hard to imagine how more liquidity would convince households and businesses to engage in more economic activity. The Federal Reserve’s attempt to lower long term interest via “Operation Twist” is not likely to help the short-term problems of the economy.

When it comes to fiscal policy it appears the federal government and states are more concerned with reducing budget deficits than dealing with the unemployment crisis. Raising taxes and reducing spending to close budget deficits will create an immediate drag on the economy and will most likely mean that a second recession is inevitable. Reducing government deficits is without question a necessary step in restoring the long run competitiveness of the national economy. Unfortunately the benefits from cutting spending and raising taxes to bring our economic house in order will be years away and will be a long and painful process for most Americans.

Due to increases in productivity and foreign sales, US nonfinancial business firms are making record profits and are sitting on nearly two trillion dollars of cash. Their reluctance to hire new workers is due to the uncertainty surrounding future government spending, tax, and regulatory policies. This uncertainty makes forecasting the long term demand for their products very difficult. In addition the federal government inability to come to a consensus concerning the budget has the effect of increasing business risk for firms. The nation’s leaders must realize they need to put their ideologies on hold, because the inability to reach a political consensus is hurting the nation’s business climate and the people of this country. It would also help to reduce uncertainty if policy changes were made permanent

After my presentation Dr. Edward Miller will speak on “Medicare: A Policy in Transition.” Medicare is a very large part of the federal government budget. Any attempts to address the budget deficit must include discussion of how to bring Medicare spending under control. So I think it is very important that we examine Medicare, a program that will affect almost everyone in this country.

TABLE 1 NATIONAL ECONOMIC STATISTICS	2010 Second Quarter	2011 Second Quarter	Percent Change
Nominal Gross Domestic Product (Billions)	\$14,467.8	\$14,996.8	+3.7
Real Gross Domestic Product (Billions of 2000 \$)	\$13,058.5	\$13,260.5	+1.5
Industrial Production (2002 = 100)	92.5	93.3	+0.9
Three Month U.S. Treasury Bill Rate	0.17%	0.03%	-84.8
Consumer Price Index (1982-84 = 100)	218.0	225.7	+3.6

CENTERGY REGION PART I

Table 2, the unemployment rate in the Centergy Region is unchanged from a year ago. The region's unemployment rate remained at 8.3 percent in June 2011, the same rate recorded in June 2010. Marathon County's unemployment rate actually fell from 8.7 percent to 8.1 percent over the past year. However, the unemployment rate in Portage and Wood rose over the same period and now stand at 8.0 percent and 8.8 percent respectively. Wisconsin's unemployment rate for all intent and purpose stayed the same at 8.1 percent. The U.S. unemployment rate edged lower from 9.6 percent to 9.3 percent. Thus, the data in Table 2 shows the persistence of a weak labor market.

	Unemployment Rate June 2010	Unemployment Rate June 2011	Percent Change
Centergy Region*	8.3%	8.3%	0
Portage County	7.6%	8.0%	+4.4
Marathon County	8.7%	8.1%	-6.1
Wood County	8.4%	8.8%	+4.1
Wisconsin	8.1%	8.1%	+0.7
United States	9.6%	9.3%	-3.1

*Centergy Region = Marathon, Portage, and Wood Counties

rate for all intent and purpose stayed the same at 8.1 percent. The U.S. unemployment rate edged lower from 9.6 percent to 9.3 percent. Thus, the data in Table 2 shows the persistence of a weak labor market.

More evidence of the lingering impact of the recession impact can be seen in Table 3. The Centergy Region's employment level rose ever so slightly from 141.3 thousand to 141.9 thousand or by just 0.4 percent over the last twelve months. In contrast to this in June 2008 the Centergy Region's total employment was 151.7 thousand.

	Total Employment June 2010 (Thousands)	Total Employment June 2011 (Thousands)	Percent Change
Centergy Region*	141.3	141.9	+0.4
Portage County	36.2	36.8	+1.7
Marathon County	67.9	67.9	-0.0
Wood County	37.2	37.2	-0.1
Wisconsin	2,824.5	2,852.3	+1.0
United States	139,882	140,129	+0.2

*Centergy Region = Marathon, Portage, and Wood Counties

Similarly, the state of Wisconsin's payrolls climbed from 2.82 million to 2.85 million from June 2010 to June 2011. However, in June 2008 the state's payrolls were estimated to be 2.93 million. There was a slight improvement in U.S. employment from 139.88 million to 140.13 million or by 0.2 percent. But in June 2008 the figure for the U.S. was 145.92 million. This means the national economy has yet to recover over five million lost jobs!

	2010 Second Quarter (Thousands)	2011 Second Quarter (Thousands)	Percent Change
Centergy Region*	\$4,705.4	\$4,793.1	+1.9
Marathon County	\$2,325.4	\$2,394.5	+3.0
Portage County	\$1,224.1	\$1,222.3	-0.1
Wood County	\$1,155.9	\$1,176.3	+1.8

*Centergy Region = Marathon, Portage, and Wood Counties

There is some evidence that the retail scene is making a tentative come back. Table 4 shows this to be the case for sales tax collections in the Centergy Region. Sales tax receipts rose from \$4.71 million to \$4.79

million over the course of the year, an increase of 1.9 percent. In June 2008 the sales tax collections in the Centergy region was \$5.07 million. The impact of the recession and the painfully slow recovery is evident in the numbers and says that retail activity has a long way to go before a full recovery is reached.

Some good news is reported in Table 5. As mentioned earlier in the report there are some tentative signs of improvement in the economy when we compare this year's statistics to last year's results. The CWERB's survey of region business executives in Table 5 shows there has been a great deal of stability in their assessment of economic conditions. Even though this group feels that recent changes in the economy have resulted in little improvement locally, they do believe that the economy will improve in the next several quarters. Specifically, the group indicates the national economy will grow, the local economy will strengthen, and most importantly that economic conditions for their business will improve in the quarters ahead.

	Index Value	
	March 2011	June 2011
Recent Change in National Economic Conditions	69	63
Recent Change in Local Economic Conditions	56	55
Expected Change in National Economic Conditions	67	63
Expected Change in Local Economic Conditions	67	66
Expected Change in Industry Conditions	65	63

The Centergy Region is a subset of the Wisconsin economy. Thus, it is very instructive to

	Employment June 2010 (Thousands)	Employment June 2011 (Thousands)	Percent Change
Total Nonfarm	2779.7	2819.9	+1.4
Total Private	2355.4	2399.5	+1.9
Natural Resources and Mining	3.2	3.3	+3.1
Construction	101.9	99.1	-2.7
Manufacturing	435.5	453.3	+4.1
Trade, Transportation, and Utilities	512.9	518.8	+1.2
Information	46.7	47.5	+1.7
Financial Activities	158.9	155.3	-2.3
Professional and Business Services	270.9	275.6	+1.7
Educational and Health Services	417.8	425.0	+1.7
Leisure and Hospitality	268.8	274.6	+2.2
Other Services, exc. Public	138.8	147.0	+5.9
Government	424.3	420.4	-0.9

examine what is taking place in the state. Table 6 shows total nonfarm employment in Wisconsin. Total nonfarm employment went up from 2.78 million to 2.82 million or 1.4 percent from last year. However, it should be pointed out that in June 2008 the state's non-farm employment total stood at 2.92 million. Thus, we have a long way to go in the recovery. The largest decline was in government where the number of jobs shrank from 424.3 thousand to 420.4 thousand a loss of about 24 thousand positions. The only

other sector to experience decline other than government employment was the construction sector. Employment there fell from 101.9 thousand to 99.1 thousand or 2.7 percent. All other sectors experienced employment gain.

Figures 1-6 give the reader insight as to how the state of Wisconsin has fared over the past four and a half years. From the figures it is also possible to see the seasonality in the data series and to determine where the turning points of the economy have been. Moreover, as mentioned in an earlier Centergy Report Figure 1 shows that it was about middle to late 2008 when the recession hit Wisconsin's employment numbers. The same thing can be said for Figures 2 and 3 where the unemployment level and unemployment rate shot up in the mid to late 2008. Lastly and as mentioned in previous reports, Figure 5 depicts the dramatic rise in Education & Health Services employment and Figure 6 shows how the manufacturing employment has fared over the past five years and the structural changes taking place in this important sector.

Figure 1: Employment Level: Wisconsin

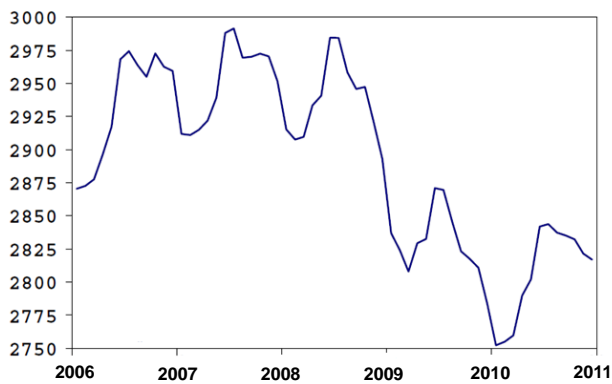


Figure 2: Unemployment Level: Wisconsin

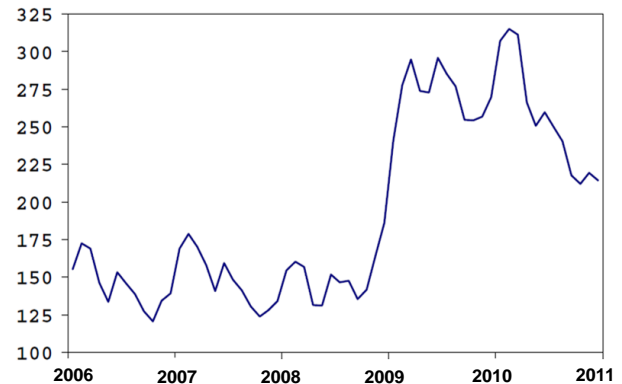


Figure 3: Unemployment Rate: Wisconsin

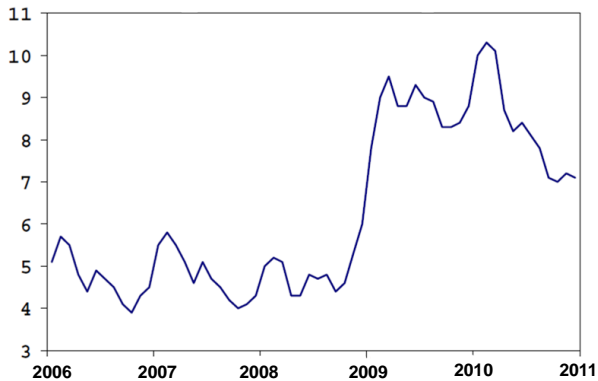


Figure 4: Labor Force: Wisconsin

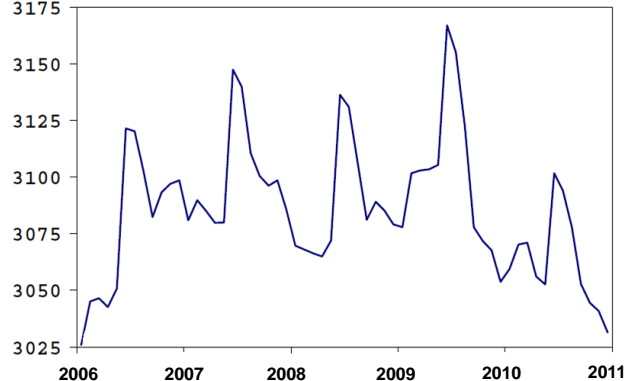


Figure 5: Manufacturing Employment: Wisconsin:
Thousands of Persons

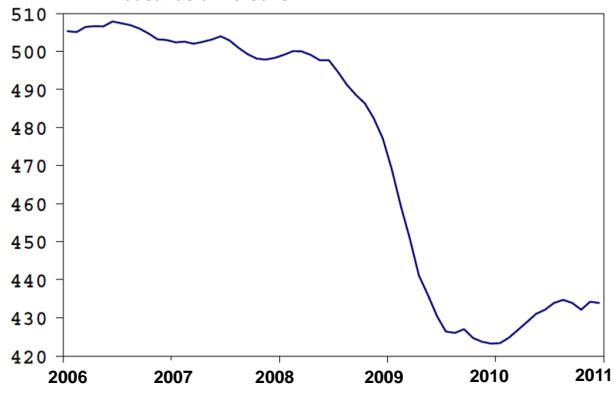
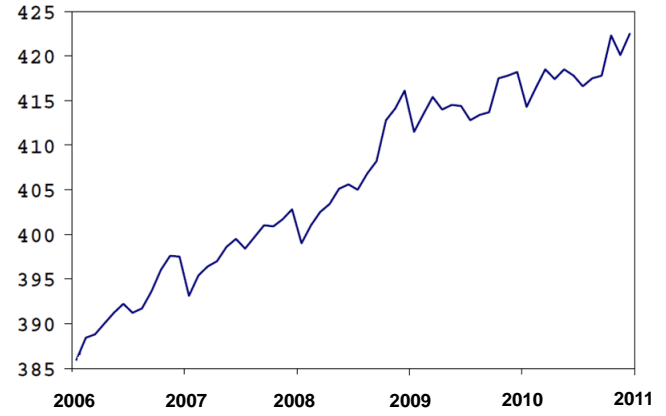


Figure 6: Wisconsin: Education and Health Services: Thousands



CENTERGY REGION PART II

The number of unemployed people in the Centergy Region decreased from 12.8 thousand to 10.3 thousand from June 2010 to June 2011, as shown in Table 7. This represents a 19.3 percent change over the past twelve months. Marathon and Wood experienced large declines in the number of people out of a job. Only Portage registered an increase in unemployment. However, the recent improvement must be put into the proper context. In June 2008 the

TABLE 7 UNEMPLOYMENT CENTERGY REGION	Unemployment June 2010 (Thousands)	Unemployment June 2011 (Thousands)	Percent Change
Centergy Region	12,861	10,382	-19.3
Portage County	2,989	3,185	+6.6
Marathon County	6,457	5,232	-19.0
Wood County	3,415	2,755	-19.3

number of unemployed in the Centergy Region was just 7.7 thousand. This statistics indicates that a significant increase in the level of family financial distress has taken place in our area.

Table 8, labor market conditions can be assessed by a variety of methods. For example, the employment figures and the unemployment rates are often used in this way. Another approach is to examine the amount of help wanted advertising taking place in a region. As shown in Table 8, Centergy Region's help wanted advertising index rose from 468 to over the past twelve months. This represents a 29 percent increase in web based help wanted advertising and indicates the degree of turnaround in our local labor markets. The gain in help wanted advertising was fairly uniform across the four major urban areas in Central Wisconsin.

Table 8 Help Wanted Advertising	Index Value		
	Fourth Quarter 2010	First Quarter 2011	Percent Change
Centergy Region	468.25	615.21	+29.1%
Stevens Point	354.50	398.30	+12.4%
Wausau	665.25	922.34	+38.6%
Marshfield	385.00	525.00	+36.4%
Wisconsin Rapids	199.75	269.31	+34.8%

Table 9 gives unemployment claims data and it clearly shows there has been recent improvement in this measure. New unemployment claims have declined from 1,201 to 1,074 or

TABLE 9 UNEMPLOYMENT CLAIMS CENTERGY REGION	2010 Second Quarter (Weekly Avg.)	2011 Second Quarter (Weekly Avg.)	Percent Change
New Claims	1,201	1,074	-10.5
Total Claims	15,248	14,493	-5.0

10.5 percent. Likewise total unemployment claims have declined from 15,248 to 14,493 in the Centergy Region. Once again to put this into context in June 2008 the number of new claims was 804 and the total number of claims was just 5,127 in the region. Thus 2011 total unemployment claims are three times greater than three years ago. The elevated numbers mean there has been a substantial rise in the level of local family financial distress.

Table 10 presents public assistance claims in the Centergy Region. The number of claims rose from 478 to 541 or 13.2 percent. Likewise, Marathon and Wood County experienced gains of 13.7 and 21.5 percent respectively. Only Portage County registered a decline in public assistance, falling by 9.0 percent. Thus, overall, the Centergy Region experienced an increase in family financial distress.

TABLE 10 PUBLIC ASSISTANCE CLAIMS* CENTERGY REGION	2010 Second Quarter Total Caseload	2011 Second Quarter Total Caseload	Percent Change
Centergy Region*	478	541	+13.2
Marathon County	161	183	+13.7
Portage County	89	81	-9.0
Wood County	228	277	+21.5

* Data according to W-2 total caseload (April, May, and June) with payment placement and without payment placement.

* Centergy Region = Marathon, Portage, and Wood Counties

Centergy Region Part III

The following seven tables contain information on the national, regional, and local housing market. Housing activity is an incredibly important aspect of the economy. We believe the reader will gain valuable insight into housing markets conditions and greater insight into the local economy in section III of the report.

TABLE 11 NATIONAL MEDIAN HOME PRICES	SECOND QUARTER 2011				
	U.S	NORTHEAST	MIDWEST	SOUTH	WEST
2006	\$221,900	\$271,900	\$167,800	\$183,700	\$342,700
2007	219,000	279,100	165,100	179,300	335,000
2008	198,100	266,400	154,100	169,200	271,500
2009	172,500	240,500	144,100	153,000	211,100
2010	173,000	243,500	141,699	150,100	215,100
June 2011 p	175,600	258,300	145,400	154,800	205,900

Table 11 gives national median home price for the U.S. and major regions in the U.S. housing prices in the Midwest are the lowest in the country. The median home price in our part of the country has dropped from \$167,800 in 2006 to \$145,400 in 2011, a decline of 13 percent. Housing prices

have declined dramatically in all parts of the U.S.

Table 12 National and the Midwest existing home sales data shows a substantial drop off in sales activity over the past six years. In the Midwest 1,483,000 homes were sold in 2006. The preliminary estimate for 2011 is that only 1,040,000 homes will be sold in our part of the county, a decline of 33 percent.

TABLE 12 NATIONAL EXISTING HOME SALES	SECOND QUARTER 2011				
	U.S	NORTHEAST	MIDWEST	SOUTH	WEST
2006	6,478,000	1,086,000	1,483,000	2,563,000	1,346,000
2007	5,652,000	1,006,000	1,327,000	2,235,000	1,084,000
2008	4,913,000	849,000	1,129,000	1,865,000	1,070,000
2009	5,156,000	868,000	1,163,000	1,914,000	1,211,000
2010	4,908,000	817,000	1,076,000	1,861,000	1,154,000
June 2011 p	4,840,000	730,000	1,040,000	1,870,000	1,190,000

*Annualized Basis

TABLE 13 NATIONAL INVENTORY	SECOND QUARTER 2011	
	INVENTORY	MONTH SUPPLY
2006	3,450,000	6.5
2007	3,974,000	8.9
2008	3,700,000	10.4
2009	3,283,000	8.8
2010	3,560,000	9.4
June 2011 p	3,717,000	9.2

The national inventory of homes is given in Table 13. The inventory backlog is up to 9.2 months. In 2006 the national supply of homes was only 6.5 months.

Table 14 presents the national affordability index. Low interest rates and falling home prices have greatly improved the affordability of homes. The preliminary estimate for 2011 of 174.4 means that a household earning the median income has 174.4 percent of the income necessary to qualify for a conventional loan covering 80 percent of a medium-priced existing single-family home. The higher the index, the more affordable housing is becoming for the typical family.

TABLE 14 NATIONAL AFFORDABILITY INDEX	SECOND QUARTER 2011						
	MEDIAN PRICED EXISTING SINGLE FAMILY HOME	MORTGAGE RATE	MONTHLY P & I PAYMENT	PAYMENT AS A % OF INCOME	MEDIAN FAMILY INCOME	QUALIFYING INCOME	COMPOSITE
2007 r	217,900	6.52	1,104	21.7	61,173	52,992	115.4
2008 r	196,600	6.15	958	18.1	63,366	45,984	137.8
2009 r	172,100	5.14	751	14.6	61,845	36,048	171.6
2010 r	173,200	4.89	735	14.3	61,583	35,280	174.6
June 2011 p	176,100	4.75	735	14.3	61,537	35,280	174.4

P&I = Principal and interest
 Composite = measures affordability. For example for the year 2011, the index of 174.4 means a family earning the median family income has 174.4 percent of the income necessary to qualify for a conventional loan covering 80 percent of a median-priced existing single-family home.

Table 15 displays data on state and local area median prices. For the most part state and local area prices have been more stable than the U.S. as a whole. In the Centergy Region the lowest median home price is in Wood County at \$92,600. Portage has the highest priced homes at \$136,000 and Marathon falling somewhere between other the two counties.

TABLE 15 LOCAL AREA MEDIAN PRICE	WISCONSIN	MARATHON	PORTAGE	WOOD
2008	\$154,000	\$134,500	\$135,000	\$94,000
2009	142,500	126,800	132,000	94,500
2010	141,000	123,000	132,375	97,000
2011	132,682	114,000	136,000	92,600

In

Table 16 gives the number of local housing units sold. The state and the counties of the Centergy Region have all experienced substantial declines in the number of units sold. Home sales on a yearly basis have contracted by approximately 38 percent in Wisconsin over the past four years.

TABLE 16 LOCAL UNITS SOLD	WISCONSIN	MARATHON	PORTAGE	WOOD
2008	54,924	1,142	533	652
2009	55,132	1,090	532	714
2010	51,263	1,074	474	620
2011	36,828	727	329	398

Tables 17 and 18 present the changes that have taken place in the local median prices and units sold, and compare second quarter 2010 to second quarter 2011.

TABLE 17 LOCAL MEDIAN PRICE	SECOND QUARTER 2011		
	MARATHON	PORTAGE	WOOD
Second Quarter 2010	129,000	164,695	91,000
Second Quarter 2011	118,000	132,000	113,900
Percent Change	-8.5%	-19.9%	25.2%

TABLE 18 NUMBER OF HOME SALES	SECOND QUARTER 2011		
	MARATHON	PORTAGE	WOOD
Second Quarter 2010	132	70	74
Second Quarter 2011	109	47	77
Percent Change	-17.4%	-32.9%	4.1%

Centergy Region Part IV

Measuring Entrepreneurial Activity as Potential Measure of Job Growth

UWSP Small Business Development Center
Vicki Lobermeier, SBDC Director of Entrepreneurship Activities
Mary Wescott, SBDC Counseling Manager

According to a March 2011 release from the Ewing Marion Kauffman Foundation report on the index of entrepreneurial activity, more Americans chose entrepreneurship during the recent recession than at any time in the previous 15 years. The economy and high unemployment rates may have led individuals to start businesses, but most of them started as non-employer entities, which are companies that do not hire employees.

According to the same index, 0.34 percent of American adults created a business per month in 2010, or 565,000 new businesses, a rate that remained consistent with 2009. This rate represents the highest level of entrepreneurship over the past decade and a half. In contrast, the quarterly employer firm rate has dropped from 0.13 percent in 2007 to 0.10 percent in 2010.

Entrepreneurial activity is closely linked to job growth. Many studies indicate that entrepreneurs and startup companies are the source of most new jobs in the United States.

The Kauffman index stresses the following three measures:

- **New Business Development** – New incorporations and LLC formations
- **Access to Capital** – US Small Business Administration Loans
- **Intellectual Property Creation** - Patents issued to individuals and companies

We'll use these measures to show entrepreneurial activity in the Portage, Marathon and Wood Counties for the second quarter of 2010 compared to the second quarter of 2011. In future reports we'll continue to benchmark these measures.

Please note that New Business Development includes only separate legal entities of LLC and Incorporations and does not include formations of sole proprietors.

Additional reports available are reports from Economic Modeling Specialists, EMSI, which projects job growth by industry and impacts of job loss by industry.

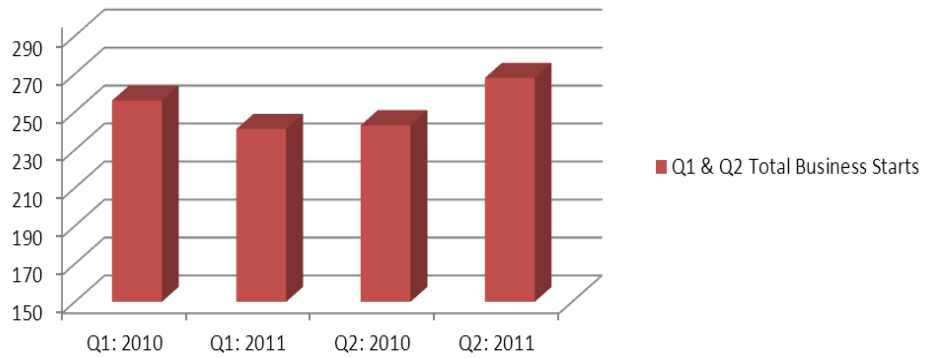
New Business Development

2010 Total Business Starts: Approximately 230

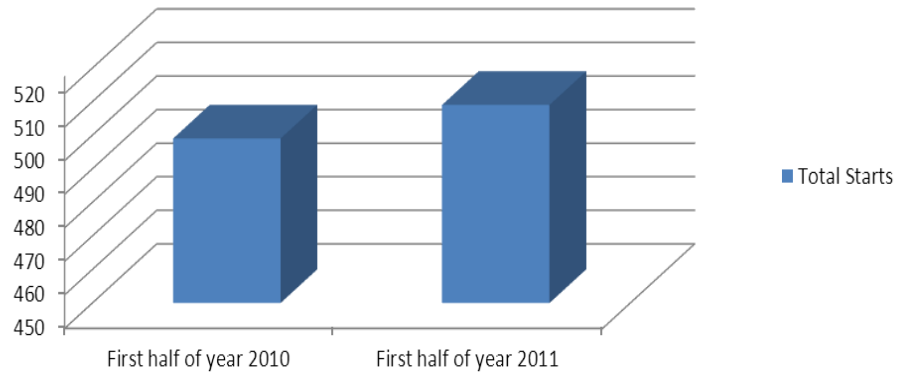
2011 Total Business Starts: Approximately 260

Second quarter 2011 there were a total of 275 new business entities created. Second quarter 2010 there were a total of 260 new business entities created.

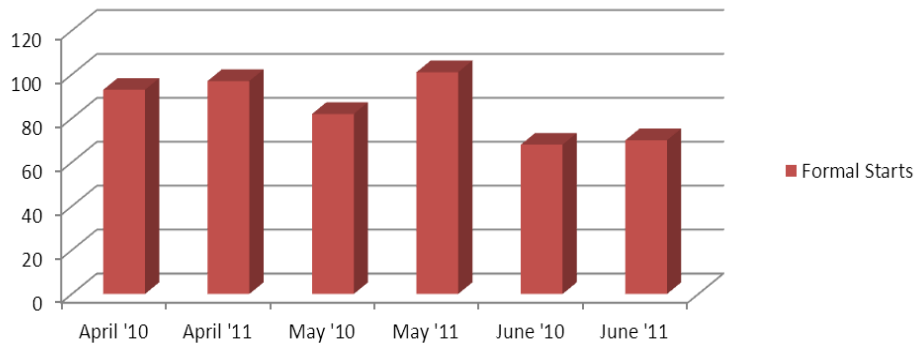
Q1 & Q2 Total Business Starts

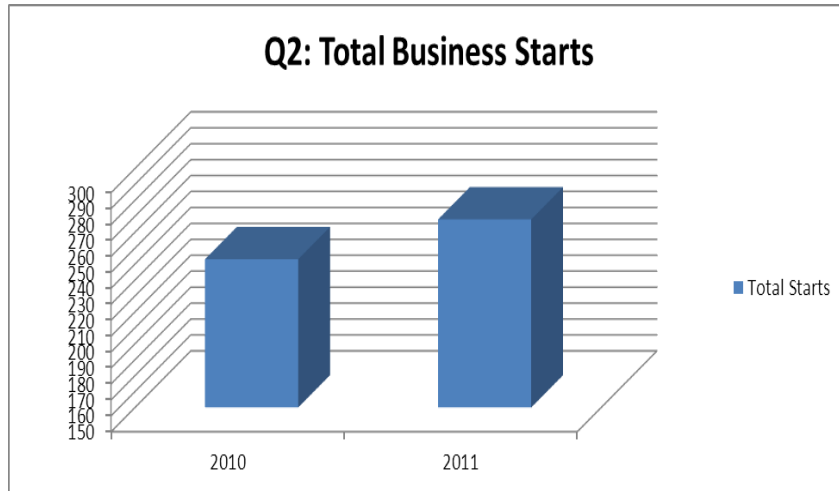


Total Starts



Q2: Formal Starts

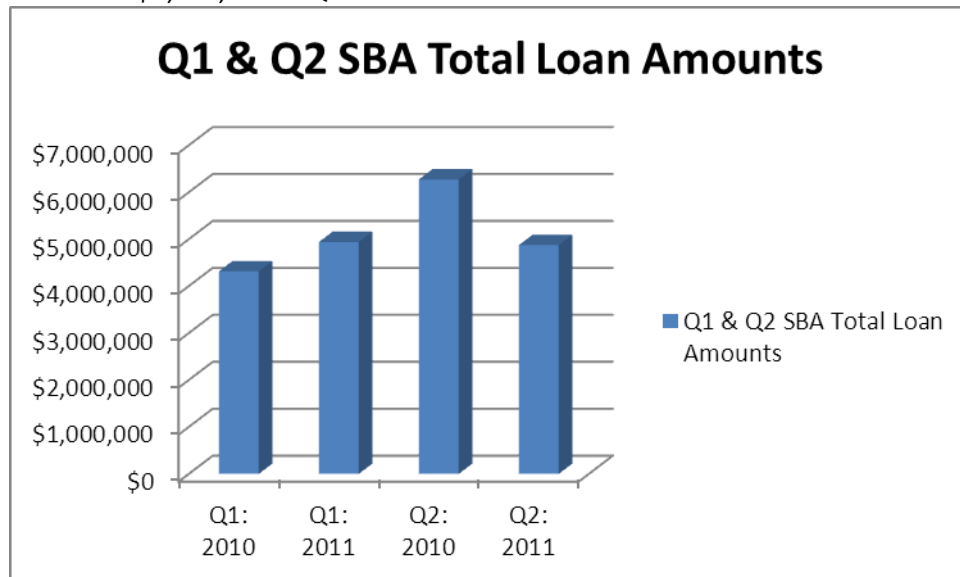


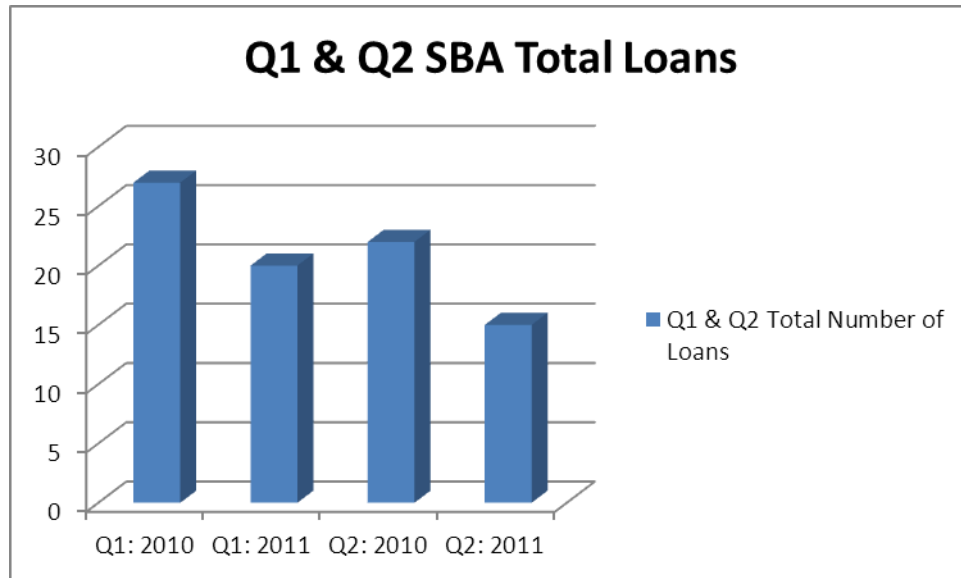


Access to Capital

In our 3-county region, SBA Total Loan Amounts for 2nd quarter 2011 were about \$1.25 million lower than the second quarter of 2010 while the total number of loans decreased from 22 to 13. About 6 million dollars in SBA loans were issued in the second quarter of 2010 compared to 4.75M in 2011. Also, the number of loans was fewer in 2011.

2010 \$6,000,000: 2Q
 2011 \$4,750,000: 2Q





Intellectual Property Creation

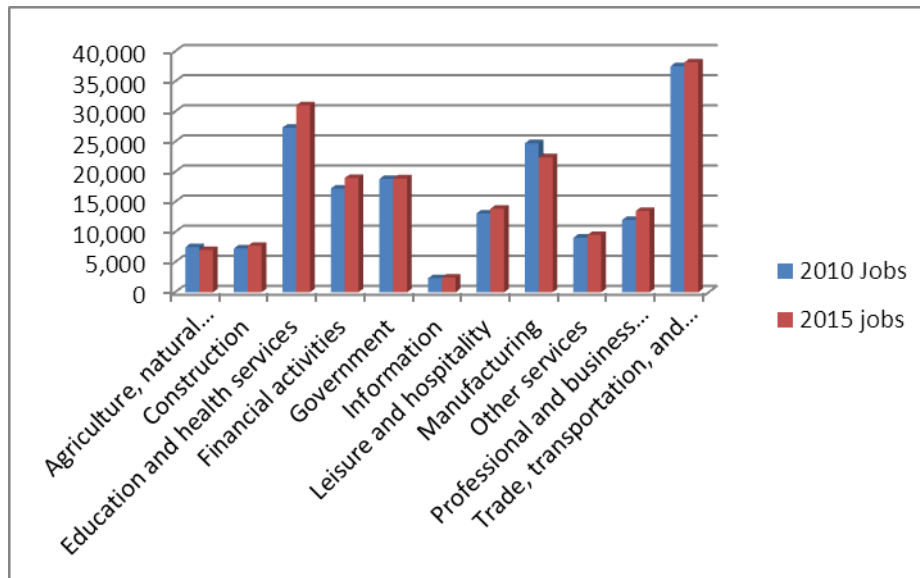
During the first quarter of 2011, 419 patents were issued in Wisconsin. Of those, 3 were assigned to companies in the three-county area of Portage, Marathon and Wood. Another 3 patents were created by local inventors, but assigned to WI companies outside of our area. The patents assigned to local companies were vehicle, equipment, or agricultural related.

Industries Projected for Job Growth

According to EMSI software data compilations, the total number of jobs in the three county areas will rise by 832 positions between 2005 and 2015. Growth is projected for education and health services, professional and business services, and leisure and hospitality.

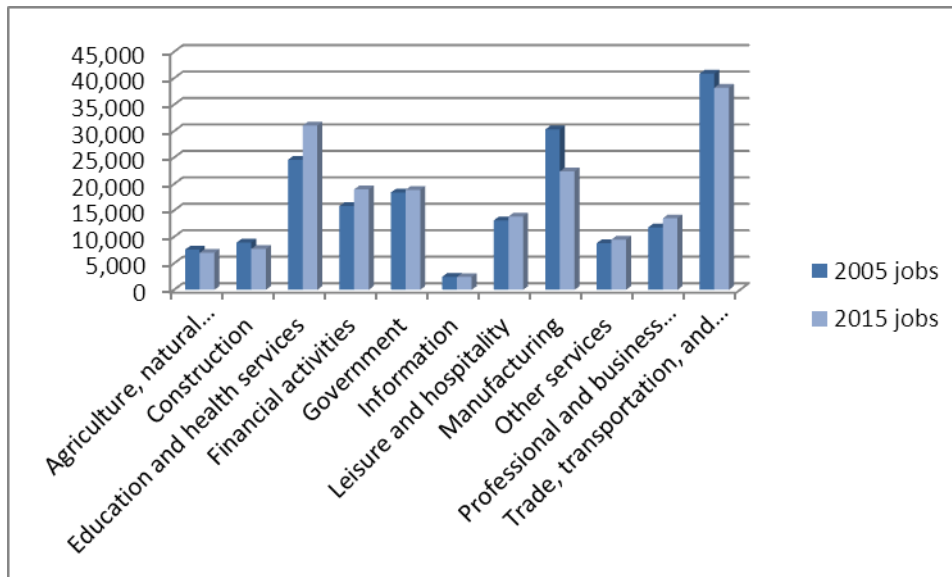
Industries Projected for Growth 2010 - 2015

Description	2010	2015	Growth	%
	Jobs	jobs		
Agriculture, natural resources, and mining	7,484	6,992	-492	-7
Construction	7,260	7,708	448	6
Education and health services	27,327	31,052	3,725	14
Financial activities	17,235	18,979	1,744	10
Government	18,816	18,899	83	0
Information	2,320	2,421	101	4
Leisure and hospitality	13,091	13,864	773	6
Manufacturing	24,739	22,408	-2,331	-9
Other services	9,058	9,487	429	5
Professional and business services	11,986	13,511	1,525	13
Trade, transportation, and utilities	37,529	38,186	657	2
Total	176,844	183,507	6,663	4



Industries Projected for Growth 2005 – 2015

Description	2005 jobs	2015 jobs	growth	%
Agriculture, natural resources, and mining	7,591	6,992	-599	-8
Construction	8,920	7,708	-1,212	-14
Education and health services	24,579	31,052	6,473	26
Financial activities	15,832	18,979	3,147	20
Government	18,394	18,899	505	3
Information	2,480	2,421	-59	-2
Leisure and hospitality	13,125	13,864	739	6
Manufacturing	30,307	22,408	-7,899	-26
Other services	8,808	9,487	679	8
Professional and business services	11,789	13,511	1,722	15
Trade, transportation, and utilities	40,851	38,186	-2,665	-7
Total	182,675	183,507	832	0



Medicare: A Policy in Transition

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Since the beginning of the 20th Century, presidents and members of Congress have pressed for a health care policy that would cover all citizens. President Theodore Roosevelt argued that a nation had to have social insurance, including health insurance, to be strong because no country could lead the world if its people were sick and poor (Starr, p. 243). During the depression health insurance was second in priority, just behind unemployment compensation, for social insurance advocates. When Social Security was first considered, the inclusion of health insurance was a priority of some reformers. However, the American Medical Association (AMA) called a special session of its House of Delegates, which opposed compulsory health insurance but did accept a voluntary plan as long as it was controlled by the county medical associations and followed AMA guidelines. Fearing that the inclusion of health insurance would doom a Social Security bill, President Franklin D. Roosevelt recommended the bill without the health component, intending to seek it in separate legislation. Although the AMA offered some concessions, it strongly opposed any compulsory health insurance program and any program that would impact physicians' business by a financial intermediary. Franklin Roosevelt was reluctant to go up against the AMA but subsequently indicated that he would press for a health insurance bill following the war. After Roosevelt's death, President Harry Truman proposed a single payer health insurance plan (Starr, p. 281). In reaction, the AMA said that the Truman proposal would make doctors "slaves," though it would not affect the private practice of medicine. Arguments that it amounted to "socialized medicine" were regularly heard. Although the U.S. failed to extend government provided health insurance coverage, many Western European nations did; especially Britain, for example, that adopted the National Health Service in 1945.

President John Kennedy was a strong supporter of the adoption of a Medicare program, but it was not until the significant Democratic victory in the 1964 election that there was sufficient political support to pass a program. Enacted in 1965, Medicare covered those 65 and over, while Medicaid covered the poor. Neither act was very controversial at that time. When it began, Medicare had two parts: Part A covered hospital care, which was compulsory, and Part B covered outpatient services, including visits to doctors, which was voluntary. Both the voluntary nature of Part B and the basis of payment of services, customary and usual fees, were the result of pressure from the AMA. Today, Part B remains voluntary but because there is a financial advantage to join (and a penalty to delay joining after 65) enrollment is close to 100% of the eligible population.

Medicare Changes Since Its Adoption

The Medicare program, adopted in 1965, has undergone considerable change, responding both to financial pressures and changes in medical care. Of particular note is the basis that Medicare pays providers. In 1983 Medicare instituted a cost containment method in Part A for hospital care, wherein instead of essentially paying the billed amount, Medicare paid a specific reimbursement to hospitals based upon diagnosis, called "diagnostic related groups" (DRGs). This method of payment was intended to encourage hospitals to economize on the time that patients stayed in the hospital and reduce the number of in-patient days. Safeguards were instituted in an attempt to avoid hospitals releasing patients before they should be. However, the data show that admissions to hospitals were reduced, the average number of days spent in the hospital significantly declined, hospital censuses fell, and nursing home admissions of patients discharged from hospitals increased. It was said that hospital discharged patients "quicker and sicker." Nonetheless, the bundling of service did reduce costs. For Part B, the major reimbursement change was made in 1993, moving from customary and usual fees to a payment schedule for services, known as Resource Based Relative Value Scale (RBRVS). The declared purpose was not to reduce costs but to reallocate reimbursements, providing more for diagnostic services, such as provided by primary care physicians, and less for interventionist procedures, such as cataract surgery. The argument was that Medicare was paying too much for interventions but not enough for "contemplative" services.

A further Medicare change, pushed by Republicans, was the addition of the Medicare Advantage Plan, which is often called "private Medicare." In Medicare Advantage (earlier called Medicare + Choice), Part C of Medicare, patients can join an insurance program that bundles regular Medicare services with a supplemental Medicare policy. Instead of paying fee for service as in traditional Medicare, Medicare Advantage plans receive a fixed payment per enrollee, called capitation. These plans charge their enrollee a premium in addition to the capitation payment and often provide enhanced services to attract enrollees. In the 2000s, Medicare Advantage Plans, whose capitation was set at 95% of average cost of Medicare recipients in their region, argued that they were underfunded. Because of this, some had ended their plans. To rectify this, the Medicare Modernization Act in 2003 increased payments to Medicare Advantage Plans. However, it was soon discovered that the increase was too large. Overpayments are to be gradually reduced under the Patient Protection and Affordability Act of 2010. It is primarily in this area where funds from the claimed Medicare reduction of the Patient Protection and Affordability Act came. About 35% of Medicare beneficiaries are now receiving their services through a Medicare Advantage Plan. Fundamentally, Medicare Advantage was intended to rely upon managed care to reduce costs, be competitive, and be more efficient. Opposition contended that by introducing a separate plan, Medicare beneficiaries were divided into different plans, negating the ideas of Medicare being a single, national plan.

To save money in Medicare, Congress also enacted a payment formula, known as the sustainable growth rate (SGR) in the Balanced Budget Act of 1997 (BBA) (Patel and Rushefsky, 2006, p. 145; Hillman and Goldsmith, 2011, p. 90). However, when the formula was found to

reduce reimbursements, physicians and other affected groups (especially through the American Medical Association and state medical societies) put great pressure on members of Congress to eliminate the reduction. Congress consistently responded, negating the projected reductions for every year except 2002. Given the growth of the SGR based deficit, it is probable that the savings from the 1997 BBA will never occur (Hillman and Goldsmith, 2011, p.91). The expansion of expensive imaging services reduces the amount of funds available for physician services under the SGR formula.

The Medicare Modernization Act in 2003 introduced a drug benefit (Medicare Part D). In 1965 outpatient pharmaceuticals were not included in Medicare. Over the years, a limited number of drugs were covered, especially for kidney transplants. To rectify this deficiency, a drug benefit was added to be fully implemented in 2006. The benefit is offered through private insurance companies, some as a stand-alone benefit and some as part of a Medicare supplement policy. The consequence was that seniors were faced with choosing among many plans, each differently priced and covering different medication. The choice is critical to seniors for the failure to pick a plan that covered drugs they were taking would result in large out of pocket expenditures. The drug plans also included a so-called "doughnut hole," the dollar amount that the plans would not cover before they then picked up 95% of the costs. This has become a major problem to a number of seniors. The Patient Protection and Affordability Act addresses this, gradually closing the doughnut hole.

Taxes and premiums for Medicare have changed several times as well. When Medicare began, its payroll tax for Part A was limited to the same income ceiling as Social Security. With the increased cost of Medicare, the income ceiling for that program was pegged at an earnings level higher than Social Security and ultimately the ceiling was eliminated. Now the full earned income is subject to the Medicare payroll tax. In 1997, the payment from general taxes for Medicare Part B was fixed at three-quarters of the cost of the program, where previously it had fluctuated based upon a formula. Also in Part B an increased premium for higher earners was adopted as part of the 2003 Medicare Modernization Act. A similar income based provision will be added to Part A in 2013, levying an additional .9 percent for earnings over \$200,000 for individual filers and \$250,000 for joint tax payers. The additional premium, together with other Medicare changes, is estimated by the CBO to extend the life of Medicare 10 years beyond the previous estimate for Part A trust fund.

Problems Confronting Medicare

Of all problems, demographic change is paramount. Individuals are living longer and therefore beneficiaries are receiving medical care for more years than decades ago. Now surviving or avoiding illnesses with high mortality rates, beneficiaries live long enough to encounter diseases that in prior generations they would not have experienced. Many of these conditions, such as Alzheimer's disease, are expensive to treat and care for and provide very complicated care situations since these seniors have multiple conditions. Conditions that at one time where there was little medical treatment available are now being routinely addressed. Heart disease, which once had a high mortality rate with treatment mostly restricted to hospital

stays on oxygen supplement with a few medications, are now treated with an armory of drugs, cardiac artery stenting, and cardiac bypass surgery. Cancer, once a death sentence, is now treated in an increasing number of cases as a chronic condition. The consequence for Medicare is that it is insuring patients at much more medically expensive phases of their lives. This is especially true in the last months of their lives, where medicine addresses their conditions with sophisticated and often expensive modalities. Palliative care, hospices, living wills, and durable power of attorney are available, but many patients and their families have hope and want their relatives given all treatments. For Medicare the consequence is an escalation of costs.

Demographically we are also beginning to see an increased eligibility for Medicare as the baby boom generation reaches 65. Sharing the problem with Social Security, Medicare is seeing a significantly reduced ratio of working individuals to those retired and eligible for Medicare benefits. Unlike nations with a very young population, the U.S. shares with other countries, such as Japan, a shrinking ratio between those working and those retired. It should be noted that the ratio issue affects Medicare Part A, hospital care, and not Part B. Only beneficiaries pay into Part B. The payroll tax is specific to Part A. This is critical to understanding that Medicare's so-called solvency problem relates only to Part A, which must pay all his benefits from its trust fund.

The rapid inflation in health care costs is also affecting Medicare. U.S. health care costs, the most expensive in the world, increase at rates exceeding inflation every year and in most years are greater than the increase in Gross Domestic Product (GDP), resulting in a rising percent of GDP being devoted to health care. It should be noted that studies have shown that U.S. residents get neither more nor better health care than many countries around the world, but health care provided is clearly more expensive in the U.S. (Nolte and McKee, 2008). Cost increases affect everyone, but also impact Medicare. Although Medicare does pay less than private insurers for services, Medicare payments cannot drop too low because providers will refuse to see Medicare patients as many do for Medicaid patients. Although some claim that this has already occurred (e.g. with concierge practices), data show that provider refusal to see Medicare patients remains small.

Technological changes have ratcheted up costs in Medicare as well as in private insurance. Unlike some fields where technological change reduces costs, in medicine, it more typically increases costs. MRIs, CT scans, and PET scans, among others, have escalated imaging costs, which at one time were mostly plain x-rays. (Hillman and Goldsmith, 2011) New surgical procedures, medical devices such as artificial joints, and biotech drugs have proved to be major cost drivers. Cost containment measures can help, but they can go only so far at keeping costs down. Efforts such as reducing multiple CT scans in the same day, overuse of spinal fusion, and use of unproven surgeries can provide some cost reduction but this is only the tip of the cost iceberg. The Patient Protection and Affordability Act does develop a new committee to examine the efficacy of medical practices, but unlike the National Institute for Health and Clinical Excellence (NICE) in Great Britain, it is prohibited from rationing and can only make recommendations.

Fraud and abuse weigh heavily on Medicare. Reports from a number of national organizations maintain that a significant percentage of bills for Medicare reimbursement are fraudulent. Considerable effort has gone into reducing this. The Obama administration arrested a record number of individuals in one sweep. All reform proposals include capturing dollars from fraudulent expenditures, but to do so requires difficult investigatory work. Data-mining computer technology has helped, but it is still difficult.

Financial Projections for Medicare

In Medicare, the greatest financial concern is Part A, Hospital Care, because its expenditures are restricted to HI Trust Fund money, including sums from the payroll tax and interest on federal bonds that the Trust Fund holds. Although increased medical expenses for Part B, outpatient care (including medical tests), are clearly a problem, there is not a solvency issue because 75% of the costs are required to be funded from general taxes, premiums, and interest on bonds. Thus, increased cost trigger required increased premiums. The so-called "doc fix" raises the cost of Part B, but does not affect Part A. Recently Part B saw smaller premiums than necessary paid because the Social Security law limits premium increases to increases in Social Security benefits. Given that Social Security beneficiaries saw no Cost of Living (COLA) increase in December 2009 and 2010, premium increases for Part B were restricted to new enrollees. Thus the 2009 premium of \$96.40 remains in force in contrast to \$115.40 for new beneficiaries, constituting 25 percent of the total. Beneficiaries with incomes greater than \$85,000 and \$170,000 for joint income tax filers pay more per month with amounts ranging from \$161.50 to \$369.10 per month in 2011 (2011 Annual Social Security Report).

For Part A, Hospital Insurance (HI), the 2011 Annual Social Security Report shows the beginning of the drawdown of the surplus in the HI Trust Fund. Because of the weak economy, contributions to the fund are lower (fewer people working) and more payouts (more people relying on Medicare than their employer sponsored insurance), the fund is projected to be exhausted by 2024, five years earlier than it had been estimated in the 2010 Annual Social Security Report. However, it should be noted that payment for hospital expenditures would not cease because it *will still be able to pay 90% of hospital costs* even if no additional reform is made to the system. Projections show this, declining to 75% by 2045 and then, interestingly, increasing to 88 percent in 2085. Thus to say that HI will be "broke" is more rhetoric than reality. Medicare could manage the reduced percentage by stretching out payments (2011 Annual Social Security Report).

For Part B, although the solvency concern is not an issue, there is the worry that it provides an increased drain on the Treasury because general taxes pick up three-quarters of the cost. Thus the combined drawdown in HI, where the Treasury must sell bonds to the public or increase taxes to pay off the HI Trust fund bonds, and the increased direct cost of Part B result in a major impact on the federal budget. As a consequence, reform is warranted. It should again be stressed that this would not be the first time that Medicare has been changed since its introduction in 1965. Both its revenue stream and payment methods have been modified.

Reform Proposals

There are many potential changes that would assist Medicare's financial viability, some amounting to incremental change and others more radical. It is likely that some combination of reform options will ultimately be enacted, more in line with several smaller changes that have occurred in the past than major restructuring. Medicare is highly popular and radical change can be pushed only at the political peril of its supporters. Although this paper will focus on Medicare options, it should be noted reforms that reduce health care costs in general would help both Medicare and non-Medicare health care recipients as well as the macroeconomic environment.

1. **Increase the Medicare Age to 67 from 65.** This reform is logical in that the Social Security age of full benefits is gradually increasing from 65 to 67. However, given that U.S. policy is aimed at having more residents insured, increasing the age to 67 would be moving in the opposite direction. With Social Security's full benefits age increasing and people living longer, one could argue that employees should simply work longer; receiving their employer sponsored health insurance, which may be more readily available under the Patient Affordability and Protection Act. But critics have noted that while this may be possible for white collar workers, manual laborers may find it physically impossible to work to 67.

Raising the age to 67 is projected to reduce Medicare spending (estimated at \$7.6 billion in 2014), but would also reduce premiums going to Part B (\$7 billion). However, all the cost savings would not be realized because expanded coverage under Medicaid would increase (\$8.9 billion), affecting both the national and state governments, and additional federal cost for insurance subsidies under the Exchange as provided by the 2010 health reform law (\$7.5 billion). Further, employers would pay more as individuals who would have become eligible elect to stay employed or as retirees and on their employer sponsored plan. (\$4.5 billion) Those who seek insurance from the Exchanges would pay more in premiums and cost sharing under the new arrangement. Overall, the forecast is that 42% would elect their employers sponsored plan, 38% would enroll in the Exchanges, and 20% would be covered under Medicare (Neuman, Cubanski, and Waldo, 2011).

2. **Increase Medicare Taxes and Premiums.** The Medicare Payroll tax percentage can be increased as well as the premium for Part B. Some have suggested that tax increases be limited to higher income individuals by either increasing the percent that they pay or their premium. Given that this is in the law now, it would be a small move to increase rates. Rather than increased rates, some have recommended that the Medicare tax be paid on unearned income, such as dividends and capital gains. Some wealthy earners pay little Medicare taxes because most of their money comes through non-earned income. Support would be based upon the "ability to pay" principle. Opposition would

be similar to opposition to any tax increase, which could include the argument that there would be less income to invest which may go to create jobs.

3. **Changes in Reimbursement Methods.** There are multiple possibilities here that would contain costs, including paying physicians to treat an illness rather than fee for service, where there is an incentive to increase services. Incentives need to be provided to hospitals to reduce costs, including reducing hospital acquired infection rates and errors that extend patient stays. It should be noted that the largest health care expenditure is for hospitals. States could again be mandated to institute certificate of need laws and rate review commissions. Wisconsin had both at one time that restrained costs, but both were not renewed by the legislature, resulting in the escalation of health costs in the state.
4. **Remove Physician Training Cost from Medicare.** The federal government essentially helps hospitals support physician residency programs by paying a higher reimbursement rate to cover these costs. Some analysts claim that this has also provided an incentive to increase specialty residency slots over primary care training. Nonetheless, many health care policy analysts have recommended that financial support for training should be separate from Medicare.
5. **Increase deductible and co-payments.** Medicare can increase the deduction that beneficiaries or their supplemental insurer pays for both hospital stay and outpatient services. The 2011 hospital deductible is \$1,132 and outpatient deductible is \$162. As for co-payments, Medicare now pays 80% of approved charges in Part B and does not have a co-payment until an individual is in the hospital greater than 60 days. For outpatient services, the percentage paid by Medicare could be reduced to 75%. One limitation in doing this is that the Patient Affordability and Protection Act, which adds preventive services to Medicare, requires that these preventive services not have co-payments. The other problem is that if supplemental insurance will cover the additional expenses not paid for by Medicare, then the cost of that insurance will rise.
6. **Voucher Plan (called premium support by Rep. Paul Ryan).** This option has been periodically suggested to replace Medicare. It would substitute private insurance for individuals now less than 55 years old for Medicare's single payer plan. Essentially, it transforms a defined benefits system to a defined contribution system. Government would not be held responsible for medical expenditure increases because it would set specific amount that individuals would get to purchase private plans. The one exception would be for lower income individuals, who would get a bit more to purchase private health insurance. Such a plan would specify the benefits and the specific costs that insurance policies would be required to include. This plan is somewhat similar to the current Medicare Part C, Medicare Advantage Plan, but with a lower level of government funding and fewer defined services covered. Specifically
 - Individuals 65 and younger disabled individuals will only have the option of obtaining private insurance in 2022 (i.e. those now under 55).

- Government makes payments directly to private plans
- Government payment adjusted for health status--average estimate \$8,000 in 2022 or 39% of projected Medicare spending per beneficiary.
- Premiums can't vary by health status but can increase by age. Older beneficiaries would pay more (CBO, 2011).
- Higher income Medicare beneficiaries would get less--70% reduction for top 2% of income distribution and 50% for next 6% of income distribution
- CBO (2011) estimates that beneficiaries would have to pay an average \$12,500 out of cost versus \$5,630 under current Medicare. Under Ryan's plan typical 65 yr. old Social Security beneficiaries in 2022 would pay 50% of their Social Security benefits in out of pocket medical expenses. (Those receiving payments at an earlier age would pay a greater percent).
- Payments would rise based upon Consumer Price Index (CPI-U), which has been lower than medical cost inflation (CPI-Medical) or Medicare spending.
- Elimination of Medicare Part D as a separate program.
- Return the prescription drug doughnut hole scheduled to be eliminated under the Patient Affordability and Protection Act.
- Eliminate Independent Payment Advisory Board intended to recommend Medicare spending reductions under the Patient Protection Act
- Eliminate voluntary Community Living Assistance Services and Supports (CLASS) long term care insurance supplement authorized under the Patient Affordability and Protection Act.
- Raise eligibility for Medicare beginning in 2022 from 65 to 67.
- Does not include support for Medicare Education and rural health care as existing Medicare program does.
- Lower-income beneficiaries would have a subsidy deposited in a Medical Savings Account (MSA) for them. Amount would increase by CPI-U. Amount estimated at \$7,800 is short of the \$12,500 CBO estimates as average out of pocket costs.

Arguments in favor of the plan are that it would limit government costs and provide an environment for plans to compete for policy holders on the basis of price, quality, and service (Fuchs and Potetz, 2011, p. 2). Government costs could increase if it becomes necessary to raise the subsidy to attract private plans to participate as occurred with Medicare Advantage plans. Private insurers will impose greater utilization controls than currently with Medicare (Fuchs and Potetz, 2011, p. 6).

The most significant problem cited for the plan is that it would cost seniors considerable more. The amount suggested for premium support, around \$6,000- \$8,000 a year, is insufficient to cover the cost of private insurance. In addition to Medicare taxes and premiums, seniors would have to pay an additional \$12,500 a year in additional expenses including premiums. Older seniors will pay more for premiums with no limit specified in Ryan's

plan. It is possible that costs could result in some seniors becoming uninsured (Fuchs and Poetetz, 2011, p. 14). A second major issue is that private insurance has significantly greater administrative and marketing costs than Medicare. Further, private insurers, representing a smaller percent of the market, will have less leverage over providers to contain costs. Currently, private insurers pay more for services than Medicare. Without a doubt medical cost for seniors will increase. However, government would be able to save money by paying a fixed sum and shifting costs to seniors. Further, although "a standard for benefits" would be established by the Office of Personnel Management (OPM), based upon current practice by OPM they would require plans to include benefits to cover certain costs but would not specify a defined set of benefits as the current program does (Kaiser, April 2011). Thus it is possible that plans could design a benefit structure that could discourage sick people from enrolling (Fuchs and Potetz, 2011, p. 8).

In conclusion, there are multiple possible options to improving the financial position of Medicare. Without any change, it will still be able to pay 90% of its costs. Policy changes present not only a technical problem in analysis and trade-off, but a political situation in changing a very popular program. It is doubtful that today's super-partisan Congress will be able to agree on reforms.

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