

*HP4Life<sup>SM</sup>*

*“A Practical Health Coverage Solution for our Health Care Crisis”*

## **Report #6**

**Health Plan for Life (*HP4Life<sup>SM</sup>*)**

**Workshop Summary**

Health Plan for Life  
(*HP4Life*<sup>SM</sup>)

**Proceedings from a**  
Two-day Invitational Workshop  
September 10 & 11, 2003

## ***Table of Contents***

ACKNOWLEDGMENTS .....	4
STEERING GROUP AND WORKSHOP FACILITATORS .....	6
DISCLAIMER .....	7
OPENING STATEMENTS .....	8
OVERVIEW & OBJECTIVES.....	8
OVERVIEW AND RATIONALE FOR <i>HP4Life</i> <sup>SM</sup> .....	9
SUPPLY-SIDE HEALTH CARE MANAGEMENT STRATEGIES .....	9
KEY DYNAMICS OF HEALTH CARE .....	10
MARKET IMPERFECTIONS .....	10
RATIONALE FOR A CONSUMER-DRIVEN HEALTH PLAN (CDHP).....	11
QUESTIONS REGARDING MODEL.....	12
DEMAND-SIDE HEALTH CARE MANAGEMENT STRATEGIES .....	13
<i>HP4Life</i> <sup>SM</sup> .....	15
SUMMARY OF CDHP/HMI .....	15
WORKSHOP SESSIONS.....	16
PERCEIVED ADVANTAGES OF <i>HP4Life</i> <sup>SM</sup> .....	16
PERCEIVED DISADVANTAGES OF <i>HP4Life</i> <sup>SM</sup> .....	17
QUESTIONS ABOUT PRESENTATION.....	18
SMALL GROUP DISCUSSIONS.....	20
CDHP RECOMMENDATIONS .....	21
HEALTH MANAGEMENT INTERVENTION RECOMMENDATIONS .....	21
PARKING LOT ISSUES.....	22
DAY TWO.....	22
REVISED MODEL/Q&A .....	22
SMALL GROUP DISCUSSIONS/POPULATION-BASED .....	23
REPORT OUT FROM SMALL GROUPS .....	24
PRIVATE SECTOR .....	24
LOW-INCOME, EMPLOYED UNINSURED .....	25
BASIC HEALTH PLAN & HEALTHY OPTIONS .....	26
NEXT STEPS—BEST and OTHER ACTIONS .....	29
WORKSHOP CLOSURE.....	29

## ACKNOWLEDGMENTS

### HOST and GRANTOR INFORMATION

The following organizations provided direct support to *HP4Life<sup>SM</sup>* in the form of grant monies, and served as host and co-host of the two-day invitational Workshop in September 2003. *HP4Life<sup>SM</sup>* developers and steering committee members are indebted to them for their gracious and generous support.

---

**The Evergreen Freedom Foundation**, based in Olympia, is a nonprofit public policy research organization dedicated to individual liberty, free enterprise and limited government. The foundation—which was established in 1991—provides and distributes research and policy recommendations to help policymakers and the general public understand how principles of limited government, personal responsibility and the free market can work in today’s world.

Research from the Evergreen Freedom Foundation is based on the following principles: government works for the people and must be accountable to them, the constitutional and inalienable rights of each individual must be protected and government must be limited in scope and authority by its constitutional boundaries.

The Foundation offers research and policy recommendations for issues including budget and taxes, welfare reform, health care reform, education reform and citizenship and governance. In the health care realm, Evergreen Freedom Foundation aims to advance consumer-based reforms that allow individuals to choose the health care, short-term assistance and retirement options that will suit them best.

#### Contact information:

**Evergreen Freedom Foundation**  
**PO Box 552**  
**Olympia, Washington 98507**  
**(360) 956-3482**  
**<http://www.effwa.org>**

The Seattle-based **Washington Health Foundation**, established in 1992, has a broad mission of improving health for the people of the Evergreen State. The nonprofit foundation is dedicated, specifically, to improving health and access to quality health care for the people of Washington State, including those residents who are medically underserved in both rural and urban communities.

Washington Health Foundation approaches its mission by supporting access to health coverage and care, and by supporting efforts to improve the quality of health care and the effectiveness of

the health care system. The organization also engages in leadership projects and builds long-term relationships among community leaders, advocates, members of the business community and policymakers.

The foundation's programs include referral and support for low-income families, pregnant women, and people living with HIV/AIDS, as well as grants to health care providers to sustain vital medical services in rural communities. Washington Health Foundation also sponsors The Future of Rural Health Program to stimulate the development of new local models in rural health systems and Improvement grants to support provider and community efforts to improve health and health care.

**Contact information:**

**Washington Health Foundation**  
**300 Elliott Avenue West, Suite 300**  
**Seattle, Washington 98119-4118**  
**(206) 285-6335**  
**<http://www.whf.org>**

---

## STEERING GROUP AND WORKSHOP FACILITATORS

Stephen Barchet, MD, RADM  
*HP4Life*<sup>SM</sup> Coordinator  
[barchet@earthlink.net](mailto:barchet@earthlink.net)

Larry Chapman, MPH  
*HP4Life*<sup>SM</sup> Model Architect and Developer  
[larryc@summex.com](mailto:larryc@summex.com)

Federico Cruz, MD  
Steering Group Member  
Director-Tacoma/Pierce County  
Department of Health

Bernadene Dochnahl  
Steering Group Member & Facilitator  
Denbe Enterprises

Lori Evans  
Facilitator  
CEO – Abrige and Sagacity

Jeff Gingold  
Steering Group Member  
Director- Health Practice, Lane Powell et al

Tom Jones  
Facilitator  
Executive Director  
Community Choice Healthcare Network

Aaron Katz  
Steering Group Member & Facilitator  
Director- Health Policy and Analysis  
Program, University of Washington

John Pierce  
Steering Group Member & Facilitator  
Executive Vice President  
*script iQ*

James Whitfield  
Lead Facilitator  
Director, Transforming Health Care Project  
Washington Health Foundation

Vicki Wilson  
Steering Group Member  
Director, State Planning Grant on Access to Health Insurance  
Governor's Executive Policy Office

### ***HP4Life*<sup>SM</sup> Model & Workshop Proceedings**

Mary Guiden  
Editor and Health Technical Writer

## **DISCLAIMER**

These proceedings were developed as a synopsis of a two-day Health Plan 4 Life (*HP4Life<sup>SM</sup>*) workshop held on September 10 and 11, 2003. The document is not intended to be an endorsement of *HP4Life<sup>SM</sup>* by any individual whose name appears in the publication, nor does any participant who attended the two-day meeting personally endorse *HP4Life<sup>SM</sup>*, unless otherwise noted.

## OPENING STATEMENTS

The two day Health Plan 4 Life (*HP4Life<sup>SM</sup>*) workshop was held on September 10 and 11, 2003 at the South Seattle Community College in Seattle. Sixty participants were charged, over the course of two days, to scrutinize and help shape *HP4Life<sup>SM</sup>*, a consumer-centric model for taking aim at health care costs while improving health outcomes. Participants were selected based on years of expertise in health care and health policy, and included individuals from the public and private sector as well as academia. Industries and sectors represented include state government, federal government, medical facilities, insurers, public health, advocacy groups, state associations within the medical field, high tech, legal and utilities.

Participants were welcomed to the workshop by South Seattle Community College (SSCC) representatives Tom Malone (Seattle Community College District Board) and Jill Wakefield (SSCC President), who said that the school's employees have been affected by rising health care costs as much as anyone else in the United States.

## OVERVIEW & OBJECTIVES

Steve Barchet, MD and *HP4Life<sup>SM</sup>* coordinator, kicked off the meeting by providing an overview and objectives for the two-day workshop. To lighten the mood, Barchet provided a metaphor to the issue of health care reform, comparing it to elements from the popular, recently released animated film *Finding Nemo*. In discussing the cruel sea of health care and health care reform that everyone is "swimming" through these days, Barchet referred to the relentless maelstrom, thunder, air of overprotective behavior and disability, among other descriptions.

Barchet declared that the workshop would promise to be one of the most intense and most difficult attended by participants. Those in attendance were specifically invited or had been referred by a host, sponsor or one of the members of the steering group.

Participants had been called to action because, as Barchet explained, good ideas by themselves are not self-fulfilling. Health care reform has been talked about endlessly, for many years now. Barchet said it is time for action and whatever that action may be, it should be subjected to science and evaluation.

Participants were charged to take the draft *HP4Life<sup>SM</sup>* model, review it, revise it, disassemble if necessary and put the pieces back together and figure out how to apply the model within various state programs. Why state programs? Because in January of this year, Barchet noted, state health program accounts ran a deficit of more than \$620 million. Steering group members chose, in particular, to focus on state and private sector groups for the purposes of the workshop. Barchet suggested that participants see how to integrate the model into existing health plans, with existing funds to help stabilize the growth in health care spending while improving the health of the people. "After all, that is what health care is about," he noted.

Barchet then said during the course of the workshop, participants should also feel free to challenge the *HP4Life<sup>SM</sup>* model, to query and interrupt, so that everyone would gain a real sense and understanding of the draft model. Group facilitators, in turn, were instructed to question group members about the model and its workings within particular population groups. In a

nutshell, the *HP4Life<sup>SM</sup>* model combines a consumer-driven health plan with a patient-centric demand management health intervention plan. Barchet instructed the workshop participants to test and compare the model for measurable outcomes. Questions individuals should consider include: what are the changes in health care, spending, satisfaction, changes in employer pay, employer profitability, and carrier profitability.

*HP4Life<sup>SM</sup>* is not a comprehensive health benefit, not a substitute for health insurance, not a source of financing of coverage. Participants were urged, at least for the purposes of the workshop, not to worry about where the money comes from, if it's a single-payer, nationalized plan or if it is fragmented, with multiple sources of financing. *HP4Life<sup>SM</sup>* is not an alternative to medical case management, not a new type of managed care plan, and it does not replace risk-based coverage. "It is a vehicle to get on the road to reform and that's what we want. We want to get to sustainable, workable actions," said Barchet.

## **OVERVIEW AND RATIONALE FOR *HP4Life<sup>SM</sup>***

Larry Chapman, MPH, chairman and founder of Summex Corporation, a for-profit group that specializes in health cost management for private sector companies, provided the *HP4Life<sup>SM</sup>* overview and rationale for such a model.

As an introduction, Chapman explained that the health care world is changing dramatically, due to things such as new technology. All populations have become highly entitled to health care, and the expectation exists that we all have that good health plan that allows individuals to access any needed health care, and to have somebody else pick up the cost. This sense of entitlement extends to employees of a local dry cleaning business and to the Medicaid population. Still, a lot of the key efforts of managed care on the supply side have squeezed some of the fat out of health care cost cuts. More than 40 million people are now uninsured, many people have significant gaps in health care coverage and prescription drug costs continue to rise dramatically

## **SUPPLY-SIDE HEALTH CARE MANAGEMENT STRATEGIES**

What usually happens with health care management strategies is that there are some early effects and then the effects dissipate as the system adjusts, and also as the consumer and provider learn how to get around the constraints, Chapman explained. Supply side strategies are those that work within the health care system. Demand side strategies, conversely, are clinical needs and wants of people within those populations.

The United States has in recent years experienced the phenomenon of high rates of growth in per capita health care costs. Experts say the costs dipped slightly during the time of the failed Clinton health care reform efforts, then costs went back up. Now, the most recent Kaiser Family Foundation study shows a 13.2 percent rate of growth for 2003. The medical trend pattern is higher than the medical consumer price index (CPI), overall inflation and worker earnings.

Everybody wants more in terms of health care, Chapman noted. Employers and taxpayers, in general, are the ones paying for that care. Part of the problem is that we do not have any

incentives for using less health care. All of the involved stakeholders want to move towards more care, instead of saying, “how much is enough.” What’s more, a small percentage of individuals in any population account for a large percentage of costs. This results in a high skew phenomenon, yet there are also people all around the spectrum that can gravitate down to this high-cost group.

## **KEY DYNAMICS OF HEALTH CARE**

Chapman outlined several facets of health care that exist within the current system. The points outlined below contribute to rising costs and disparities within the health care system.

- All incentives lead to more care
- Few don’t get enough, many get too much
- Technology improves care but raises its costs (There are a few exceptions, but by and large the system moves in this direction, Chapman noted)
- We need more care as we age
- Pareto’s Law: Few use much
- Treatment is emphasized over prevention (This creates an imbalance. The U.S. Department of Health and Human Services estimates that three percent of health care dollars are focused on pure prevention. By and large, don’t put a lot of resources into that.)
- Due to the complexity of health care there many choices
- Direct regulation is virtually impossible
- Many major market imperfections exist in health care.

## **MARKET IMPERFECTIONS**

Chapman highlighted market imperfections that contribute to the flaws in today’s health care system. In the market economy, the consumer bears the consequences of the high costs, there are sufficient sellers in the market place, there is freedom to enter and exit markets and the consumer has full knowledge of the system.

In the health economy, the consumer has few monetary consequences but has limited knowledge, choice is limited in some markets (managed care arrangements, preferred provider organizations), and entry and exit from the market is limited.

Chapman noted that in the realm of consumer cost sharing, the consumer has become more insulated. Out-of-pocket costs as a percentage of total health expenditures has dropped over the last few decades, from more than 30 percent in 1970 to just more than 10 percent projected in 2003.

What are some ways to cost share within the system? Chapman pointed to service maximums, deductibles, co-payments, co-insurance, premiums and maximum out-of-pocket. We need to see if there is a sufficient use of cost sharing, Chapman said. Patients should ask themselves, “If I go

to the emergency room, it will cost me this much versus this other amount to go to my primary care provider,” he explained. Part of the problem is how do you balance point of use versus what people are putting in.

## **RATIONALE FOR A CONSUMER-DRIVEN HEALTH PLAN (CDHP)**

In a typical plan, individuals usually have some sort of deductible, then major and catastrophic care coverage. In a sense, with minimal cost-sharing, people end up with a fairly small amount of financial involvement, financial incentive.

It is now possible, under current Internal Revenue Service (IRS) regulations, to create what are called health reimbursement arrangements (HRAs). Money may be carried over to subsequent years with HRAs. According to a recent IRS ruling, only the employer can put money into the account. There is also a bridge that can be thought of as the amount between what has accumulated in the HRA and the high deductible level. The bridge can be funded through a Flexible Spending Account (FSA) or on a “pay as you go” basis. The bridge can be funded with an FSA on a tax-advantaged basis, meaning money is put in before withholding and federal income tax are taken out. Then on top of the HRA and the bridge is the traditional high deductible health coverage for major and catastrophic care.

What does the future hold? It may soon be possible to have Health Savings Accounts, in which the employer and the employee can both contribute tax-advantage (pre-tax) money. (Editors Note: recent passage of the 2003 Medicare legislation now authorizes HSAs)

In terms of the consumer-driven part of the health plan, studies from Rand and HIAA (Health Insurance Association of America), tell us that it is not a good idea to put any form of cost sharing on preventive services because people will delay getting the preventive care that they need. Chapman said he would venture even further to say don’t just have a preventive care benefit, but actually incent the use of preventive care.

The concept of consumer-driven health plans means we will need this kind of vehicle (Health Savings Account + Traditional Coverage) to get to a consumer-driven plan. There are reform efforts currently underway in the U.S. Congress to move toward this goal. It would involve changing the mindset of consumers from having a relatively small financial involvement to a much larger level of involvement. Will people be happy with that? Not likely, but the alternative is significantly higher premiums, Chapman said. We are talking about how to create a pool or pot of money that people will have some ownership of, he noted.

Now, if you end up leaving employment before the age of Medicare coverage, the individual will have to figure out how they are going to secure health plan coverage. An additional dilemma is to figure out how people can save for future medical expenses. What happens if an individual gets to a certain age and goes bankrupt because they have a major illness. This type of CDHP may not be for everyone, some population groups will not be able to handle the cost burden due to illness. The true purpose of what the plan is all about is that it is not designed to pay for every

treatment need at the low end; it is really structured to cover the big problems and to provide a tax-advantaged method for saving for these costs.

*HP4Life<sup>SM</sup>* might be structured using an employee-funded flexible spending account (FSA), but Chapman pointed out that one of the problems now with a FSA is that it is a “use it or lose it” account. People at the end of the year figure out how to spend the leftover money, and typically purchase an additional pair of eyeglasses or sunglasses, or have some type of elective dental care performed. Chapman said it is important to have health care consumers think about the money in the same way they do retirement or pension funds.

## QUESTIONS REGARDING MODEL

One participant said the model looked as if it would further exacerbate adverse selection, because what was essentially being taken out of the pool was all the low-cost health care. Would *HP4Life<sup>SM</sup>* create a pool in which more of the risk-covered lives would end up being people that did not need large amounts of health care?

Chapman said if you offer a CDHP along with other traditional plan options, there will likely be adverse selection because healthy people will go for this choice. It would be similar to what happened with managed care. Instead, the CDHP should be the only health plan option to prevent adverse selection within the group. For example, before the onset of managed care, there were basic indemnity plans and then managed care came along, and healthy people began to gravitate to managed care. This phenomenon caused an increase in the costs of traditional indemnity plans. The issue, or questions underlying a CDHP involve what level of care you are looking at, and trying to manage the health care costs of each group separately. People that need significantly more care over their entire life span may eventually have to be moved into a more regulated and publicly subsidized health care environment, where case managers will work with them. If the dominant form of health coverage is a CDHP then adverse selection becomes a moot issue.

In this way, it will also lessen morbidity, if case managers work with them and in that process, create efficiencies that will hopefully cover people with more need. This will *not* be a solution for high-risk, high cost individuals who do not have much of an ability to make decisions about health care. This CDHP is geared to introduce market forces to people that manage their own budgets, that is where case management and other utilization management will come into play. We can potentially get rid of the consumer-driven side of the model and still use the prevention side in these situations.

Another question came up regarding the potential size of the population covered under *HP4Life<sup>SM</sup>*. A participant cited a statistic that five percent of the Medicaid population, for instance, incurs 53 percent of the costs. There are relatively marginal amounts of money where discretion comes into play, this participant pointed out, and a large group of the population is perhaps not capable of making good decisions despite the type of information we get. Would *HP4Life<sup>SM</sup>* ultimately work for a relatively small portion of the population?

Chapman said if you look at the cost distribution, there is a relatively small population incurring those high costs in all health plans and populations. How much of that will be on continuing basis? In addition, you have other healthier groups, and those other folks are potentially heading in the higher-cost direction unless you do some type of intervention. That is the point of the CDHP linked with health management interventions, trying to keep people from gravitating to a high cost group. It is possible to actually reduce or compress morbidity, produce a much lower-cost involvement and use some of the other strategies outlined above.

A basic factor in prevention is trying to get upstream. In one study by Zook and Moore, approximately 60 percent of catastrophic cases had at least one significant modifiable lifestyle issues. Reducing risk in the more catastrophic populations is one of the dynamics of the CDHP.

Part of the process behind the *HP4Life<sup>SM</sup>* will likely lead to a reassessment of policy priorities, as policymakers and other stakeholders begin to see the results and needs for modification. What is important is to move from dedicating two or three percent to ten percent of total health care dollars spent on prevention, public health education, lifestyle intervention and personal coaching.

What factors determine health care use? Chapman outlined supply-side and demand-side factors, and discussed how a person decides on health care use based on age, sex, and a sense of responsibility for personal health. On the supply side, which are factors outside of the individual, health care use is dependent upon the extent and scope of insurance coverage, geographic access to services, regional or local practice patterns and provider incentives affecting diagnosis and treatment decisions.

## **DEMAND-SIDE HEALTH CARE MANAGEMENT STRATEGIES**

These factors alter health care use patterns, affecting the health and well being of participants. The issues outlined are ones that are embedded in health care design. First off are **Educational Interventions**, which include benefit use communications, medical self-care, consumer health education, injury prevention, and advanced directives. **Plan Design Modifications**, second, also fall under the umbrella and include factors such as preventive medical benefits, point-of-use cost sharing and consumer-driven health plans. Next, **Individual Interventions** may be used to improve health care management, by including high-risk intervention, disease management and condition management. **Wellness Incentives** round out the health care management strategies, and include HRA incentives, preventive care incentives and wellness achievement incentives. Chapman said in a nutshell, if plan administrators see, for instance, a large number of people in a plan not taking care of themselves, administrators should try to figure out what can be done to create an incentive for them to take care of themselves.

Chapman then touched on a handful of studies that show the cost effectiveness and efficiency in targeting prevention for better health outcomes. Research from the September/October 2000 *American Journal of Health Promotion* found that in the working population, 25 percent of all claims are associated with seven risk factors—depression, stress, blood sugar, smoking, obesity, blood pressure and sedentary lifestyle. All told, there are nearly 300 different prevention issues that cover the seven risk factors. Primary, secondary and tertiary prevention interventions for

individuals affected by the risk factors could make a major difference in preventing health care use, and related costs.

Other studies cited by Chapman at this point include an overview of the *Full Cost of Illness* presented in the November/December 2001 *Health Affairs*, which detailed per capita health costs per person, percentage of workers missing workdays because of specific conditions and estimated work loss costs (in billions) for mood disorders, diabetes, cardiac disease, hypertension and asthma. As an example, diabetes was estimated to cost \$10,823 in health care costs per person, causes 10 percent of workers to miss work due to the condition and results in an estimated work loss cost of \$3.5 billion.

Repercussions from these disease conditions are not only being felt in the realm of health care costs, but also in areas such as sick leave, workers' compensation and disability. We need to determine how to help **HP4Life<sup>SM</sup>** improve the health of working populations to affect all health related costs not just the health plan costs.

Among other research cited, Chapman shared some statistics from the HERO database that show the effects of single-risk factors for individuals. An individual who did not exercise, for example, had excess health care costs of 10 percent. With elevated blood pressure, the percent of higher annual health plan costs rings in at 12 percent. The figure is 20 percent if the person is a smoker, 21 percent if obese, 36% for elevated blood sugar, stress caused costs to be 46 percent higher, and depression resulted in 70 percent higher costs. The study was conducted on a 44,000+ working population, but Chapman said some testing is currently being proposed for the Medicare population.

Workers' compensation costs also reveal the effects of certain single risk factors. Poor physical health for an individual causes costs to be more than eight times higher, smoking about 12 times higher, and if a person's overall wellness score was low, this resulted in costs being around 20 times higher than those for healthier individuals.

Chapman noted that a majority of the risk factors outlined in the studies cited are widely distributed in all working populations and quite prevalent throughout Washington State.

To better understand the **HP4Life<sup>SM</sup>** model, Chapman discussed the evolution of work-site health promotion in the United States. In the traditional sense, work-site health promotion (WHP) has had mostly a health focus, includes some risk reductions, has a limited health care management (HCM) focus, is strictly voluntary and site-based and holds minor incentives, among other issues. The Health & Productivity Management (H&PM) approach, conversely has a strong HCM focus, boasts major incentives, includes a strong evaluation component and has some required activity for the enrollee. There are larger economic returns on health impacts with a H&PM approach, Chapman said it is truly the realm in which the innovators are working. Numerous large companies have figured out they need to manage health of employees.

But changing people's behavior can be difficult, there are a lot of reasons why people don't do things they should for their health and well-being. Common reasons listed by individuals

include, “I’m too busy,” “I’m afraid [to get started on an exercise plan],” “I’m confused [about what I should do],” and “I can’t afford it.”

What will it take to change the mindset of the general population? People need economic incentives to change or alter behavior, for starters. What’s more, plan administrators need to include:

- health consumerism education
- choices and consequences, which may be financial
- easy to access information
- proactive support
- effective supply-side solutions
- effective demand-side solutions
- efficient administration, and a
- strong focus on wellness

### ***HP4Life<sup>SM</sup>***

The ***HP4Life<sup>SM</sup>*** model involves a consumer-driven health plan (CDHP) without any specific plan design parameters or amounts. For most of the population, we can help them to use health care more effectively if they use their own money, Chapman explained.

Plan administrators need to implement programs to help the population get to that way of thinking. They need to also figure out the most effective way of instilling the concept of prevention for every population group because there is not a single model that should be used across the whole country. ***HP4Life<sup>SM</sup>*** would, in a sense, be adapted across particular population groups. For the purposes of this workshop, the population groups discussed include: private sector employers, state and school district employees, Basic Health Plan enrollees, Medicaid enrollees and the uninsured.

What is the context for ***HP4Life<sup>SM</sup>***? Chapman explained that it is a form of model health coverage that is adaptable to any group’s prior health plan. ***HP4Life<sup>SM</sup>*** is consumer-centric and requires selective health management interventions (orientation workshop of two hours and an annual health risk appraisal). The appraisal would delve into health status of the participant, health-related issues that prevent the participant from reaching goals and questions regarding the best way to impart or relay health-related information. ***HP4Life<sup>SM</sup>*** is intended to improve upon if not actually correct key market imperfections, so that administrators and participants could determine how best to use market forces to improve quality and cost.

### **SUMMARY OF CDHP/HMI**

Why should we move towards a CDHP with related HMI? Health care costs will continue to increase, with most forecasts projecting continued upward movement.

Supply side HCM interventions have natural limits, Chapman said. Managed care will not solve the problem, despite what has been taught in the past. People want choices; they do not want to be told where to go for health care.

An additional reason for adopting a CDHP is that a large part of the underlying morbidity driving health care demand is avoidable or modifiable. What's more, if nothing is done, health care use and cost will simply increase with aging populations. CDHP is somewhat cutting edge, in that we have newer promising demand-side HCM strategies, and an aggressive approach to prevention/health management and consumerism must be an integral part of any solution. Chapman believes that *HP4Life<sup>SM</sup>* is the preferable form of model health coverage for the future.

## **WORKSHOP SESSIONS**

The sixty-two participants who attended the first day's session were divided up into small groups, with a mix of expertise and experience at each table. The task at hand for all involved was to discuss key questions regarding the CDHP presentation. Among the issues discussed, participants were asked:

- What are the advantages of the proposed CDHP design?
- What are the disadvantages of the proposed CDHP design? and
- What changes to the CDHP design does your group recommend?
- What are the advantages of the proposed Health Management Interventions (HMI)?
- What are the disadvantages of the proposed HMIs?
- What changes to the HMIs does your group recommend?

Workshop participants spent approximately four hours over the course of the day to delve into the questions cited above. Given the variety of experiences and education among participants, it is not surprising that feedback and discussions were intense, sometimes heated, always lively and engaging. Listed below are complete lists from all groups, which reflect the broad spectrum of opinions:

## **PERCEIVED ADVANTAGES OF *HP4Life<sup>SM</sup>***

- Emphasis on prevention is good and incentives are provided to use preventive care
- Increases personal responsibility and patient motivation
- Choice is good and of proven efficacy
- Will likely improve health and decrease morbidity, and have healthier aging
- Will likely increase consumer involvement and increase cost-conscious behavior
- Health care mentors for patient assistance and education may improve quality
- The goal of 100 percent access is positive and desirable
- Income distribution issues can be addressed
- Objective measurements will be provided for measuring effectiveness and outcomes
- Parts of the plan such as improvements in health status have been demonstrated in the private sector

- People's motivation is often money, people are usually motivated by their own self-interests

### **PERCEIVED DISADVANTAGES OF *HP4Life*<sup>SM</sup>**

- Needs a long-term relationship with employee for most benefit
- Small employers may not have time or money to do this themselves
- Some people can't administer their own finances, how can we assume they will be able to administer a H.S.A.
- Concept appears sound but will it produce the desired effects
- Hard to see how existing health care programs and plans will be changed to arrive at this model
- The model places a strong emphasis on the ability of the average consumer to make wise choices about health care services

There were also a range of concerns and issues expressed by the workshop participants. Several of these seemed to be due to insufficient understanding of *HP4Life*<sup>SM</sup>, lack of knowledge of existing study data, or just uncertainties. These included:

- Will insurers go along; participation requirement of insurers needs to be defined
- Question ability of current plans to accomplish the full continuum of wellness and health intervention; do not see integration of all elements
- How do we get there? Concern about operational barriers
- Cost to implement *HP4Life*<sup>SM</sup> is likely to be approximately \$100 to \$150 per employee/year
- Cost savings may be in subsequent years, possibly not in first year
- How would employee and employer relationship be maintained?
- How do you get employers to buy into a two-hour workshop requirement.
- How do you find uninsured to get insurance, educate and pay for them?
- For HSA accounts, how do you encourage cost efficiency and appropriate requests for tests (sigmoidoscopy vs. colonoscopy)
- Health care is not a commodity industry
- Difference between wellness care versus illness care
- What economic and health benefits are there for me if I do everything right?
- Will consumers feel responsible rather than right?
- How do you move people along the continuum of entitlement to self-responsibility?
- Non-English speaking populations will need more support including education and consumer knowledge
- Some individuals with marginal incomes don't have adequate financial resources to begin with
- Participants will likely need more awareness to change behavior
- Preventive measures are sometimes cared about by the patient
- Saying that we are not going to consider financial issues is not acceptable

- Concern that this program might be manipulated by the Legislature to cut public funds for current health programs like Medicaid

The groups then took a break after the intensive working and discussion sessions. Dr. Barchet continued to drive home the economic reason for the workshop – in some cases to try to reverse or slow the slope of ever-rising health care costs. Barchet cited Department of Defense spending of 55 cents on health care for every dollar of cash paid to active duty members. CBO projects this will increase in seven years to 75 cents on every dollar paid in cash wages and salaries.

## **QUESTIONS ABOUT PRESENTATION**

A participant raised a question regarding evidence that supports a *HP4Life<sup>SM</sup>* -like plan. What research exists to prove a CDHP model is effective? Dr. Barchet responded that as of now, there is no fully evaluated model based on decision-science. CDHP models have not yet been tested; the models have only been marketed. Barchet said that he would very much like to see a long-term comparative study that evaluates the economic and health effects of such a model against a traditional plan. Early evidence by vendors of current CDHPs, will soon be published.

Locally, officials for the Washington State Health Care Authority’s Uniform Medical Plan (UMP)—the self-insured preferred provider plan for more than 97,000 public employees—announced on September 8, 2003 details of a joint initiative with Patient Choice Healthcare, Inc. Patient Choice, which is based in Minnesota, develops tiered health care network programs that differentiate providers on measures of cost, quality and service for its own network and in partnership with health plans and other purchasers. Thanks to the joint venture, UMP will offer its enrollees in three counties this fall a pilot program that allows consumers to choose physicians and hospitals based on their ability to deliver quality cost-effective care. Officials said they were embarking on this effort to increase incentives for both providers and enrollees to make cost-effective health care decisions.

Barchet cited medical device company Medtronic—which is based in Minnesota—as an example of a CDHP through Definity. Baylor in Texas engaged Washington DC based Lumenos for its CDHP-like plan, and officials there reported an 18 percent reduction in total health care costs in the first year. There are currently 126 vendors offering variants of consumer-driven health plans to employers, but none of the plans have been scientifically tested to date.

A Lumenos representative, who was present at the meeting, said while the company does not have three years of good clinical data, they are getting close. Right now, officials have two complete years of data and they are seeing “very impressive” numbers. The numbers, the representative said, look a lot better than any managed care or preferred provider organization (PPO) plan, in terms of the pharmacy benefit and utilization. People with chronic conditions are not being penalized either. Lumenos currently has 40 clients and the list is “quickly growing,” the representative said.

A participant said there is a difference between Medtronic employees, who have a certain level of education, and the average person on the street. Implementing CDHP requires a different

mindset and a change in attitude for people who perhaps do not have the wherewithal to understand such a plan. When are premiums adjusted for the Lumenos plan a participant asked.

The Lumenos representative said the company develops a plan to be cost neutral in year one. Since costs are currently coming in at 13 to 15 percent below projections, there are savings in the first year. With the exception of one client (out of 40), every client is either below projected costs or on target.

Question from participants: of 40 clients, how many are blue collar, gray collar and have English as a second language?

The Lumenos representative said communication is a key part of the company's model. A full one-third of the clients are blue collar, one is a shipbuilding group in Mississippi. The representative said it is important to have a strong health management component, build incentives, and push people to participate because of the dollars involved (and saved). The company spends a tremendous amount of time on communication, and asks questions such as: do you want Internet-based information, do you want information *via* your cell phone, do you want someone to speak Mandarin? What is key in the model is you need to identify the culture of the company. The Lumenos representative said an interesting aside is that blue collar populations seem to understand the message more quickly than highly paid executives.

A participant said the *HP4Life<sup>SM</sup>* workshop was akin to people going in their garages 100 years ago to try to build an airplane. Prevention is a great concept, but the individual was not aware of data on health outcomes.

A participant asked what research exists that shows a CDHP might work with a Medicaid population. Chapman said he is not sure that there is data, and he pointed out that the CDHP he has outlined wouldn't necessarily translate directly over for the Medicaid population. Such a plan would need to be modified, and different incentives shaped.

Barchet pointed out that in several states, officials have implemented a Cash and Counseling program that essentially puts money in the hands of Medicaid patients so they can make their own decisions about health care. James Frogue, director of the Health and Human Services Task Force at the Washington, D.C.-based American Legislative Exchange Council, highlighted the program as part of testimony delivered to members of the Colorado Legislature in August 2003. Frogue said Arkansas, New Jersey and Florida were the first three states to implement such a plan. (Editors note: Mathematica Policy Research, Inc. Final Report June 2003; Q146901)

Under the Cash and Counseling program, Medicaid enrollees receive a cash allowance based on the level of assistance needed. Enrollees or beneficiaries have flexibility to hire, fire and alter service providers (for home and community-based services), and the allowance must only be spent on health care needs. A counselor reviews the list of services being purchased to ensure proper usage, and the state also provides a fiscal middleman to cut checks, pay appropriate taxes and handle associated paperwork. Frogue said, as part of his testimony, that the program boasts patient satisfaction rates of nearly 100 percent, though the numbers participating remain

relatively small (Florida's Consumer Directed Care has a plan to allow 3,300 of 47,000 Medicaid enrollees to participate.)

James Whitfield, lead facilitator, broke in after some discussion to help keep participants on task. He said that participants should remain focused on what is good about *HP4Life<sup>SM</sup>*, what is bad and where can we go with the model in the future? Groups should be working toward developing recommendations for the *HP4Life<sup>SM</sup>* model. At the second day's session, a newly revised *HP4Life<sup>SM</sup>* model would be presented, based on recommendations made by the group. During the second day, facilitators will conduct exercises geared toward how to implement and evaluate *HP4Life<sup>SM</sup>* with specific populations. For the second day, participants will choose the population group for *HP4Life<sup>SM</sup>* (i.e. private sector, Medicaid, uninsured, others).

A participant asked, "What is the difference between Household Health Accounts (HHAs) and Medical Savings Accounts (MSAs)?"

Barchet explained that MSAs are provided to individuals, and serve as an account for whatever health care expenses per IRS Pub 502 the individual would like to pay for. The employer or employee contributes into a MSA. HHAs, similar to health reimbursement arrangement dollars entirely belong to employer (or state) and are solely employer contributions. There are no employee/individual contributions into a HHA. (Editor's note: The signing of the Medicare Legislation by President Bush on December 8, 2003 established "Health Savings Accounts" that simplify the structure and operation of the HHA.)

Chapman reminded participants that the accounts mentioned—MSAs and HRAs, for instance—all reflect current benefit laws and regulations. Participants should not feel bound by these accounts, but should instead consider making suggestions about how the accounts should be structured to work better. Depending on the suggestions put forward, part of the outcome decided by the group may be to propose legislation for a revised type of account.

## **SMALL GROUP DISCUSSIONS**

In the post-lunch discussion of day one, a participant pointed out that while the morning presentation had focused on cost effectiveness, stabilizing demand and cost implications to deal with the health care cost crisis, there was not much talk about financing issues, how savings will be captured and how those excluded from the system will be covered. The participant said that is a "fatal flaw" of the *HP4Life<sup>SM</sup>* model. It is hard to evaluate the model, the participant added, without knowing what the financing details are.

A different participant said the group had already stated that the model would not fit all needs. People with several morbidity issues or those who are incapacitated, mentally or physically, or do not have capabilities to work within the system, will need another form of coverage. These populations should including preventive care and a minimal "bridge". In that way, when those individuals have a catastrophic need, the health care is there.

A participant asked how *HP4Life<sup>SM</sup>* will be implemented across the board. Will it be a voluntary system, will we put it in public programs or require employers to implement *HP4Life<sup>SM</sup>*?

After extensive discussion, the groups came up with the following recommendations for the CDHP and HMI interventions. Workshop participants developed a lengthy list of recommendations and selected their respective highest choices (thereafter displayed by rank) at the closing of day one of the workshop.

### **CDHP RECOMMENDATIONS**

- Clarify and simplify the CDHP
- Consider use negative co-pays for preventive service (i.e., pay people for getting the preventive care)
- Clarify economic and non-economic benefits of *HP4Life<sup>SM</sup>*
- Modify bridge with increments to minimize amount to be paid (Adjust the bridge for very wealthy individuals, who could afford to have a larger bridge. Someone with a low income would have a very small bridge.)
- Share the economic benefit among provider, consumer and employers
- Age adjust the preventive care annual maximum expense (i.e., \$200 for under age 40, \$300 for 40- 49, \$400 for 50- 65, etc.)
- Establish standards for preventive care (Simplify and clarify role of prevention and wellness, once you meet your deductible.)
- Emphasize benefits for the individual consumer
- Clarify what “prevention” means for chronic diseases and other conditions

### **HEALTH MANAGEMENT INTERVENTION RECOMMENDATIONS**

- Include evidence-based prevention
- Clarify funding mechanism for Health Management/prevention
- Improve incentives for health status improvement
- Establish the organizational structure to do the *HP4Life<sup>SM</sup>* (Structure around intervention, who is doing what? Also, structure needed to manage benefits against one another and extract savings.)
- Make sure nutrition, mental and behavioral health and alcohol (substance abuse) are addressed

- Clarify insurance product options for major and catastrophic coverage
- Put cultural sensitivity issue into preventive interventions
- Link incentives to disease management
- HHA funds used according to IRS broader definition of services in section 213(d)
- Provide well-integrated case management for those with chronic conditions (Preventive care is addressed, but for chronically ill people, for example, case management needs to be provided in a multidisciplinary way.)

## **PARKING LOT ISSUES**

White spaces were placed throughout the room near the group tables, and participants and the facilitator were instructed to write down “parking lot” issues, topics that put a wrench in the discussions and those that could not be resolved in a timely manner. Only a few of those items showed up, including a question on which community or geography is under discussion for *HP4Life<sup>SM</sup>* (rural or urban), and what is the cost of technology for the model. One additional question posed cost implications for health management interventions.

## **DAY TWO**

The second day of the workshop began with a “welcome back” from Dr. Barchet, who said the goals/questions of the day are: where are we going, how will we get there and how will we know when we have arrived?

Barchet said he is hopeful that the re-worked and post Workshop *HP4Life<sup>SM</sup>* model will be in a presentable form to share with decision makers and stakeholders, and that the model will be implemented in some form of a test or a pilot. What’s more, the model offered should then be carefully and rigorously evaluated as to whether it does or does not work.

Barchet reminded participants that the spending objective under the *HP4Life<sup>SM</sup>* model is to stabilize health care costs, make the increases more predictable. Even more importantly, the model when implemented will work to substantially improve the health of those people who are covered and served.

## **REVISED MODEL/Q&A**

Larry Chapman took over at the podium at this point to present the revised model, Version 6.0, based on the first day’s top 10 recommendations ranked by participants. In terms of the consumer-driven model, Chapman said approximately seven percent of the working population will meet or exceed the maximum out-of-pocket costs of most health plan. That leaves approximately 93 percent who would see their HHA account grow annually. Those individuals

do not necessarily spend all the money in the account, so it gets larger over time. As that money “grows,” when the individual does run into a large health care event, liability is limited to the maximum out-of-pocket amount from their health plan for that year. Chapman said you could consider it almost like a medical Investment Retirement Account (IRA) account.

Participants then decided, after some discussion about carry-over monies and what would be allowed under current insurance regulations (as well as additional questions about HHAs) that for the purposes of today’s exercise, participants should develop a *HP4Life*<sup>SM</sup> plan for “today”, revising it in the future as future legislation alters the insurance and financial terrain.

A participant raised the point that in some modifications for the *HP4Life*<sup>SM</sup> model, one group’s intent was to run the bridge concurrently with the HHA, so that someone would not get to the end of the HHA dollars and end up deferring care. If incrementally and concurrently people were paying, it wouldn’t be a barrier to care, the participant explained.

Chapman said participants would have carryover monies that would apply to the next year’s bridge, but if participants wanted to piecemeal the monies out, it would add another level of complexity to how people perceive the instruments and the accounts. Reconfiguring the bridge in this way could also complicate the claims process. He said that it was a good idea but also added some complexity to the administration of the plan.

A participant joined in the conversation and said reconfiguring the bridge was meant, perhaps, for people that have an income but live paycheck to paycheck. They are used to paying co-pays so why not include modest cost-sharing for them?

## **SMALL GROUP DISCUSSIONS/POPULATION-BASED**

Lead facilitator James Whitfield took over at this point, and announced that participants would now break into small groups for additional discussion. Participants were charged with developing a way to demonstrate *HP4Life*<sup>SM</sup>, and then design an evaluation of the demonstration based on specific population groups. Several population groups had been selected by workshop facilitators and steering group members, including:

- State and school employees
- Uninsured
- Basic health plan
- Private sector employers
- Medicaid
- Others

Participants were told to try to get as specific as possible, to lay out steps and plans to get *HP4Life*<sup>SM</sup> up and running for the specific populations selected. Groups might consider and discuss legislative or regulatory changes, potential grants or federal Medicaid waivers, for example. Groups should also consider how the health care world “works” for the populations

being discussed, and consider: where does the money come from, and who makes decisions about the money?

## **REPORT OUT FROM SMALL GROUPS**

With 30 participants on the second day of the workshop, three discussion groups were formed for the second day's exercises. Participants chose to work on the private sector, low-income and employed uninsured and enrollees in the Basic Health Plan/Healthy Options Health Maintenance Organization (HMO).

### **PRIVATE SECTOR**

The private sector group said one of the first priorities would be to cost out the *HP4Life*<sup>SM</sup> model. Participants also said it was important to develop a marketing and communications plan to make sure employees buy into why *HP4Life*<sup>SM</sup> is good for them, and also to ensure that Chief Executive Officers (CEOs) know why *HP4Life*<sup>SM</sup> is good for them to invest in.

In order to implement *HP4Life*<sup>SM</sup>, the group also thought it would be important to prioritize *HP4Life*<sup>SM</sup> elements, decide which ones are the most important and perhaps eliminate a few so that the model is easier to sell.

Participants also said for the HMI, they would prioritize and customize based on the private sector population. They recommended greater clarity for each selected intervention and more explanations. What is a wellness coach? What steps would an enrollee go through in order to tap into that service? The group said employees want to know how the system works; an employer may not know if an employee is sneaking cigarettes during the day when that person has told the company (based on the health assessment) that he or she has quit.

Confidentiality is also important. Support groups should be encouraged, too. Similar to the structure of the Employee Assistance Program (EAP), there might be an employee group with teenagers and they're all having problems with their teenagers, a weight loss support group or a diabetes support group.

What needs to be done to plug it in? Participants said the case needs to be strong and convincing to sell to CEOs, employees, insurers, doctors (do they have assurance they will get paid?). Participants said spell out the plan, give us steps listing each from one through twenty-five. The plan may not be the same for all organizations, but it gives people something to work from.

There is potentially an opportunity in Washington State because Insurance Commission Kreidler is working on a plan to cover everybody in the state with some form of health insurance. The Commissioner's plan now revolves around mandating everybody have a high deductible plan. Participants also suggested that *HP4Life*<sup>SM</sup> be added to a cafeteria plan already in place. Healthier enrollees might just flock to it, but at least you'd still have a demonstration project.

The private sector group said there needs to be a change in federal law that would allow employees to put their own money in to a HHA. (Editor's Note: This has happened with the Medicare Legislation signed on December 8, 2003)

Participants said there is a downside from the insurance brokers' perspective. Brokers get a commission consisting of a certain percentage of the premium of a traditional health plan. If they sell a high deductible plan, they lose money and it comes out of their own pocket. How do we change that? *HP4Life<sup>SM</sup>* would need to design a different way to pay brokers so they don't kill it before it has a chance to be adopted.

Groups like the Young Presidents might be interested in *HP4Life<sup>SM</sup>*. CEOs talk to other CEOs and might be willing to take the risk if they know someone else is trying it. *HP4Life<sup>SM</sup>* needs somebody else out there that is the champion of the model, and it will take tenacity and persistence to get the demonstration done.

One additional recommendation was to tap into an employee decision-making group, who would then recommend the plan to management (Puget Sound Energy has such a group).

## **LOW-INCOME, EMPLOYED UNINSURED**

This group decided to apply the *HP4Life<sup>SM</sup>* model to the uninsured. In 2000, the number of uninsured in Washington State was 484,000. Of that number, 25 percent are unemployed, 75 percent are working. Employers offer insurance, in some cases, but employees do not always opt for the coverage. The primary reason low-income uninsured individuals identify the reason for not joining a health plan is self-described lack of affordability. So these particular individuals have access to coverage but don't do it because it costs too much.

In trying to come up with a way to use the dollars that the group figured exists, members looked at another model that believes catastrophic coverage is an option. The employee would use a HHA contributed to by the employer and employee. (Group Note: one of the things we've talked about is you really have to find out where this person is. Is it a 25-year-old male, married with two small children or a 63-year-old woman with \$600,000 in the bank? So many variables, we chose the hardest one and then said how can we use this model)

The group's decision was that primary care and preventive care would lead to the most benefit for this population. Members discussed a *HP4Life<sup>SM</sup>* model in which preventive care and primary care were not covered by a HRA. This design would be similar to a contract for services for \$25 a month that covers preventive care and primary care. This does not include x-rays or labs.

This option for the model would basically mean that monies that are typically used to buy catastrophic coverage would be used instead for primary care/preventive care. The uninsured are ages 18 to 26, and are either young, unmarried or young and married with small children. There's no bridge in this particular plan.

Primary care would be under a co-pay arrangement, it wouldn't include, for example, a \$200 deductible. Group members did not want the bridge to be a barrier to people getting primary care.

Even though the model has changed from what's been previously discussed, group members said it would still be possible to provide incentives to people for adopting healthy lifestyles. For the self-employed, the incentives would come from the individual. While the whole model includes catastrophic, if there was the ability to have the option, money spent for the low-income uninsured would be better spent here in this way (without catastrophic coverage). People will ask however - but what about a car accident or falling from bungee jumping?

Several participants said they have heard of similar plans that are now up and running. A group of physicians in Spokane recently banded together and said they will perform certain services for a set amount each month, and the fee doesn't include x-rays or blood work. The physicians have put together a primary care and preventive care plan and charge \$25 a month. Preventive care brings with it a \$5 co-pay, primary care is a \$10 co-pay. The doctors are now looking at adding labs and x-rays, and the cost would be around \$50 a month.

The group said there are, of course, different and varying pockets of uninsured. In Eastern Washington, for example, there is a large group of uninsured individuals who are 55 to 65 years of age. It is the fastest growing uninsured population in that part of the state. A participant said one way for consumers to save money is to ask for a cash discount. If an individual goes to a doctor or pharmacy, those offices are typically willing to cut the price. Because claims processors want \$8 to \$12 per claim, with cash, the provider gets paid in 24 hours rather than 30 to 60 days. Every one of the hospitals in Eastern Washington has said they would give discounts for patients who pay cash.

## **BASIC HEALTH PLAN & HEALTHY OPTIONS**

This third group decided, after some discussion, to design a plan to implement *HP4Life<sup>SM</sup>* specifically for Healthy Options enrollees who are in a managed care plan. First off, the group said there would be a 12-month lock in for enrollees, because what happens right now is that plan participants can change plans every month.

The group said there needs to be a level playing field for participating providers, because right now there are different prices for the same services. Looking at the preventive care issue, there are secondary issues (smoking cessation) as opposed to getting a mammogram or immunizations. Members decided to give people an incentive to "earn" the bridge, creating a menu of options and implementing preventive care on a sliding fee scale. The group decided the figure should be half a percent of a person's annual income. This means an individual with an annual income of \$19,000 would have a \$80 or \$85 bridge per year. If *HP4Life<sup>SM</sup>* participants meet secondary preventive measures, they would receive credit towards the bridge. What if they don't do it? Some enrollees may have problems getting to an appointment. *HP4Life<sup>SM</sup>* would match them up with a care manager to help with compliance and health care mentoring, to encourage

participation in the model. Some of that would require a waiver from the federal government (Center for Medicaid and Medicare Services, CMS).

With the current Healthy Options plan, it often happens that an individual is on the program two or three months, then off and on again a few months later. One of the things officials hear from families is, “What do you expect, they threw me out there with nothing. The first time I got sick, I had to go to the hospital.” There should be a way to use incentives to build these individuals, not a big nest egg, but a nest egg that will be there when they get off Healthy Options.

If the enrollees haven’t used up the HHA, those dollars could be used for the bridge. The group also discussed how to carry the *HP4Life<sup>SM</sup>* model forward. One participant said there seems to be an incentive in current laws to keep people where they are. The big goal should be how to help people take some kind of ownership.

During the course of the discussion, group members discussed moral implications of the carrot and stick approach to *HP4Life<sup>SM</sup>*.

## **PLAN FOR EVALUATION: PRIVATE SECTOR**

The private sector group said that health status, cost and employee satisfaction are the most important items to measure in terms of the *HP4Life<sup>SM</sup>* model. Employees should fill out a self-evaluation, in a before and after manner. Researchers might also study claims utilization, drug utilization and accidents. Employers could put in place a number of different productivity measurements (i.e. use of sick days.) Again, the need for employee support groups was stressed—weight control, high blood pressure, etc. Studies might include an evaluation of any disease management programs included.

One participant suggested comparing how often enrollees select *HP4Life<sup>SM</sup>* over another model/plan. The group said adverse selection should also be monitored, does everyone think it is going to happen or does it in fact happen? Over time, officials should measure the value of preventive care, and administrative cost difference. By putting the *HP4Life<sup>SM</sup>* plan in, do I have to hire more folks or does my Third Party Administrator (TPA) have to add more staff?

Quality of life over time should be measured for enrollees. Do participants feel they are better off?

Employee satisfaction (data could be gathered even during exit interviews and with new hires) should be measured over time, as well as that of the employer, the decision-maker. Is *HP4Life<sup>SM</sup>* a pain to implement or has it been a good thing? If implementing the model annoys employers, the next year they will yank it.

The group decided that using grant monies might be a good way to get *HP4Life<sup>SM</sup>* up and running with an employer, specifically if that employer does not have the time or money to hire new staff to oversee the model.

Participants also suggested looking at various associations for possible funding. With the focus on wellness, would some association of vendors be willing to participate? Would the University of Washington want to see the results of implementing *HP4Life<sup>SM</sup>*? Would a group that backs smoking cessation want to help fund a *HP4Life<sup>SM</sup>* pilot, and what about a long-term care organization, would they want to throw some money in, to see if it makes a difference for the future population, are people aging gracefully?

### **PLAN FOR EVALUATION: LOW INCOME UNINSURED**

This group envisioned a Smart Card or debit card-like system, so that data could be compiled *via* transactions. There would need to be a control group and a pilot group, but the control group should be some sort of virtual control group, so that researchers could make an entire link, the cause and effect of implementing *HP4Life<sup>SM</sup>*.

Participants said they would use a health status survey for enrollees. The patient would complete one survey initially at the start of one year, then provider would also complete a survey. One idea for evaluating is the primary care physician, at the start of the program, would evaluate health status and then one year out.

Other items to be measured include drug utilization as well as avoidable hospitalization.

What determines if we're successful? Better health and less cost, better health for the same cost and same health for less cost. In addition, how big is *HP4Life<sup>SM</sup>* membership and do we have a decreased number of uninsured in our region?

### **PLAN FOR EVALUATION: HEALTHY OPTIONS**

A participant said to develop a set of measures for any intervention, there needs to be a relationship between the intervention and better health. One outcome might be completion of all required and recommended immunizations.

Another participant said there are already tons of evaluation and measurements already being conducted for preventive care parameters and services, as well as utilization of those services. The U.S. Centers for Disease Control and Prevention (CDC) has ten such measurements on its Web site. Morbidity and mortality should be evaluated and there should be an overall health evaluation of enrollees. Secondary prevention should be evaluated *via* those who have met their bridge amount through those programs. One of the hopes in our group's design is that it reduces costs beyond the premium. Does that really happen?

At the end of the year, see how much money is in an enrollee's HHA account. Evaluate the redirection of care for utilization and appropriate care (through case management and utilization review). We make an assumption or theorize that there is a sense of ownership of HHAs; measure that through how much money is left in the account and through surveys. Has access to health care increased? Is it less complex, have we added to overhead? Are more doctors

participating or pulling out, are more carriers interested in being involved, more IPAs participating?

## **NEXT STEPS—BEST and OTHER ACTIONS**

Dr. Barchet closed out the workshop by assuring participants that the two days of work would not be an empty exercise. Where do we go from here, what do we do now? We have a framework, an outline, interest in *HP4Life<sup>SM</sup>* and we have had two full days of difficult, contentious discussions. Where do participants want to see this thing now go?

One participant said enrollees need some type of account through which the employer and employee contribute, and the employee is then allowed to take the account with them when they leave that job.

Another participant said there needs to be increased awareness of the growing prevalence of consumer-driven plans. Right now, small employers are not really choosing to go the CDHP way due to their unavailability. It is unlikely the government will jump on this concept, but five years from now, with the number of CDHP programs being implemented, accepted and utilized by consumers (including largely employers) and a track record being created, then perhaps government can at least start considering these approaches more readily. The *HP4Life<sup>SM</sup>* model is too big of a leap for government to make, but it is not too big of a leap for employers and consumers.

Barchet asked participants what could be done to interest decision-makers. One participant said “new money.”

One participant suggested pitching the *HP4Life<sup>SM</sup>* plan to a self-insured company because of current regulations.

Another participant said there is broad interest in improving health and strategies that can be employed to do just that. That type of program can reduce costs. Improving health status of individuals and having them put their own money in (even though they may be low income) - in the long run people will stay in that type of a program. There is a real interest in the legislative level in that.

When queried, a majority of the group said they would be interested in attending a meeting in the future to help develop further and grow the *HP4Life<sup>SM</sup>* model.

## **WORKSHOP CLOSURE**

With sincere expressions of appreciation, Dr. Barchet thanked participants for their contributions and brought the Workshop to a close.

For more information on the Health Plan for Life (*HP4Life<sup>SM</sup>*) visit the Evergreen Freedom Foundation (EFF) website identified below. You can download any of the following reports depending on your interest in this new model for health coverage. Go to [EFF's website](#) and download any or all of the following:

Report Number	Title	Brief Description	File Size
<a href="#">#1</a>	<b>Overview Graphic</b>	A one page graphic of the <i>HP4Life<sup>SM</sup></i> health coverage model.	90k
<a href="#">#2</a>	<b>Background Document on <i>HP4Life<sup>SM</sup></i></b>	This report provides the rationale for <i>HP4Life<sup>SM</sup></i> and sets the context for why it was developed.	200k
<a href="#">#3</a>	<b>Workshop Charge Documents for Testing and Refinement of <i>HP4Life<sup>SM</sup></i></b>	This documents provides the workshop charge, objectives and plan for testing the soundness of the <i>HP4Life<sup>SM</sup></i> concept and sets the stage for the workshop event that happened in September of 2003. The original version of <i>HP4Life<sup>SM</sup></i> is included in this document.	400k
<a href="#">#4</a>	<b>Workshop Participants and Facilitators</b>	This document identifies the individuals who participated in the Workshop including; Steering Group Members, facilitators and participants.	200k
<a href="#">#5</a>	<b>Summary PowerPoint Presentation on <i>HP4Life<sup>SM</sup></i></b>	This PowerPoint presentation presents the background, rationale and specific forms of the <i>HP4Life<sup>SM</sup></i> and completed note pages.	900k
<a href="#">#6</a>	<b>Workshop Summary</b>	This is the annotated record and summary of the two day invitational workshop to review, refine and modified <i>HP4Life<sup>SM</sup></i> .	325k
<a href="#">#7</a>	<b><i>HP4Life<sup>SM</sup></i> : Final Model and Concept Paper</b>	This is the formal outcome of the refinements recommended by the participants at the invitational workshop on <i>HP4Life<sup>SM</sup></i> .	375k
<a href="#">#8</a>	<b>About the Workshop Sponsors</b>	This document describes the sponsoring organizations for the <i>HP4Life<sup>SM</sup></i> invitational conference: Evergreen Freedom Foundation and the Washington Health Foundation	75k
<a href="#">#9</a> (all eight docs)	<b>Full <i>HP4Life<sup>SM</sup></i> Report Package</b>	This download includes all eight documents described above.	2.6meg

For more information on *HP4Life<sup>SM</sup>* contact Stephen Barchet, MD

Issaquah, WA (425) 644-9594

<mailto:barchet@earthlink.net>