

## **Discussion - Draft**

### **Asheville for Hawaii**

The Healthcare Task Force (Task Force) has been asked to study the issues of the uninsured in Hawaii and offer a plan of options for health care coverage for the uninsured. One alternative to be investigated by the Task Force is a single payer health care system for Hawaii. The single payer system is thought to be a solution for the vision of coverage for all. However, being able to finance a single payer system has been an issue or concern from the onset of the Task Force.

The Lewin model has proposed an alternative that requires a new payroll tax, as well as other significant changes to the current financial structure of the healthcare system in Hawaii. Implementing these significant changes would require careful consideration and input from many stakeholders. This could take several years and require many hours in order to investigate all the issues. Implementing the Lewin model would also require the Legislature to increase taxes in an environment that may not support that step. If a tax increase was not passed, then the proposed Lewin model could not be implemented. Consequently, trying to solve the coverage for all issue in one fell swoop may result in no solution at all.

Perhaps there are single steps that can be proposed that don't require significant changes to the health care financing system. A thought would be for the Task Force at least find an alternative to finance health insurance coverage for Hawaii's uninsured population. This is one step closer to the coverage for all vision. Pursuing a means to finance the uninsured population would solve a major issue and perhaps open the door for a means to eventually finance a single payer system.

How can this be accomplished? Let's begin by first understanding the facts placing pressure on the health care economic model and financing alternatives today.

Our current health care system is far too expensive. In 1970 at his inaugural address, President Nixon, in reference to the health care system, stated, "We face a massive crisis in this area in the next two or three years unless something is done immediately." The US threw money at the problem and insurance solutions were proposed. That didn't solve the problem. Because 36 years later we have repeated this solution, every administration since Nixon has proposed insurance solutions and the problem still exists.

Our health care expenditures as a percent of GNP have risen at an alarming rate. Today, health care accounts for 13% of our GNP. Based on historical trends, by 2010 our health care system will exceed 16% with no reduction in sight. See Exhibit I attached. Health care inflation over the last 6 years has been 3 times that of over all inflation.

What is driving this alarming expenditure growth? Is it the demand side of the economic equation? Let's pursue that subject. Today, 20% of the US population is consuming 80% of the health care resources. And, a look at most health plans reveals that the same people typically are in the system (a revolving door, if you will) and most of them have chronic diseases like diabetes, asthma, hypertension, etc.). If the population grows each year, disease prevalence rates increase, and rates for health care providers increase each year, then health care inflation will continue at 3 times the over all inflation rate.

Let's consider the chronic disease rates for the US. People in the US with diabetes now exceeds 20.8 million. Diabetes is growing at the alarming rate of 900,000 people per year. One study released last week indicated that children with diabetes grew 30% last year. According to the American Heart Association, from 1979 to 2000 the number of cardiovascular operations and procedures has grown by 397%. That is an alarming rate of 18.9% each year. Cardiovascular disease killed 945,836 people in the US last year. 20 million people in the US have chronic kidney disease. 556,902 died from cancer in 2003. According to the

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Center for Disease Control, the prevalence rate for cancer from 1950 to 2003 has only decreased by 1.95%. But population has grown tremendously since 1950 which results in a growth in cancer cases in the US.

The results of all this data points to a booming growth rate on the demand side of health care. Up until now, no one has launched a significant campaign to slow the demand of the health care economic equation. We spend only 4% of our health care expenditures on prevention. See Exhibit II attached. From the facts that exist, it is evident this small amount will not slow the demand growth.

It is quite evident that the growth in the demand side could be the major cause for the health care cost crisis in America. It is also possible that the tremendous demand growth is the overburdening our current health care delivery system. Therefore, it is possible that the only way we can slow the skyrocketing health care costs and address the overburdened health care delivery system is to switch our focus to preventing disease and slowing the demand growth. As many experts have stated, we must shift our current health care system from a sickness oriented delivery system to a prevention based and wellness system.

What would be the results if in fact we accomplished a shift to increase the effort of prevention and reduced the demand rate? Perhaps we could actually reduce health care expenditures and in fact save money. The savings could then be invested in providing coverage for the uninsured. Hawaii could produce a financing mechanism to address the uninsured. Improve the health status of the population. Improve the quality of life of our population. Increase the average life expectancy. And everyone would win.

A model to begin to accomplish this vision does exist and has been tested for 9 years. The Asheville model has lowered total health care expenditures for people with diabetes over the last 9 years. The Asheville model has been implemented in 9 markets in the US, is currently being implemented in 10 more markets, and under consideration in 7 more markets. That is a total of 26 markets across the US. Hawaii is one of the markets currently under implementation. 4 employers are implementing and 4 more are vetting the concept with their senior leadership. The Asheville model has only been implemented by public and private employers. West Virginia is currently the first state to attempt to implement state-wide implementation. Maryland will be the first state to attempt to implement Asheville for the Medicaid population. Medicare has not yet been attempted.

Assuming Hawaii implements the Asheville model on a statewide basis, what could be the results? If we rely on the data from the Asheville experiences to date, we could save between \$1,000 and \$1,750 per individual. Assuming the high-end range of \$1,750 and if we were to enroll 103,000 in the Asheville model all across the state that would produce a reduction in health care spending of \$180,250,000. Adding a reduction in admin spending of 8%, the total savings for health care expenditures would be \$194,670,000. The Lewin model estimated the total cost to supply coverage for the uninsured in Hawaii to be \$192,000,000. The Asheville model could produce the savings needed to finance coverage for the uninsured. Exhibit I attached shows the calculations supporting the savings projected.

Assuming that 20% of the Hawaiian population has a chronic disease or 240,000 people, we are projecting the need for an enrollment of 103,000 or a 43.9% rate. The average enrollment rate for populations implementing the Asheville model is 50%.

Implementing the Asheville model will allow the providers to collect cash to cover their previously under reimbursed care from the uninsured population. If the providers maintain their same net margins, the savings will allow the providers to reduce annual rate increases and the savings will be passed on to the payers by reduced health insurance premiums or lower out of pocket expenses.

In the current economic model in Hawaii, the private employers, the public employers, and the cash paying patients are financing the uninsured population. By reducing the demand, thus reducing the expenditures

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and reducing the rate increases for the uninsured population, the payers will pay less for the uninsured population.

The next step is to reinvest the 1/3 of the savings each year by extending the uninsured coverage. Hence the employers are reinvesting 1/3 of the savings each year to pay for the uninsured. Consequently the payers see 1/3 of the savings each year. Utilizing a 1/3 per year approach for increasing uninsured coverage provides an incentive for the employers to support the system.

The payers of health care will also see a reduced rate of health care expenditures each year. Providing a reduced level of health care expenditures each year will be the incentive for employers to continue to support this system.

At the point the demand is under control, health care expenditure increases should equal over all inflation rates. Next a goal should be set to increase enrollment beyond the 43.9% level. Thus decreasing demand more and increasing savings.

In order for this system to be successful, a measurement system must be in place. The system will have to measure clinical, as well, as financial improvements. Then each payer will be able to see the return on investment for participation in the demand control system.

One factor that has to be considered also relates to the reduction in human resources generated by lowering volume. Some of the displaced employees will be redeployed as life coaches and counselors. The other economic impacts should be minimal.

In conclusion, this concept offers a solution that does not just throw money at our problems. Hawaii does not have to wait for legislative action for implementation to begin. The Asheville model also has proven it improves the health status of individuals. See Exhibit II attached. It enhances the quality of life for individuals. The concept is designed to control health care expenditures. It stimulates economic growth in other sectors by lowering health care inflation rates. Every factor points to reasons why Hawaii should proceed with a state wide implementation.

### **Asheville Model Overview**

#### **EMPOWER THE PATIENT. IMPROVE THE OUTCOMES. CONTROL THE COSTS.<sup>SM</sup>**

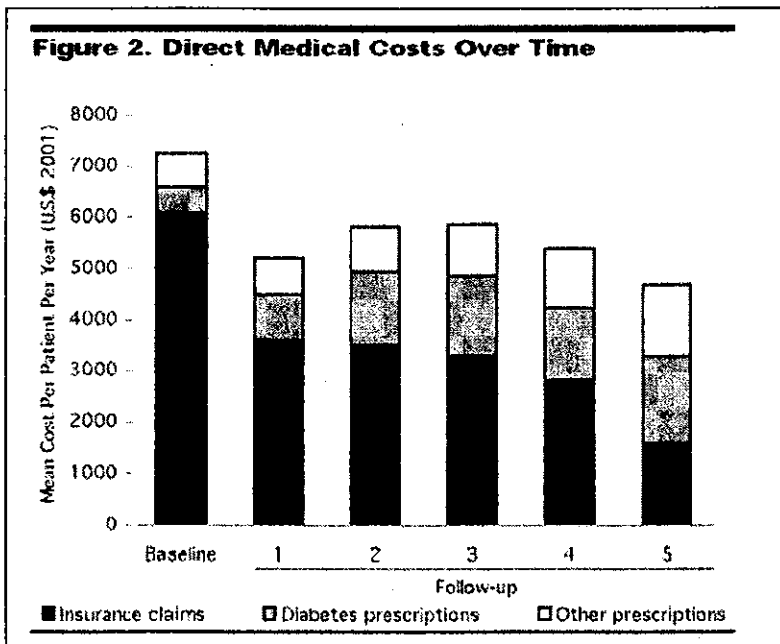
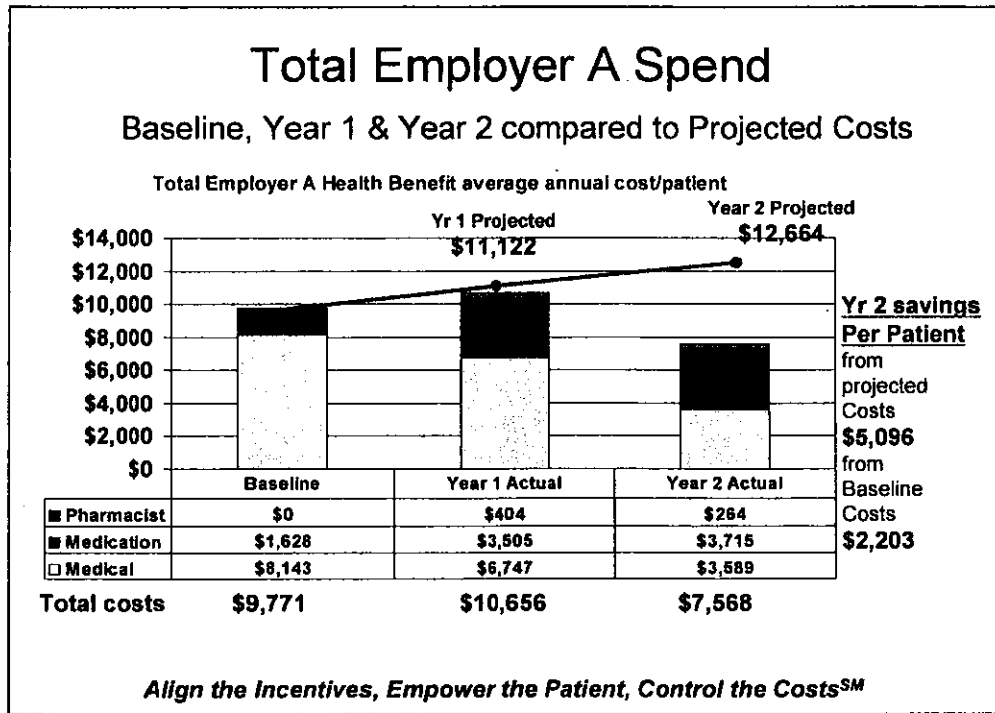
What is Asheville and how does it work? The American Pharmacists Association (APhA) Foundation sponsored private/or public employer groups to participate in a proven healthcare model that improves the quality of care and reduces overall healthcare costs. The APhA Foundation is a non-profit organization whose mission is to improve the quality of patient health outcomes that can be affected by pharmacy. The APhA Foundation is affiliated with the American Pharmacists Association, the national professional society of pharmacists founded in 1852.

Replicated based upon the highly successful "Asheville Project<sup>1</sup>," the APhA Foundation will provide participating employers with the support and tools to link employees, retirees and their dependents with community pharmacists to help them actively manage their diabetes through regular visits and communicate with the participant's physician and other health care providers to help assure good outcomes. A unique project component is a diabetes credential the patient can earn through program participation that acknowledges the participant is indeed capable of self-managing their condition<sup>1</sup>.

#### **Results from the Asheville Project<sup>1</sup>:**

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## An Employer's Results Participating in the APhA Foundation Patient Self Management Program<sup>iii</sup>



Total mean savings in overall direct medical care per patient per year in The Asheville Project:

Minimum = \$1,622      Maximum \$3,356

### Success of the Model

The model that will be utilized in this project aligns incentives that encourages collaboration among healthcare stakeholders to provide patients with a service that will teach them how to better self-manage their diabetes and improve their overall health, which in return reduces the employer's medical costs.

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Aligned economic incentives begin with the employer who provides an incentive to patients, such as waived co-payments for diabetes-related medications while active in the program; and provides payment to the certified diabetes educators and pharmacists for providing education and diabetes care management. The employer will receive a return on investment as a result of healthier workers, decreased absenteeism and a decrease in overall health care costs.

### **Care Management<sup>2</sup>:**

- Healthcare providers are encouraged to treat patients to clinical goals using national treatment guidelines and are not asked or required to use any specific pharmaceutical product.
- Participating Pharmacists are required to complete a certificate training program in diabetes or have earned the Certified Diabetes Educator (CDE) credential.
- Patients enroll in this program as a voluntary health benefit offered by their employer's health plan.
- Clinical results in APhA Foundation Patient Self Management Program shows that the average A1c values have been reduced from 7.9% to 7.1% for the entire enrolled population in the first year of the program. This reduction is significant as the goal for A1c set by the American Diabetes Association is 7.0%.
- There have also been dramatic improvements in other key indicators of diabetes care, such as influenza vaccinations, recorded blood pressure, lipid profiles and the percentage of patients receiving foot and eye exams.
- Over 95% of the patients have also reported that they are either very satisfied or satisfied with the pharmacists' care.

### **Employer Reports:**

Participating employers in the Asheville model will receive clinical, economic and patient satisfaction reports throughout the program, tracking their own enrolled population's progress and economic effect the program has on total health care costs.

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<sup>i</sup> Cranor CW, Bunting BA, Christensen DB. The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program. *J Am Pharm Assoc.* 2003;43:173-84.

<sup>ii</sup> Garrett DG, Bluml BM. Patient Self-Management Program for Diabetes: First-Year Clinical, Humanistic, and Economic Outcomes. *J Am Pharm Assoc.* 2005;45:130-137

Exhibit I

# National Healthcare Expenditures

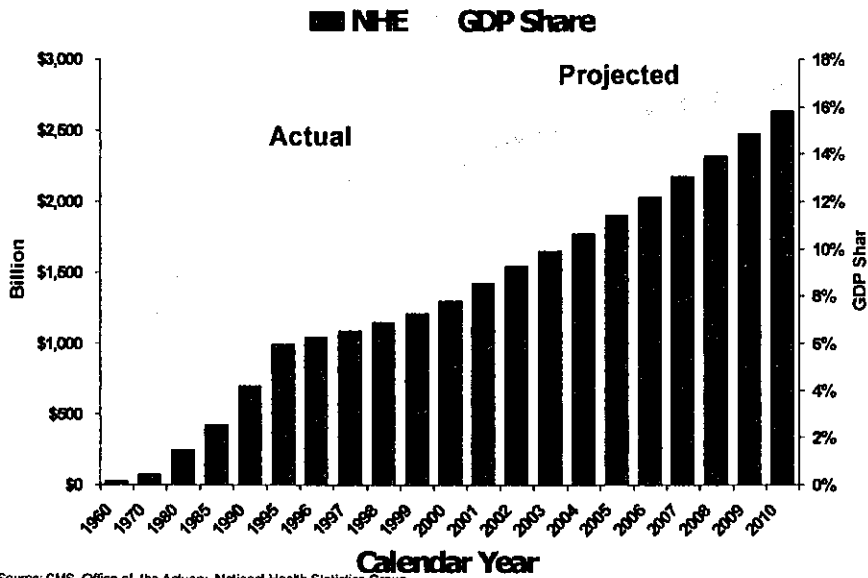
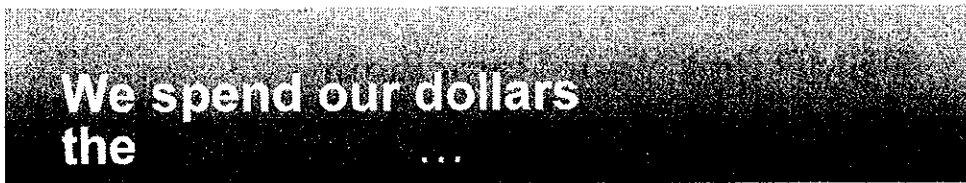
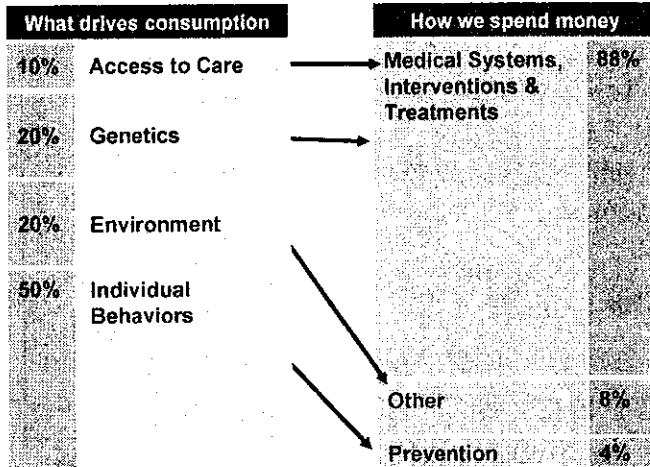


Exhibit II

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**Factors that Impact Consumption**



Source:  
CDC Univ of California -  
RWJ Foundation

**Exhibit III**

**PSMP 2nd Year  
Participant A1c Results\***

	Initial Visit	2nd Year
Average A1c	7.8	6.9
% of A1c < 9.0 (HEDIS Goal)	71%	95%
% of A1c < 7.0 (ADA Goal)	46%	63%
% of A1c < 6.5 (ACE Goal)	31%	51%

\*for 65 patients with baseline, 1<sup>st</sup> and 2<sup>nd</sup> year results

***Align the Incentives, Empower the Patient, Control the Costs<sup>SM</sup>***

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### PSMP 2nd Year Participant LDL-Cholesterol Results\*

	Initial Visit	2 <sup>nd</sup> Year
LDL-C Average	107	101
% with LDL-C Recorded	62%	100%
% LDL-C < 130 (ATP II Goal)	77%	86%
% LDL-C < 100 (ATP III Goal)	38%	55%

\*for 65 patients with baseline, 1<sup>st</sup> and 2<sup>nd</sup> year results

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### Exhibit III (continued)

### PSMP 2nd Year Participant Nutrition, Exercise, Weight Goals\*

	Baseline Visit	2 <sup>nd</sup> Year
% Nutrition Goal (Achievement %)	42% (33%)	92% (66%)
% Exercise Goal (Achievement %)	42% (32%)	97% (57%)
% Weight Goal (Achievement %)	42% (22%)	91% (40%)

\*for 65 patients with baseline, 1<sup>st</sup> and 2<sup>nd</sup> year results

*Align the Incentives, Empower the Patient, Control the Costs<sup>SM</sup>*



Exhibit 1

**State of Hawaii Health Care Task Force  
Potential Savings For Chronic Disease Enrollment**

			<b>Year One</b>		
Population of Hawaii			1,230,000		
80% consume 20% Health Care Resources			246,000		
Consumption Focus Program - Diabetes and Cardiac					
Medicaid/Quest Population					
100,000	20%	20,000			
Diab/Cardiac	50%	10,000			
Savings per individual		\$1,750	\$17,500,000		
Admin Savings		8%	\$1,400,000		
Total Medicaid Savings				\$18,900,000	
Medicare Population					
133,000	20%	26,600			
Diab/Cardiac	50%	13,300			
Savings per individual		\$1,750	\$23,275,000		
Admin Savings		8%	\$1,862,000		
Total Medicaid Savings				\$25,137,000	
EUTF					
200,000	20%	40,000			
Diab/Cardiac	50%	20,000			
Savings per individual		\$1,750	\$35,000,000		
Admin Savings		8%	\$2,800,000		
Total EUTF Savings				\$37,800,000	
Total Public Programs				\$81,837,000	
Commercial Population					
HMSA		480,000			
Kaiser		210,000			
Total		690,000			
EUTF		(200,000)			
Federal		(50,000)			
Net		440,000			
440,000	20%	88,000			
Diab/Cardiac	50%	44,000			
Savings per individual		\$1,750	\$77,000,000		Enrolled in Chronic Program
Admin Savings		8%	\$6,160,000		Medicaid 10,000
Total Commercial Savings			\$83,160,000		Medicare 13,300
Total Population Addressed					EUTF 20,000
Uninsured and Underinsured					Commerc 44,000
Total Population					<u>Total 87,300</u>
Total Savings for All Groups				\$164,997,000	add enroll 16,095
					Total 103,395
Additional Enrollment					
1,073,000	3%	32,190			
Diab/Cardiac	50%	16,095			
Savings per individual		\$1,750	\$28,166,250		Offered 174600
Admin Savings		8%	\$2,253,300		Consumers 246000
Total For Additional Enrollment Savings				\$30,419,550	Not Enrolled 71400 29%
Total Potential Savings				\$195,416,550	
Admin Savings				14,475,300	