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Session 58 PD
Defined Contribution Health Plans

Track: Health

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Summary: Panelists discuss product designs and strategies of interest to employees, as well as the impact of defined contribution (DC) plans on the health insurance market and third-party administration business. At the conclusion of this session, participants have an understanding of the fundamentals of DC health plans.

MS. BETH GRICE: Welcome to Session 58, "Defined Contribution Health Plans." I'm Beth Grice, the moderator. We have three distinguished panelists here: Penny Hahn from Humana, Lindsay Resnick from HealthMarket, Inc., and Dave Tuomala from Definity Health Plans. Lindsay is going to talk to us first about small group; Dave will follow up with large group; and then Penny is going to share a case study on one particular large group.

Are too many choices driving Americans crazy? Will consumers be happy when they get what we think they're asking for? Those are questions I want you to consider as our panelists talk. They'll be talking about what I call "consumer-centric plans." These have come about with the introduction of defined contribution. In the March 20, 2002 issue of *Health Affairs*, Laura Tollen and Robert Crane have asked the question, "Is this movement from managed care to the consumer-centric plans

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Note: The chart(s) referred to in the text can be found at the end of the manuscript.

moving out of the frying pan and into the fire?" I think you'll find that very interesting reading after you hear each of our panelists.

MR. LINDSAY RESNICK: As I look around the room, I see a lot of people who have been through many eras in health care. In the '60s (some people may not want to admit it), we saw Medicare and Medicaid come around; in the '70s, we saw the early movement and development of HMOs. Everybody looked at them and said, "No one's going to join those things. Maybe Kaiser and maybe Harvard Community Health Plan." Then we saw the eruption in the '80s of PPOs and networks and products built around provider networks, and then they moved from large group into small group.

By the end of the '80s, every small-group product had a PPO network attached to it. Then in the '90s came disease management, case management and more aggressive PPO plan designs in network physician only. HMOs boomed in terms of their enrollment, and particularly in your profession, we've seen trailblazing careers made in each of these segments of our industry. Now we're approaching a new one, and that's consumer-driven health plans (CDHPs) under a larger umbrella of defined contribution. I'll try to draw the distinction as I lay a context for the presentations today in terms of why this is happening and what some of the more common features of CDHPs are.

We have issues. As an industry we have issues, and I'm not going to harp on them. I'm sure there have been other sessions during your meetings about premium increases and the numbers of small employers, particularly under 20 or under 10, who are no longer even offering health coverage. There are issues that are starting to surround cyber losses. This is an emerging term that everyone needs to be cognizant about, the changing in population demographics. As an industry, we're struggling. There continues to be erratic price competition in the marketplace. A difficult regulatory climate exists on a state-by-state basis: Who wants to participate where; Who's jumping in and out of the individual market; Who's in small group; Who's exiting small group. Internally, we've developed a series of penalty-based, network-restricted, pre-certification benefit plans. While there is movement away from those, they have had their effect on our customers.

I think some overall assessments can be made about managed care cost controls. If you don't want to go so far as to say that they're no longer working, they are no longer as effective as many people thought they would be on a sustained basis. We've isolated members from what the actual cost of care is and as a result, our clients are frustrated. Frustration drives change. The consumer's perspective is that we've created a co-pay mentality. We've desensitized the customer to the cost of health care. For the most part, a haircut and shoeshine is the same cost as going to the physician—$20. That's created a problem. The co-pay mentality that is in the marketplace has created a problem. The intrusion into the care decisions of us as individuals—people in this room and the customers of our companies—has created a problem. As a result, a movement has begun over the last several years toward

consumer-driven health care. The big question that the Crane and Tollen article asked, and the big question that we're asking, is: Is John Q. Public ready to take on some tough decisions? Many of these health plans are technology based. Many of these health plans put significant decision making on a cost basis, on a quality basis, into the hands of the end user. The end user has said: "I don't want faceless bureaucrats interfering with my health care." Well, be careful what you wish for; because new plans are emerging that allow that.

Are employees ready to make these decisions? Are they technology based? Seventy percent of consumers are online; 50 percent are making purchases online. When asked in survey after survey of the major consulting houses, upwards of 50 percent wanted some change in their benefit model. What's important to them? What's important to them is convenience and medical expertise, and they're willing to make changes for those things.

Are physicians ready? I think so. Physicians are online. Physicians have a new term that you're going to have to price for, called information therapy. It's house calls over the Internet. They want to put a current procedural terminology code out for it; they want to bill for it. It's time out of their day; it's medical information. They're ready.

Are employers ready? They are probably the most nervous about pushing consumer-based plans onto their employees, but on the other hand they're faced with premium increases that are just out of hand. What are some of the common features? I would say, the way they're playing in the marketplace. Since I'm the marketing guy at an SOA meeting, I guess I could give you the marketing spin that's being put out there—they're an alternative to managed care. They're plans that empower the customer (the consumer) with information to take more control over the benefit and cost decisions, and their goal is to achieve more premium stability and price predictability.

Again, if you look at the surveys, what are the three largest product trends that are gaining the attention in our industry? They are CDHPs, long-term care and individual health insurance. Survey after survey showed that those are the areas in which the product development people are spending their time.

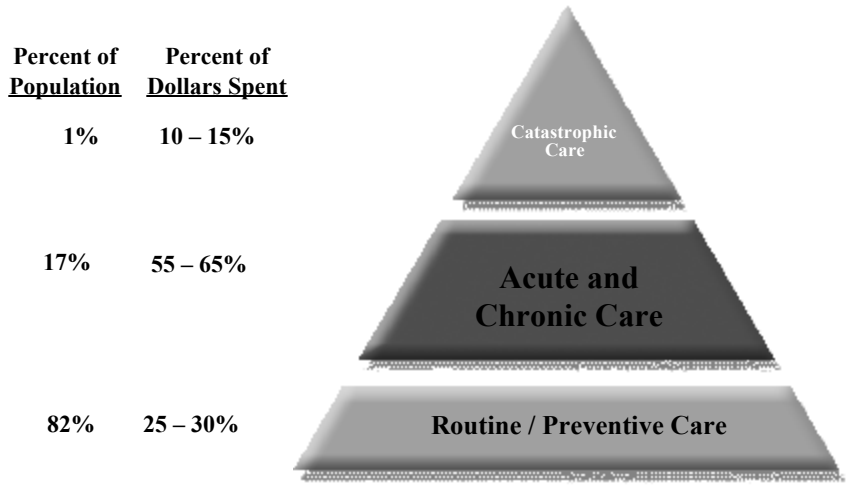
Let me talk from a definition standpoint. From a definition standpoint, defined contribution really is an employer mechanism. An employer is paying a fixed amount on behalf of each employee into the employee's benefit plan. They maintain the role as an employer of vetting the vendors. They may be offering an HMO, they may be offering a PPO, and they may be offering a CDHP. They're making a contribution. If that contribution covers the premium amount, then the employee has no out-of-pocket cost. If it doesn't, then the employee has to pay the difference in that premium. In a pure defined contribution on an individual basis, an employer says to its employees, "You have $4,500 for the year; go buy an individual policy.

I'm defining that contribution to you to go buy health insurance." We're not seeing a lot of those.

In the small-group market, there's less of a defined contribution and more of a plan offering on a full replacement basis. Let me talk a little bit about the CDHPs. I would define those as a health insurance product or plan that gives consumers more discretion over the use of their benefit dollars and medical care choices. The distribution of health dollars and percentage of the population spending them is detailed in Figure 1. Common features of these plans are health savings accounts, sometimes called personal care accounts (PCAs). (I will talk a little bit further about those.) There is an information-based segment of the product that accesses the information on price and quality to the consumer. There's a spectrum to the design of these plans. For medical savings accounts, generally there's a catastrophic piece and a core chassis of the plan that has a comprehensive major medical, and again, access to information and technology applications.

Figure 1

Self Directed Health Plans



Let's look at the spectrum of these products. Really, you can say that the trendsetter was prescription drugs when the industry moved to the tiered co-pay of $10 for generic, $25 for formulary and $50 for name brand. Now, we're seeing more and reading in *Business Insurance* and *Employee Benefit News* about plan designs that put more responsibility to the consumer in using the tiered co-pay approach in terms of what hospital you select. You can go to a community hospital and there may be no co-pay, or you can go to a university hospital and there's a $500 co-pay. You can go to this set of specialists and there's no co-pay, or you can

go to this set of specialists and there's a $250 co-pay. You, the consumer, choose. Here are the price differences; here are some quality differences; and there may or may not be that component of it. It may be more of a network steerage plan design.

Then what we've seen is a movement toward putting a savings account in place. Those may be on one end of the spectrum, a medical savings account that falls under full tax incentives and disincentives, and on the other end it may be built into the product and funded out of premium. Really, it's a benefit dollars savings account. You may have a $1,000 individual or a $2,000 family savings account that covers all your routine and preventive care, and you draw out of it. The concept is that you're going to spend your money differently than you're going to spend your employer's money. You're going to be looking at what you're spending your dollars on because you have this savings account. After the savings account is drained, a traditional coinsurance and deductible plan kick in, so you're not left without coverage, but while you have that savings account fully funded it's first-dollar coverage.

At the end of the year, most plan designs (and I'm generalizing) allow you to roll over if there's money left at the end of the year. As you're making your care decisions throughout the year and drawing down your account, you know that on one hand, if you draw it all down, a traditional comprehensive major medical plan kicks into place and you're not going to be left without coverage. However, you have a deductible and coinsurance to meet. If, on the other hand, you have money left over by the end of the year in that savings account, it rolls over to the next year. Those are typical plan designs in looking at the savings account.

We're really seeing the principles of free market and comparison-shopping applied to health care. It is a leap, and there's no question that it's putting the responsibility on the consumer. It's responsibility that consumers have been asking for in moving toward what's been coined CDHPs. Again, a typical plan may consist of a base comprehensive major medical plan, a savings account that covers routine and preventive care, and information tools that allow the consumer to go online or call a customer service representative (I'll give some examples of going online) and really look at three different areas.

They're able to see their benefit plan and track their balances and see how much of their savings account is funded. They're able to do provider searches and price and quality comparisons of their providers. Lastly, they're able to access medical content. If a patient has been diagnosed with diabetes and wants to look up information, that person is able to access information on diabetes and what to look out for in terms of what comorbidities there may be. Should that person be going in for a hip replacement when he or she has diabetes? All this information is available.

A member would sign up for a plan and get a home page. On that home page, the member would see what his or her savings account is funded at, and as he or she utilizes services that fall into the savings account, would be able to see and track that balance for him or herself and the family. The member would then be able to access provider information.

For example, I need a knee replacement; where should I go? I would be able to put in my ZIP code and see, within 10 miles of where I live or 10 miles of where I work, who's available in my marketplace to handle a knee replacement. I would be able to go out and look at the range of physicians in the area performing this type of procedure and access quality measures about that individual physician. Those quality ranges today are all over the place. I think the ideal of where the industry is headed is to be able to put quality measures out there that say where the person went to medical school, where he or she has admitting privileges, and how many knee replacements has he or she done. That would be good information. Excellent information, I think, would be not only how many the physician has done, but what were the outcomes? How many readmits were there? And so on. I think we're a ways away from having excellent information out there. There's good information out there today.

Then the consumer would be able to do some price comparisons. I know that my plan would pay $175 for the initial assessment and office visit for my knee replacement. Of all these physicians out here, who charges $175 or less and who charges more? Then let me base some of my decisions on this, because it's going to be my benefits that are affected. Let me see what kind of prices are out there. This kind of price transparency is new and groundbreaking, and I think it's something that will continue to grow in the marketplace because consumers haven't seen it. Go ask a small employer and the 15 employees how much a knee replacement costs or even how much an office visit costs. The answers are all over the place. There is no idea from a bright group of people in an entrepreneurial business what these costs are. They're going to have access, and today they have access to this information, to begin guiding some of their own decisions in their use of their benefit dollars and in their selection of who's going to perform the services for them.

In addition, again for most plans, the employer has a home page in which it is able to see and perform basic administrative functions. The employer can add, delete, change addresses and draw down forms through the Internet and manage its employer groups. Generally the distribution system has access and has an agent home page in which it is able to look at the status through underwriting and through claims of its member groups.

What's going to make this all happen? I would say that the continued and aggressive push of providing information to consumers is going to make this happen. Over time, you're going to see more and more consumers asking for access to information and be in a position where you have to respond with it. As for

accountability, I believe in the theory that people are going to spend their own benefit dollars differently than they would using a co-pay or a benefit plan that's simply selected and pushed on them by their employer. Consumers are using the Internet. They will go online to access and manage their benefits and look for medical information and access expertise. Basically consumers are curious, and they want choice and they want to know what their options are.

From the employer's standpoint, I can give our own experience because our market is the fully insured 200- to 250-employee group. Employers get it. It isn't such a great leap that employers and their employees don't get it. When you get down to a 15-life group, the employer is the employee and generally a close-knit decision is being made. They understand that putting some parameters around a benefit plan, letting people access it through a savings account fund, and having a wraparound comprehensive and catastrophic plan for that smaller percentage of the population that used those dollars is something that works. They're treating this like other business decisions that they've been making. When they go out and buy office equipment, they price shop, and they understand the value of price shopping. Employees can understand the true cost of health care; they've just been insulated against it. I think we're going to see a great acceptance of this from the employee segment.

From a provider standpoint, I think this is one of the few things that has come along that will really stimulate competition among providers. I was talking with Jim Oatman from Milwaukee, where there's a lot of news lately about providers in the marketplace trying to market against each other with who has better prices and why their services are higher quality. See what happens when you put all the physicians in the marketplace who do knee replacements and put their pricing and quality measures out there. Things are going to tighten up, and providers will respond. Is there pushback? Absolutely. Over time as the guy down the street has his quality indicators and price out on the Internet, is that going to change the thinking of the provider community? Absolutely. For the CDHPs, in my view the naysayers call this a fad. I would say, clearly based on the early adopters from the small employers to some of the much larger employers that my colleagues are going to talk about in a few minutes, it's happening. It is more of a trend than a fad. We will reach a point where we look back and see CDHPs and defined contribution as what managed care was in the '90s and HMOs were in the '70s.

I'll leave you with the thoughts that, in a few words, are behind this movement. Customer empowerment clearly is at the top of the list. Customers want information, they use it when you give it to them, and for the early sales that we have out there, absolutely more people are calling customer service and making people look it up for them. Are we seeing the movement of them accessing it more from the Internet and less through customer service? Certainly. That's just going to take time and it's something that we expected and that we knew was going to take time.

As for innovative products, there is the move away from restrictive benefits, allowing people to go to any provider, but having responsibility out of their pocket when they do go to any provider and knowing up front where their exposures are. I think these are going to become more and more common features in these plan designs. Information tools are going to get more and more sophisticated and more and more adequate as the information is available. Numerous platforms have been developed that allow the access through the Internet to these kinds of quality and cost indicators and allow that transparency in terms of price and quality that we've never dealt with before. These are now available and are being used.

It's too soon to tell, and I hope there will be a session here next year and the year after to look back at some of the experience, but the ultimate goal is more stable and predictable pricing in the industry.

I'm now going to hand the program over to Dave from Definity.

MR. DAVID TUOMALA: I am Dave Tuomala, the actuary for Definity Health. We're another start-up company, similar in many ways to HealthMarket, with some notable exceptions that we can probably address during the question-and-answer part. Probably the biggest difference is that we're focused primarily on the large, self-funded market and not the insured market. HealthMarket is definitely focused on the small-group insured market.

I'm going to cover four main topics today. First, I want to do a brief overview of the market environment, particularly with respect to what the thinking was like a year ago at the Dallas meeting and where I think it is today, at least from my perspective. Very briefly I will talk about how the Definity Health Plan works, which Lindsay has already covered much of, and probably my main topic is some of the common criticisms or concerns that people bring up about consumer-driven health care. I think there are a lot of misconceptions out there, particularly in the media in some of the articles about that, and I wanted to go through those step by step and talk about those. Finally, I will show some very preliminary results related to the experience under our plan.

I'll start with some of the market environment issues. Just from my own impressions from the Dallas Spring meeting last year, I think we found that there's really a confusion of terminology being used. There was a lot of one-size-fits-all terminology where we talked about defined contribution, e-health, consumer health, and probably a variety of other terms that I'm just not thinking about at the moment. There was a tendency, I think, to put them all in the same category and say, "These are all the same things." I think if you look closely at the business models, there are a lot of competing business models that were very different. People weren't differentiating at all between those models, again saying that they're really the same thing. I think there was a lot of focus, too, on e-health and the dotcoms and everything else. There was a lot of skepticism regarding these start-up companies, and they were really lumped in with the dotcoms. It was said,

"These companies aren't going to survive." At the time there was really not a lot of hard information about what people were really doing as far as announced employer clients. Certainly there were employer clients. Definity Health had many clients at that point, and we had a lot more that we had sold but not announced yet, so there was some skepticism surrounding that, too: Will people actually buy this concept? I think now the environment is radically different, at least as we sit here today. I think certainly CDHPs have become the recognized early leaders in this market. You've seen a lot of the competing plans sort of go by the wayside. A lot of that has to do with that dotcom blowup and the lack of venture capital funding, but certainly consumer-driven plans are out there in the lead. We're certainly seeing an accelerating employer acceptance. I'll talk a little bit more about that later.

We've seen market entry by the traditional carriers, including Humana and a lot of other ones as well. Certainly, there has been a lot of significant positive media coverage, or at least semi positive or nonnegative. But in both the trade and the mainstream, I think it would be hard to find a major publication that has not had a story about consumer-driven health care and talked about HealthMarket, Definity Health and other players. Certainly, there's been increased interest and acceptance by the benefit consulting community. At this time last year, a lot of times we were out really pushing ourselves to benefit consultants to get into requests for proposals (RFPs). Today, a lot of times it's just a natural thing. They'll do a consumer-driven RFP as part of their process, so it's really not as hard to sell as it was even a year ago.

Briefly, I'll talk about the three components of Definity Health Care. We've got the PCA, a kind of health savings account, which includes benefit dollars to pay for those first dollar health expenses. We've got a health coverage component, which is really just a high-deductible health coverage PPO plan that would cover things after the PCA is exhausted. Then the third component, which in some ways is probably the most important component, includes the health tools and resources. That's really the care support, the online tools and things like that that help people become consumers, because today as Lindsay mentioned, people don't really know what things cost. They don't know what treatment and alternatives are available besides what their doctor tells them. This gives them a lot of information about what things cost, what alternative treatments are available, and some prescreened health content that helps them understand their disease and what the expected treatment protocols are for those diseases.

How does it work? Basically, a PCA is for those first-dollar expenses. This is all employer money; you're not contributing to that. It covers traditional services, but can cover nontraditional services as well, so a lot of employers will put in some expanded-scope items like massage therapy or alternative medicine, things that are not traditionally covered by health plans. As Lindsay mentioned as well, unused balances will roll over at the end of the year, so if you don't use the entire amount you can carry that over into the next year.

Typically we pay preventive care at 100 percent. That's actually one of the common criticisms, that these types of plans don't promote preventive care and that people will hoard their dollars and not get the care that they need. Actually, that's one of the reasons that we do that; we think it's important that people have incentives to get regular preventive exams. Finally, the health coverage piece just covers costs that exceed the PCA.

Member responsibility, of course, is the part in the middle. All we've done here is move the member responsibility from that point-of-sale type limited-amount co-pay to a fairly substantial amount that takes place after the member has used up his or her PCA.

I want to give you an idea of what types of benefits are actually being offered by employers. A typical employer is offering a PCA deposit of about $1,000 for single and $2,000 for family. Frequently, there's a middle tier in there as well for the two-person type of contract. The range, though, is anywhere from $500 to $1,000, and I think we've actually quoted in 2002 some groups that have had PCAs above $1,000. The most common deductible is about $1,500, although we've had a good range on that, from as low as $1,000 up to as much as $4,500. Coinsurance most frequently is 100 percent in network, and most commonly about 70 percent out of network, although we've had a range on that as well (80 to 100 percent for in network, and 50 to 80 percent for out of network).

I'll talk briefly about our client list. In 2001, we started out the year with three external clients enrolled. We had Definity Health employees enrolled as of October of 2000 already. We had three clients enrolled with about 5,100 members on January 1, 2001. By the end of the year we had 7,000 employees or members, I should say; we had one additional employer that joined in October of 2001, but most of that growth was through new hires through the existing employers. As of January 1, 2002, we had 16 clients with 24,000 members, and as of July 1, 2002, we have 26 clients with about 40,000 members enrolled currently. We have obviously a lot more who have been sold for effective dates later in 2002 as well as 2003 and quite a few more besides that that are in the final stages of the sales process, so we've seen exponential growth in the employer adoption of these plans.

I'll jump right into the common criticisms, and probably the first one that always comes up is the aspect of risk selection. This says CDHPs are great for the young and healthy people, but terrible for everyone else in the world. Under our plan we've seen an average age and sex mix. Obviously that doesn't relate directly to risk selection, but it is generally a component of that. When we've looked at our enrollment results and really analyzed those, we've found that it really suggests that people choose this plan the same way that they choose any plan. They're looking at things like contribution and plan design. Is it a rich plan? Is it a poor plan? Do I pay a lot? Do I pay a little? It's the same kind of thing that they always do. I don't think that anyone would argue that considerable risk selection exists. Any time you have a multiple-option plan; you've got that potential in there, so this

really isn't anything new. We are offering only self-funded options, and generally speaking if that's all you have in a plan, that tends to minimize your risk selection. I would argue that risk selection is always an issue, and it's really not something that is tremendously different. I think the conventional wisdom always says you'll get all the young and healthy people. If you actually dig deeply into that, you'll find that you should have at least 20 percent enrollment because 20 percent aren't going to have any claims at all. In reality, you should probably have about 70 percent enrollment in a given group, because 70 percent of the people aren't going to have claims that are above their PCA either. We haven't been seeing that, obviously; I think I would be a lot happier if we were, but I really just think that's not a very valid concern.

In the same breath, people often talk about the cost shifting. Probably the second issue is that employees are assumed to be worse off under a CDHP than they are under a traditional plan. That's really not true either. I think this comes up most often in the media, but I think there's just a lack of understanding of how health plans really work or, in fact, how much cost sharing really exists in plans today. Most employers that we've worked with offer a plan with similar actuarial value to the plans that they're offering today, so there isn't really a benefit reduction for most employers when they're doing this type of a plan. Obviously most employers, at least the very large employers, are offering a choice, so you have a choice of a CDHP or a traditional plan. If you really feel like you're getting a bad deal with the CDHP, you can stay on the traditional plan.

We also found in doing modeling for employers that the total out-of-pocket expenses for high claimants—and high claimants are very liberally defined as having $5,000 or $10,000 in annual expenses—are often the same as or less than with traditional plans. We don't have co-pays that are evergreen, that don't stop with an out-of-pocket maximum. Our out-of-pocket maximums, as you've seen earlier, defined as the difference between the PCA and the deductible, are frequently pretty small, in the $500 to $1,000 range. I think most plans that you're seeing today would have at least an out-of-pocket maximum of $1,000, commonly higher than that. Also, the role of our PCA balance is at least on a long-term perspective. If you think about the episodic nature of health care, over a longer-term period, five to 10 years, people typically would roll over some balance at some point in time, and their out-of-pocket amount measured over that long-term period may, in fact, be less as well.

Another favorite topic to bring up is that employees will hoard their money and forego necessary care because we've given them incentive to do that. I would refer to this as sort of the nail-in-the-forehead kind of concept: "I had a nail in my forehead, but I opted to have it removed." You think about it: "Am I really going to do that?" I guess our focus is on reducing discretionary care, not necessary care. As I mentioned earlier, we encourage preventive care to be paid outside of the PCA. I think you could argue that even uninsured people generally get truly necessary care at some point. They may not get it in the most appropriate manner or the most

appropriate place of service, but frequently they do get that. I think people are going to get necessary care, even under this plan, and we really haven't seen any evidence to date that would suggest that they're not getting it.

Less frequently brought up is pricing risk. In that, CDHPs are an unproven concept. I think it's certainly true that it's an unproven concept, but I think when you again dig down beneath the surface, you're really talking about pricing a high deductible plan, and I hope we're all well versed in how you might want to do that. Certainly it uses well-established actuarial methods and assumptions. There's nothing really unique and frightening about that. When you talk about current-year PCA, you can treat that like a cash benefit. There are obviously other options that you can look at, but you can treat that as just a cash benefit even though, in fact, it is not.

Long-term PCA benefits are a more complicated issue, but I think they are interesting in many ways. So far I think that employers have really looked at this as a one-year time horizon. You start thinking about the long-term horizon and the other assumptions that you might need to start building in as far as termination rates and how much balances roll over from year to year and things like that. Then it starts getting complicated and becomes more of a multidisciplinary type of an exercise. Certainly we have the tools to do that kind of modeling. To date, though, employers have not really asked us to do that. They've been looking at it like they've always looked at it: What is my cost this year? What do I think my cost is going to be next year? They haven't really dug deeply into that sort of thing, but I think that is an interesting future development.

Lastly, and I think this is the last one, high-class claimants use most of the services, and so there's really no opportunity for behavior change. I think that you frequently hear this from the semi-informed population and people like medical directors or CEOs, for example, who tend to know a lot about health care, but not necessarily a lot about the actuarial aspects of it. Certainly, we use all the managed care tools in working with the high-dollar cases. We've got some enhancements that we're using that aren't typically being used, but generally speaking we can handle those. We're involved with the management of those and the reinsurers or stop-loss carriers are typically involved as well. I think no one would argue that large claims are unpredictable, both on an individual basis and on a group basis. Hence, we have things like reinsurance and stop loss. I think you can safely say as well that large claimants use a high portion of claim dollars.

However, if you look at all small claims as a proportion of total claims, small claims are actually a very high percentage as well. Frequently as much as 30 to 40 percent of the total claim dollars are below some number like $1,000 or $1,500. So large claimants are also small claimants if you think about it. When you tie that together with the unpredictable nature of large claims, I usually start out the year as a small claimant and I have no idea that I'm going to become a large claimant. Therefore I have the same incentives that everybody else does until I become a large claimant.

When I become a large claimant, I shift over into that managed care environment in which someone is overlooking my care and making sure that it's appropriate.

Behavior changes really involve nondiscretionary services like office visits and drugs. It's not so much things like hospitalizations and surgeries. People with chronic conditions, I believe, have more frequent opportunities to change their behavior than very healthy individuals do. You figure out that someone who is very healthy doesn't visit the doctor very often. What can that person do to really reduce health expenditures? Well, you really don't need that person to reduce expenditures because he or she doesn't really have any. It's really that person in the middle category, the chronic person who is using a lot of services, who actually has a lot of opportunities to change what he or she is doing—things like prescription drugs, frequency of office visits, that sort of thing.

I'll just go briefly into some of the results that we've seen. We've seen a tremendous usage of nurse-line services, which is really what we've hoped for, that people are using care appropriately. They are looking for advice on whether they should see a doctor or not. We're seeing rates that are nearly twice the benchmark. The benchmark is coming from our nurse-line vendor and represents calls per thousand, which are the total number of calls, and member usage, which is unique member usage. One person in the first group could call multiple times, but not in the second group. Most of the calls we are getting through the nurse line, about 76 percent, are symptom-based. This is as expected since nurse lines are for things that are symptom-based, and particularly for things that people have some ability to either go or not go. This includes things like acute sore throats, coughs, and minor symptoms, where in many cases the appropriate thing is not to see the doctor, so we're pretty excited about that. We believe that these statistics provide some evidence that people are appropriately accessing care when needed rather than forgoing necessary care.

One of the areas that is reasonably credible because we don't have lengthy claim lags is obviously prescription drugs. We've seen continuing through 2001 and actually into 2002 as well, very low rates of prescription drug utilization, really when compared to any reasonable benchmark, as illustrated by the 2001 utilization statistics in Chart 1. The two numbers that we have here as benchmarks are from our pharmacy benefit manager. We use Medico, but we've been running consistently in the 0.5 range, which I think most people would agree is fairly low. Granted, we have a fairly small population, at least in 2001, but even in 2002 with about 24,000 members at the start of the year, we're still below 0.6.

With PCA claims, I think this is interesting. As illustrated by our 2001 claim statistics, we found that the pattern of expenditure there is also really what you would expect to see (Chart 2). People exhausted their balances over the course of the year. We had about 60 percent of total employees have a PCA balance to roll over at the end of the year. The average was about $400, a little above $400, and in total about 72 percent of the available balances were used by the end of the

year, and that's on a cash basis without completing that for run out. It was interesting, though, that most employers offered some extended services for things like vision, dental and alternative therapies, as I mentioned earlier. We only saw about four percent of PCA dollars used for those services during 2001. One of the other criticisms that people bring up is if I give you extended services, you'll just use it all right away. In fact, people didn't use it all right away. They spent very little of it on those extended services.

I have just a couple of employer examples (Chart 3). The first one is actually self-reported in *The Wall Street Journa*l. We had Ridgeview Medical Center as one of our clients, with about 700 employees. They had about 82 percent enrollment in Definity Health. They claimed that they saved $480,000 in the first eight months of 2001; that was self-reported, obviously. We've done some work with them recently. We think the real number is probably closer to $200,000 to $250,000 over the full year, but still, for the size of group that they had, it's a very encouraging result. Actually, they were a very high-enrollment group, too, so the risk selection is less of an issue for them.

Table 1 is another example, a low enrollment example, also for 2001. They had about a 15 percent enrollment mix. We actually saw slightly higher inpatient admission rates, although that's not too disturbing given the size of the population, but we saw fairly substantial decreases on both office visits and prescription drugs. This is in just the services-per-thousand category. I guess emergency was a little bit equivocal, between 40 and five percent. So there could be some risk selection involved in this, but there are actually very encouraging results as well.

Table 1

2001 Employer Example (Low Enrollment)

	Plan A	Plan B
Inpatient Admits/1000	3.2% Increase	2.5% Increase
Office Visits/1000	28% Decrease	24% Decrease
Prescription Drug Claims/1000	29% Decrease	25% Decrease
Emergency Room Visits/1000	40% Decrease	5% Decrease

The last group is actually our first full replacement, which was effective October 1, 2001. Obviously we don't have a lot of data yet on this group. We were able to get some comparative information from their prior carrier. It's specifically for pharmacy, because that's obviously complete and not subject to a lot of the data issues we would typically have. We've seen fairly substantial reductions, even year over year, compared to their prior carrier. This is for a practically identical population, so you can sort of ignore the risk selection issues on that one as well. Essentially, I think we're seeing that what has happened is what we would have expected to see happen. For those discretionary services, things like office visits and drugs, people are using less of those services, at least from a frequency perspective.

MS. GRICE: Thanks very much.

MS. PENNY HAHN: I want to take you through the case study of what we did at Humana for our own employees. Because I know a lot of you are probably a bit skeptical, I'd like to say that we were also very skeptical when our product development associates came to us and asked us to price these kinds of plans and offer so many choices to employees. We had the typical actuarial reaction: Are you guys nuts? We can't do this. As we went through the enrollment process and saw how employees reacted, we saw dramatic changes in the way people we work with think, the way they behave, the way they talk, the way they consider what kind of health care to purchase, and when to purchase it and when not to. So we have seen a dramatic change in how we're doing things.

I'm going to talk to you about what we call MOCHA. It's not coffee. It actually stands for More Options and Choices for Humana Associates. That was the internal name we used when we rolled it out to our own employees. When we market outside of Humana, we call this product Smart Suite, if you've heard that name in the marketplace.

I want to take you through a bit of the history of why we decided to do this, and then at the end I'll get into the actual numbers and the results that we're seeing so far. MOCHA is the beginning of the next generation of products that we're looking at. Like Definity, we're offering some new products with some first-dollar coverage and some catastrophic deductibles in between there.

We wanted to have consumer choice in these products. We wanted to use the new technology. The Internet-enabled employees have more access to information. We wanted to give employees flexibility and choice, and we wanted to make these products more cost predictable. This seems like an oxymoron, but in reality I think we are getting there.

We did this because our own health care costs were rapidly rising. We had concerns over associates' ability to absorb the full cost. The company could not keep funding the full increases, so every year more and more costs were being shifted to the employees. The concern was the employees couldn't continue to pick those up. We're not alone. A lot of insurers out there in the marketplace are facing the same issues, as you're all aware of, so we wanted a solution that was not only short term, but also was long term. We didn't want a one-time fix of changing benefits or benefit buy-downs, but something that would actually impact the way consumers look at health care and make choices.

The solution was that we must allow the employer to manage trend while retaining employee choice. The market is pretty competitive, and you want to offer attractive benefits to retain the good employees, so that was part of it. We also wanted to educate employees on the tradeoff between coverage and cost. Surprisingly, a lot of employees have no idea what health care costs really are, and they're used to accessing the system without having any idea of what surgeries or office visits really cost. We wanted to increase benefit-design cost sharing so that would engage the consumers, and so the consumers would rethink how they're doing things. Our response, as you've heard before, is the CDHP.

The preliminary results that we've seen are real good. We started with our Louisville-based associates so that we didn't have to deal with multimarket issues and things like that. We have 5,000 employees in Louisville, so that was a fairly large, credible population to work with. We offered our initial plan on July 1, 2001, and before the enrollment, which was in May 2001, we did extensive education with the employees. There were letters from our CEO stating why we were doing this and why it was important for the employees to get engaged in what we were doing.

We had seminars for the management in the company. The management was supposed to go out and help sell.

Our president keeps telling us we're all in sales and enforces that belief by training us and having us educate all the employees in the company. We also created what we call an electronic wizard, which is actually on the Internet. Employees can go out there and answer a series of questions about their personal usage. This helps direct them to the plan that may be best for each person's situation. There were also posters and reminders everywhere. We're seeing that it is very key that the employees are educated on why a group is doing this and why they should consider the choices, and it makes a huge difference. We've marketed and rolled this product out to some of our other customers, and for the groups that have their CEOs and their senior management willing to get involved, it makes a huge difference in the enrollment results you see and the employees' choices.

We offered six basic plans. As I said earlier, I was a little concerned when we initially did that. (You want to offer how many plans to these employees?) We offered a traditional HMO plan, a typical rich HMO with co-pays. We offered what we called a tiered PPO, which actually had different levels of service depending on the provider you were using, and it was very rich if you stayed in the tier 1 benefits basically: a zero deductible and a $1,000 out-of-pocket plan. We also offered a standard PPO plan with a $250 deductible, and we offered what we're calling two CoverageFirst plans. They're similar to what you heard from Definity, except we offer first-dollar coverage. The only services that apply to first-dollar coverage are typical medical services that we would cover under the normal medical plan. We don't include the additional things like glasses and laser in situ keratomileusis (LASIK) and things that are covered under the PCA plan, so that's the only distinction. We offered the CoverageFirst plans, which are a $500 first-dollar coverage per member, and then you go into either a $1,000 or $2,000 deductible.

We had a couple of choices, because we worked with consultants in developing these plans. When we first started developing them, we looked at just offering a $1,000 deductible plan with an 80/20 coinsurance up to perhaps another $2,000 out-of-pocket, a pretty typical deductible out-of-pocket plan. The thought was, if we offered a higher deductible plan with 100 percent coverage, would we get more people interested in that type of plan? When we rolled this out, we offered both plans to see which one employees would be more attracted to. The enrollment results were evenly split, so we saw that some employees were attracted to a real high deductible and the assurance of 100 percent coverage, and other employees wanted a slightly lower deductible and then wanted to know that the insurance company was starting to pick up part of the cost. There were clearly two different philosophies in our survey results. Therefore we continue to offer both products when we roll this out to external customers. Then there was one out-of-area plan for any employees who needed coverage out of our service area.

When I mentioned a reference plan, that just means the plan that we decided to fund basically. We typically would cover about 79 percent of the cost, and employees would pay about 21 percent, so the tiered PPO plan was selected as that reference plan. From there, we used the flat contribution strategy, and every plan was funded at that same level, thereby making the CoverageFirst plans very inexpensive to purchase.

The results were that 11 percent of our employees enrolled in the new plans, which was very good. Before we moved to this plan, we had basically a triple option, which included the HMO, the rich PPO and a catastrophic type plan. In the past, we'd only had maybe one percent of the employees choose the catastrophic plan. When we rolled this out in a different way and used the flat-contribution approach, the education tools, the wizard and all of those things, we saw 11 percent movement the first year into these plans. We had 35 percent in the HMO and 54 percent in the tiered PPO.

One concern we get, especially from human resources directors, is that employees will go without coverage; they will go "bare." We did detailed surveys with our employees, and we can only identify one employee who opted to go with no coverage at all, just because this person did not like any of the choices or any of the plans, and did this. But for the most part, all employees either chose a plan or chose to drop coverage and move to a spouse's plan in some cases.

The results were very interesting. We initially took every employee who selected the new plans and mapped their prior experience back. One advantage we have over Definity is that we have all the past experience of the group. We took their prior experience; they were on richer plans typically—a rich HMO or PPO plan for the most part—and we mapped it to the new plans. We attempted to adjust for benefit differences using standard actuarial relativities. Under the CoverageFirst plans, the $1,000 plan has the $1,000 deductible, 80 percent coinsurance up to perhaps a $2,000 out-of-pocket, as I talked about earlier. The $2,000 deductible plan has 100 percent coverage after the $2,000.

The employees who selected the CoverageFirst plans had lower costs. We studied the age/sex factors on all the plans, and basically the CoverageFirst employees were the same average age as our tiered PPO members in the standard PPO. The HMO continued to attract the younger employees, mostly we think because of being in childbearing years and things like that, as you would typically see. We did see, as Definity said, the same average age on the CoverageFirst plan, but their claims costs were much lower.

As expected, the HMO has been adversely impacted, because we would have expected the healthier employees to move out of there, and surprisingly, we would have thought the same thing would have happened on our tiered PPO product, because it's a very rich PPO plan. However, that is not occurring. We're still looking into why that didn't, but we're happy about that. We did introduce some hospital

inpatient co-pays at the same time we introduced these new products, so we think that's partly impacting it. The standard and CoverageFirst plans are the more catastrophic type plans, and we did expect the improved claims cost there. Surprisingly, if you look at the CoverageFirst plans, they were running $64, $78, under prior richer benefit plans. When we move them to a CDHP like our CoverageFirst plans, we clearly saw a behavior change in these employees and the way they're spending costs.

As I said earlier, we hear a lot of the actuaries did take the CoverageFirst plans in our company, because we did most of the modeling. As Dave said earlier, when you model out the expected out-of-pocket cost on these plans and compare them to the premium contribution differentials and look at your total out-of-pocket cost, a lot of times you're better off on these consumer-driven plans because you have fixed dollars, even if you have higher claims. In particular, I like the $2,000 deductible plan with 100 percent coverage. You know you're just out-of-pocket $2,000, where on an HMO you get hit with co-pays at every service level. If something happens to you and you need a lot of services done, those co-pays add up.

Our total cost was running about $14.5 million. If Humana had done nothing (which is not likely, I like to say, but it's hard to speculate what they would have done had we not moved to these new plans), our current trends in the Louisville market are about 19.2 percent, and we would have expected the cost to be at about $17.3 million. If you annualize out those PMPM projections, it looks like we're going to run about $15.7 million, which looks like an annual trend of 7.9 percent instead of the 19.2 percent we would have expected to be running at. So overall, we're estimating about $1.6 million in savings at this time. I've done everything I can to make those very conservative estimates, because our company is using these as we speak. As actuaries, we've tried to be as conservative as we can with those numbers. At this time we expect that to be a real good estimate for the annualized number at the end of the contract year.

We rolled this product out to all of our company for our July 2002 enrollment, and for the 11 percent number quoted earlier that we had in Louisville, we saw an increase to over 30 percent. Not only did you see reaction the first year, but you also saw changes after more communication. A lot of the Louisville associates talked to people in our other markets and as the word spread, we saw a lot of movement into these plans very quickly.

MS. GRICE: I have a question for Dave. When you talked about risk selection, it was sort of contrary to what Penny has shown us in the results for Humana employees, so I'd like for you to expound on that. Also, you made a statement that there's less risk selection on self-insured plans, and I didn't understand why that would be.

MR. TUOMALA: Let me clarify the second issue first. I guess, for self-funded programs in general, I'm saying that risk selection is less of an issue from an

employer perspective. The selection itself isn't less of an issue. If you're paying for everything, much like if you have the full group on an insured basis, your risk selection is much less of an issue to the carrier in that sense since they have the entire risk pool. Obviously you still want to minimize your risk selection, but it's not a huge issue for you. That's what I was trying to say, so apparently I didn't say that. Related to the first issue, I guess I still don't have in front of me a description of what the CoverageFirst plan designs look like. I think I would say that risk selection is an issue; it's an issue with all plans, and you'll see it, depending on the nature of the plan design that you offer.

I think, in just reading between the lines of the way the CoverageFirst plan was offered, it was positioned as more of a catastrophic option with a lower contribution and more cost sharing than some of the other options. Most of the Definity health options that we've put out there have been positioned as equal options with about the same contribution and about the same actuarial value of benefits, so they are not treated as step-down benefits. They are not treated as a core option or a catastrophic-type benefit. They are treated more like one of the better benefits that you're going to get. I think in those situations we've seen a lot less selection. From a claim perspective, for example, we have not seen claims that look like what Humana has seen. We've seen claim levels that are very similar to the other options that are in there or that are at least similar to what we would have projected, including any differences for benefits and things like that. I think it depends on how you position it, and I think if you offer a more catastrophic-type benefit design, you will get selection, and I think that's true regardless of how you offer that. You could offer three HMO plan designs with a 20 percent difference in benefits, and I think the less rich plan is going to get selected against or get positive selection, and the richest plan will get negative.

FROM THE FLOOR: I am from the employer stop-loss operations of Swiss Re, and one of the things that we deal with day in and day out is the effect of leverage trend, or the leveraging effect of the deductible on trend and how that changes the costs and escalates the costs more rapidly in a first-dollar environment. To what extent have you tried to address this, either in Definity with the employers that are opting for this, or in Humana with the expectations of senior management? To what extent have you addressed those and tried to manage those expectations? I'm looking at what you're doing effectively as having someone else, the employee, take on some additional risk and offering a higher deductible plan so the residual costs are going to be leveraged, I would think. You're looking at a 7.9 percent trend at Humana this year, but I'm thinking, you've got this cloud on the horizon, due to the leveraging effect of the deductible. Have you done anything with that?

MR. TUOMALA: One of the things that we actually project for employers is an illustration of what a 5-year picture looks like for an employer based on no changes in plan design, which is obviously a necessary assumption. But we address the leverage component of that. I think what's different is the size of deductibles that we're looking at for Definity Health. These are typically, I guess, if you recall that

earlier chart, something in the 1,500 to 2,000 range, which is probably the most typical. The additional leverage on that size of deductible certainly is there, but it's not the same type of leverage that you'd see with a specific stop-loss type of a product. We do build that into our projections. What we find is that the defined contribution aspect of the PCA, if you also keep that constant, actually takes care of the leverage and then some, because you're taking a fairly significant portion of your benefit and trending it at zero. Obviously that can overcome a lot of additional leverage on that health coverage component.

MS. HAHN: At Humana we're taking a slightly different approach. We're only offering these products on a total replacement basis, therefore we are only quoting stop loss and our aggregate insurance for the total group. Therefore, in total we think we're coming back whole even though you're correct: Product line by product line you could see the leveraging impact take place.

MS. LINDA ANDREAE: I have a couple of questions. Penny, for the savings numbers that you showed, did those include the costs, the contributions to the personal savings accounts?

MS. HAHN: Yes, they included the first-dollar coverage. It's not really a PCA because we don't cover other medical services, but, yes, it did include those first-dollar coverages.

MS. ANDREAE: Then, Dave, you made a comment. I thought I heard you say that in the long term you assume that the consumers are going to roll over. They're going to save that money; they're not going to use it all, but roll it over for future years. Did I hear you incorrectly?

MR. TUOMALA: I made a comment to that effect. I guess this is one of those areas that I was talking about as being seldom studied or not quite as much. We haven't gotten there yet as far as the theory goes. When you look at what I guess I was referring to there, on average, because you would typically not have year in/year out high-claim expense, it would tend to come in as one larger claim and in-between you would have smaller claims. Certainly, some individuals will exhaust their PCA balance every year and maybe even get into their health coverage year after year. Certainly there are individuals like that. It's a fairly small percentage of your population that's going to be in that category. The average person—again, I was talking about average people—will roll over a balance, and the average person may drive down that balance periodically. But on average, over a 5- or 10-year period, they should have a lower out-of-pocket cost, all things considered, because some of that balance would roll over.

MS. ANDREAE: We're talking theory here, right, because you don't have any data to support that?

MR. TUOMALA: We've done some modeling related to that—certainly not to the extent that we'll probably need to do in the future. Certainly there's no hard evidence that that will happen, other than the fact that we did see in year 1 about 60 percent of employees roll the balance over. If you look at the single employees, it's actually a much higher percentage; you look at the families, it's a lower percentage, which I think is very logical based on how we've arranged the accounts.

MS. ANDREAE: Now, are you telling your employers that they need to go ahead and fund those amounts? Even if they're rolled over, they need to go ahead and fund them?

MR. TUOMALA: The accounting treatment or the funding of those accounts is up to the individual employer. We've established the plan as an unfunded Section 105 plan, so the employer would pay the claims as they come due essentially, so they need to, from a budgetary perspective, understand that their potential liability is greater in year 2 than it was in year 1. Employers are addressing that in a variety of ways, and it really depends on who their auditor is and what their auditor believes is appropriate treatment. Believe me, there's a wide spectrum of what people believe is appropriate.

MR. JOSEPH KORABIC: A couple of questions for Dave. You cover 100 percent preventive, and I was curious how you determined what is a preventive service. Mostly, I'm concerned about colonoscopies, for example, which are fairly expensive, but are not being considered standard preventive care. Secondly, have you done any redirection studies on the nurse-line, as to whether they are actually redirecting people to lower or higher levels of care?

MR. TUOMALA: To answer the first question, our preventive care is offered as a schedule on a standard basis. There are really two approaches that employers have used. Our standard benefit is to use a conventional schedule, and it's based on the pediatric guidelines and preventive care guidelines, so it would be very similar to what people are used to seeing. It's an age-based and sex-based schedule, so it's pretty standard. The other approach that some employers have taken is just to put a dollar cap on that and say it's upwards of $200 maximum a year. Of course, if an individual believes that he or she needs to have a more frequent colonoscopy, and I can't imagine who that would be, that money could be taken out of the PCA

The second question was on redirection. At the moment we do not have the data warehouse built in such a way that we can tie the claims activity back to the nurse-line activity, but we will have that later on this year, and that is something that we're going to investigate more thoroughly.

MR. CHRISTOPHER MATHEWSON: We have a defined contribution program, but it's not the consumer-driven health care type. It's the employer-sponsored type, where we offer our traditional plans, and we give the employer an option to

contribute a fixed dollar amount rather than a percentage contribution. My question is related to the posting of costs online. If low-cost hospitals see that they're among the lowest-cost hospitals, won't they complain to the carrier and try to get an increase for the next time their contract comes around?

MS. GRICE: I have a similar question, Chris, that I was going to ask Lindsay because he's feeling left out over here. Are providers going to go along with that? Are they going to allow us to post that information out there?

MR. RESNICK: We use an outside partner for accessing what's otherwise sold as a PPO network, and in fact, they do allow us to post what's out there, and we post it in a color code and dollar sign sort of like a Zagat guide in terms of high cost to low cost and making it very consumer friendly to go and look at what's out there. Their rates are negotiated, and they may come back and try to renegotiate. We haven't seen that occur yet. They reap the benefit of that positioning in the market of being a lower-cost preferred choice from the consumer when they're going out and looking at that data. I'll just add to the last question about the savings account. Our savings account is structured to cover routine and preventive care with a list of care where mammograms, colonoscopies, etc. would all be covered under the savings account benefit.

FROM THE FLOOR: I don't want to be a pessimist, but I think I'm going to be anyway. Where is this new product going to end up reducing the upward price pressures that we're seeing long term rather than just temporarily shifting like the PPO we see is shifting now, with 18 to 20 percent trend increases. Five years from now are we going to be asking those same questions? Where do we go from here?

MS. GRICE: I guess I'm somewhat of a pessimist, too, to ask that same question. Is this temporary? Is this going to be like with the HMOs? Let's see what our panelists say.

MS. HAHN: As I said earlier, we were very much pessimists when we started. Just from our own employees enrolling in this plan, as I stated earlier, we're hearing people talk differently, so it's a behavior change. It's the mind-shift of employees thinking about this as their own money versus them thinking of this is an entitlement, which is what most employees think of today when you talk about their benefits. For years companies have tried to make employees aware of what these health care benefits are. I've worked at some companies where once a year you get the statement of what your company paid for your health care benefits. You think, wow, that was a lot, and then you throw it to the side and you ignore it. When you have something that you think of as a bank account and you think of it as your own money, you spend that a lot differently than you do when you just think it's an entitlement. You think, I have a right to this benefit and I'm going to spend it to get my value out of this company. It is definitely a mind-shift in the way employees think.

As I said, we've seen it among our own associates in the way they think and the way they talk. You hear people make comments, "Well, I used to go to the doctor because it was a $10 co-pay and I'd get this allergy medicine because maybe once a year I have this problem, and that way I have it on hand to take it. Well, now that this is my money and this is my first dollar coverage. I only really need it once a year, so I'm not going to go to that doctor. I'm just going to get something over-the-counter and treat it just the same." To emphasize, we don't want to change or not cover medical needs that are necessary. But I think we all know there's a lot of waste in the health care system in the way services and benefits are being utilized. From what we've seen, that's the big key. As I said, I was very skeptical, too, until I saw it in action.

MR. RESNICK: You can be a pessimist the other way also. If you put your public policy hat on, I think you have to look at the current system and say, until the consumer and the end user have a stake in the game, we're spinning in circles. Until there is an understanding about cost, and they have an investment in their decision making, I don't think we have other directions to go in. Can you predict out in 5 years where this is all going, because we've never been able to do that before? I go back to the point that everybody in their own plan design or comments has made, that it's time to put some responsibility upon the consumer. Again, as we've been out in the small employer market, we don't see a mass rejection of that. They get it; they understand that they have a role in the future of their ability to offer benefits or have benefits as employees of a small employer or even a large employer like Humana, given the pressures that they were having.

MR. TUOMALA: Let me just build on a couple of things. I agree with the other two panelists. I would say that I started out as an optimist in this. Working for a start-up company, I think you have to be, but I think we're not even halfway there yet. We're at the beginning, and what we're trying to do with consumer-driven health is to give people a stake in their health care. People seem to want that, and it seems to be working okay as a first step. There are a lot of other things that need to happen as well.

Secondly, I guess I would argue that it works everywhere else in the economy; why wouldn't it work in health care? The thing that's different about health care is that it's largely somebody else's money. You could argue that that wouldn't work in almost anything else that you have to pay for. If your employer was buying your house, I imagine that your house would cost a lot more. There's a free lunch in health care, and there isn't really anywhere else in the economy. To the extent that economic principles work everywhere else, I can't imagine that they don't work in health care, too.

MS. GRICE: They convinced me.

MR. DAVID MAMUSCIA: Detroit is still dominated by big labor, which negotiates benefits particularly for the auto accounts and sets a pattern. Have you, first of all,

talked to any big labor groups about these forms of plans? In your judgment (probably more for Lindsay), do you see these being adopted or accepted by the collective bargaining process or big unions? I'd like to add a comment. It takes away one of the key roles of the union to represent employees and design the benefits, and by empowering the employees, it seems in my judgment, to weaken the reason for the unions.

MR. RESNICK: We have not approached unions at this point. Looking at this industry segment, were they adopters of managed care? No. Will they be pulled along? My guess is yes. I think that as health care and the cost issue continue to bubble at the negotiating table and apply more and more pressure, they're going to need options like any other group that's out there. I would hold Humana out as a large employer example that was wrestling with this issue. I don't know if you have any union members.

MS. HAHN: We have a few.

MR. RESNICK: We haven't approached that industry segment yet.

MR. RICHARD HALL: I have two questions on Definity. First off, I'm an actuary now in sales, so I think it's eating away at my brain. I want to believe in that product so badly. The question I have is, you had mentioned 20 percent of the people don't have claims, which I think we all know; 70 percent don't hit the $1,000 or $2,000 contribution, or whatever it is. How does that lower costs? I realize people aren't going to use benefits as much, but if you're giving somebody $1,000 that didn't have claims before, how does that lower overall cost? That's the first question.

MR. TUOMALA: I think what we're talking about—and I guess I made the same point—is that you're really not after the healthy individuals to change behavior because there's not very much behavior to change. You're really looking at those larger dollars in the middle of the claim distribution. It's the people who have chronic illnesses, who have the ability to change their treatment regimen or the frequency of their physician visits, or to just use care more appropriately—that's who we're really looking at. I would agree with you. I think that at the low end of the spectrum, there's not a whole lot you can do there, although there are a lot of acute visits and a lot of acute prescriptions that are obviously filled inappropriately. How often do you actually get an antibiotic for a cold? A lot. There are a lot of those things as well.

MR. HALL: I guess my question concerns not changing the utilization. This is for somebody who's not going to have claims and now the employer is funding $1,000 and they get to keep that money, whereas before that money went to lower the rates for the overall pool.

MR. TUOMALA: Right. Part of it is we're balancing it actuarially, so we're looking in simplistic terms at, say, an average cost of $4,000, and we're allowing $1,000 for the PCA. We're looking at what kind of health coverage you can buy for the $3,000 that's left, so that's a balance issue. Generally in talking to employers, we treat the PCA as if it were all used because it does roll over. If you actually project that out over a long period of time, you find that most of it—a very high percentage of it—is used.

MR. HALL: I have a last quick question. When employees leave the employer, do you allow them to take the money with them, or does it revert back to the employer?

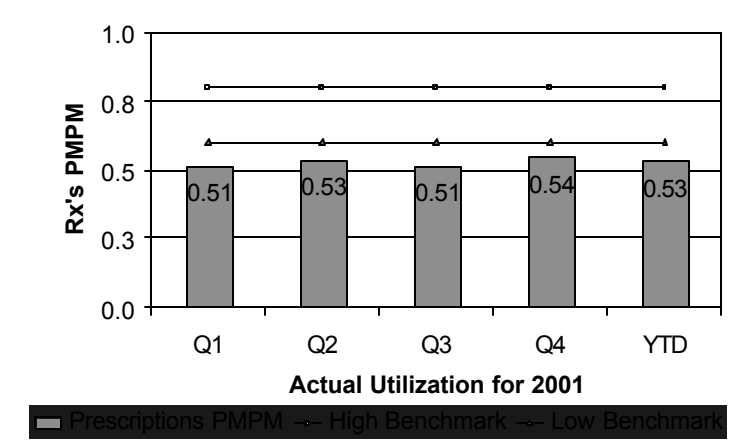
MR. TUOMALA: Actually, that would be complicated. I think it's probably doable under current tax law, but complicated. Currently, you cannot allow cash out and still maintain the account on a tax-qualified basis. You could in theory allow employees to take that with them through some sort of mechanism that the employer set up much like you do now; COBRA is certainly something we would have to do. Some employers have opted to let retirees spend that balance down if it's remaining; that's fairly easy to do. You just keep them on the plan. We haven't had any employers approach us and say they'd really like to keep terminated employees on the plan for another 10 years.

MR. HALL: I guess my concern would be the run on the bank, when somebody knew they were going to leave the plan and they had money built up.

MR. TUOMALA: I think the response to that is that there are really not that many things that you can use in a discretionary basis and time that well. Certainly there are some dental things and some vision things and stuff like that. We haven't seen any behavior like that so far. In fact, we've seen very little of the dollars spent on those services.

Chart 1

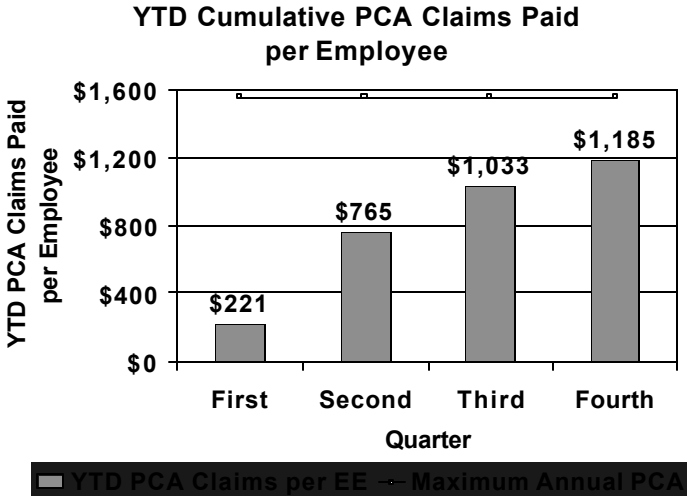
2001 Utilization Statistics



Reflects Rx data through December 31, 2001.

Chart 2

2001 Claim Statistics



Claims data incurred January 1 through December 31, paid through December 31, 2001.

Chart 3

2001 Employer Example (High Enrollment)

***Wall Street Journal,* *January 8, 2002,* 'Health Plan That Puts Employees in Charge of Spending Catches On'**

"… Ridgeview Medical Center, a Minneapolis hospital system where most of the 700 employees signed up with Definity in 2001, the system saved $480,000 in the first eight months"