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Session 64PD
Developing a Successful Defined Contribution Health Plan

Track: Health

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Summary: Panelists use defined-contribution health plan case studies to review *successful plan designs, effective plan communication strategies and plan implementation issues. Attendees gain valuable insight on how to develop defined-contribution health plans.*

MR. DAVID TUOMALA: My name is Dave Tuomala with Definity Health out of Minneapolis. With me on today's panel are Dan Plante, from PWC Consulting in Chicago, and Linda Ruth, who is not an actuary, from Hewitt Associates. As far as the session's overview, I'm going to talk about Definity's health experience around some of these issues. Dan is going to talk about some actuarial modeling and assumptions. I believe he also has some case study material. Linda is going to talk about the employer perspective and some of Hewitt's clients' experience around offering these types of plans.

I'm going to talk a little about Definity Health in general, including what we've been up to and some of our clients and enrollment results to date. I also am going to outline some common employer concerns that we've experienced and some of the impacts that those might have on this. Finally, I'm going to give a brief summary of some of the results that we've seen.

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Note: The charts referred to in the text can be found at the end of the manuscript.

Definity Health was founded in 1998. We're in Minneapolis, Minn.. We have raised about $63 million in venture capital to date. Considering the market that we've been in, it's no small feat to raise that money. We were actually the first ones out marketing consumer-driven health care (CDHC) in April 2000, and we also had the first enrollees in October 2000. We still focus on the large self-funded employer market.

We've worked with many clients since we started in 2001. We started with three external clients and about 5,000 total members on January 1, 2001. We started out in 2002 with about 30 clients and a total of about 48,000 members. Moving on to 2003, we now have over 58 clients and roughly 170,000 enrolled members, so there has been a lot of activity and a lot of interest in this kind of plan design in the past couple of years.

What is a successful consumer-driven health plan design? The key point here is to make this transition from passive participation in the health care system to becoming active consumers. In my mind I always think of an active consumer in health care as an active consumer anywhere else. It's a little more difficult to be that way in health care, but I think that's the end result of the goal. To that end, there are three key elements. First, you need to have plan components that offer financial incentives. We believe it's important that those financial incentives are at the point of care, not just once a year. Often people will use a choice model or more of a defined contribution model and call that "consumer driven." My perspective is that that's consumer driven "light," at best. Second, you definitely need tools and information to help educate members and help them become consumers. Clearly today's environment in health care is not like it is buying groceries or buying cars or other consumer markets. There's a lack of information and a lack of transparency out there. Third, we also need care support that engages. It must be more member-centric care support as opposed to health plans. It must focus on quality, patient safety and satisfaction. Catastrophic, plus health reimbursement account (HRA) design is one design. It's the most prevalent design right now, but certainly not the end-all, be-all design. I think a lot more innovation is possible.

I'm going to explain very briefly how a CDHP design works. We've got a personal care account (PCA), which is what we call the HRA component. Basically it's an employer-provided money, first-dollar benefit, account-based kind of a thing, which rolls over from year to year. We have health coverage, which is basically just high-deductible health insurance. It pays after the PCA is exhausted, and has nationwide provider access. We do include first dollar preventive in our benefit. Not everyone else does that. Lastly, and maybe most importantly, are the tools and resources and all of those things that help you become a consumer in health care. These include traditional care support services, NurseLine, coaching, notification and easy-to-use resources and information.

I want to go briefly through some of the results that we've seen. Table 1 shows a breakdown of the clients by size. As I mentioned, we're mostly focused on the larger end of the market, so you can see that most of our clients are toward the bigger end of the scale. We had 13 total replacements as of January 1,2003. We have 14 clients that offer retiree coverage as part of their benefit design.

Table 1

Client Size (# of Employees)	Percent of Clients
<500	12%
500-1,500	23%
1,500-5,000	25%
5,000-15,000	17%
15,000-50,000	17%
50,000+	6%

We had a very broad range of enrollment results and this gets us to the focus of this presentation—what works and what doesn't work. Table 2 shows our 2003 enrollment. We've had a handful of clients (about five) that were less than 5 percent enrollment on an option basis. We've also had seven that were greater than 20 percent enrollment. We'll talk later about what has worked and what hasn't worked. From our perspective, and from most employers' perspectives, success would be probably in the 10+ percent enrollment. I think most of them would view it negatively if you're offering a new plan design, going through all the effort to bring that in and you get three percent enrollment. That isn't very successful.

Table 2
2003 Enrollment

Percent of Eligible Enrolled	Number of Clients	Percent of Total
<5%	5	12.2%
5-10%	15	36.6%
10-15%	5	12.2%
15-20%	9	22.0%
>20%	7	17.0%

What kind of offerings are we seeing? Charts 1 and 2 show our plan design offerings. Quite a few of our clients actually offer more than one consumer-driven design with Definity. Normally that's a single personal care account with multiple deductible levels that vary in contributions. They might have two or three different options of that, along with the other options that they also have, such as point of service or PPO.

Personal care account levels were most frequent. There's typically a $1,000 individual account, usually $2,000 per family and something else for employee plus one. Next popular is probably $750, something in that range. So fairly substantial amounts are offered.

One of the things that I think is less well known is that the posturing associated with these plans is not generally catastrophic. Most of our clients are somewhere in the $500 to $1,000 range (on an individual employee basis), meaning the difference between the personal care account balance and the deductible level. We have seen a lot of clients also at the 100 percent of network coinsurance after that gap is satisfied. We're seeing a movement away from that with more recent implementations.

Chart 3 is a summary of some of the analysis we've done of our actual enrollment results. It is a 2002 analysis, in which we actually looked at a variety of indicators or measurements and tried to determine if any of those were statistically significant. Granted, we had a fairly small sample size so the degree of credibility around the results is not spectacular. All the elements on this page were things that we found to be significant. What's important, though, probably are the first, three or four of those, and the first two in particular measure kind of the same thing. We talked about Human Resources (HR) support. What we meant by that was how motivated was the client, the HR team and senior leadership in the company. Were they excited about the plan? Did they give a lot of support to it? The second one was employee access. Did we do a lot of meetings? Were we able to communicate with employees through face-to-face meetings, e-mail or things like that?

Was contribution rating high, low or in the middle on how the contribution for our plan design ranked with the other plan designs that were out? Probably the last important factor was the PCA and deductible gap. We talked about that measure before. Was it $1,000 to $1,500 or was it $1,000 to $2,000? A lower gap for richer benefit design typically led to higher enrollments.

For 2003, we had more clients and better data around what worked and what didn't work. In Chart 4 we used a different set of measurements and did more of a subjective look at things to try to isolate by thirds—top third to bottom third—on enrollment. The top third had about a 23 percent penetration rate, the middle third was a rate around 10 percent and the bottom third was about 4 percent.

What we found was interesting and I guess it was not counterintuitive. If you have plan disruption, such as canceling an option or making significant changes to your contribution strategy that affect a considerable number of employees, that typically leads to higher enrollment results. We've also seen that with new hires our penetration rate is often higher. Meetings per thousand eligible is a proxy for how many meetings an employer actually had.

We found through that analysis that there are key enrollment drivers. Plan disruption is important. You need to have a decent plan design versus the competing options. Pre-enrollment Web-site utilization is a driver, which I think is just an aftereffect. If people are interested, they're going to use that. Effective meeting strategy, supportive HR and duration communicating are also key

enrollment drivers. Most of our really good enrollment results have been based on a preliminary period getting people used to the plan design, then actual communication and enrollment period. They've spanned quite a length of time in getting ready for it.

I want to talk briefly about some common employer concerns. Risk selection is something that's been talked about since I started working in this field quite some time ago. There's a belief that younger and healthier enrollees will enroll in the CDHP product. That's sometimes true, but that's not always true. One thing that's important about that is understanding the current selection and the likely selection as well. What kind of people are you likely to get with a given plan design and contribution strategy? Many people make the assumption that CDHP plans will always attract healthier risks. We have seen many counter-examples to that in the groups we have worked with. Depending on how you set your plan design, your rate and your contribution, you can create a self-fulfilling prophecy. What I mean by that is if I create a plan design that is relatively stripped down and has a very low contribution to the employee, I'm going to get positive selection on that and I'm going to get positive selection whether that's a CDHP plan, an HMO plan or a PPO plan. It just happens that way. We want to make sure that we don't get too conservative when we're setting our assumptions on these things and create the outcome that we don't want to create.

Another thing that comes up often is excessive PCA rollovers. I think employers sometimes think that they are going to have employees with $10 million in their personal care account after two years. Do the math on that, but it's $1,000 to $2,000 a year. We found that most of the people are using significant amounts of those balances. If that happens (excessive rollover), they may lose their incentive to conserve. We believe the right approach to counter that potential is to offer additional deductible options so someone who does have a higher-than-average PCA balance has somewhere to go with that. They can increase their deductible and actually spend that money.

I think some employers are concerned that behavior change won't occur and want to mitigate that risk. What often happens with that, though, is that you'll assume a very conservative assumption around that point. A conservative assumption on that increases your relative cost of the plan or reduces the benefit that you can offer. So sometimes you get yourself turned around again and you have a stripped-down plan design, in some cases with very high contribution and that leads to basically zero enrollment, which isn't good for anybody.

Concern about network discounts always come up as well. We use a regional network strategy to get the best available rental networks. We realize that we're generally still at a disadvantage to some of the other carriers out there. One thing that's interesting is that it's not always possible to get good data about the networks that you're competing with, so sometimes you have unrealistic expectations around what those discount assumptions are as well. Again, this leads

to conservative assumptions and that could drive increased plan costs and contributions.

I want to give you a quick summary of what we've seen. The bottom line is that enrollment results are all over the map, depending on how you do it. We now know the criteria on how you can drive a good enrollment result, assuming that's what you're interested in.

Financial results have been positive for the most part. Most of our 2002 employees saw very low or negative projected cost increases when they renewed for 2003. That was true of both choice groups and those full replacement cases that we spoke about earlier. It does appear that there are significant utilization changes. When we have been able to study year-over-year experience for the same clients, we have seen significant changes. The number of examples that we've been able to look at is still fairly limited, but it appears that there is decreased prescription drug, office visits and, to some extent, inpatient hospitalization.

MR. DANIEL PLANTE: Most of the information on consumer-driven plans is American focused. For those of you who are Canadian practitioners, I apologize. Many of my comments will apply to both practitioners in insurance companies and in consulting firms, although in a different context. To those of you from insurance companies, the comments that I'm going to provide are from an employer's perspective and should be taken as a heads-up on what employers are talking about, thinking about and doing. For those of you that are the competition, I'm going to give away as little as I can about what we at PWC do, but I think you're going to see some validations of what you're seeing.

There are two areas that I want to spend some time talking about. The first is the types of things to take into consideration when you're considering the financial modeling— assumptions, migration and things of that sort. The second topic will be the emerging experience. I'm going to discuss what we've seen thus far in clients that have adopted these plans, and I will admit that it is limited experience. I think everyone would agree that that's the case, but it's starting to emerge on a consistent basis and I think that is promising.

Financial modeling or plan design modeling has four broad areas. The first is plan design issues. What do you need to think about when you put together a consumer-directed plan design? The second is utilization change assumptions. This is one of the big areas on which we have a lot of discussion. How are people going to change their utilization practices? What about consumerism? The third area is other assumptions, which is everything else, such as trends, discounts, adverse selection and so forth. The fourth area is migration. Who is and who is not taking these plans? What do we think that's going to do over time? Is it going to change from one year to the next?

Let's talk about cost distribution. We hear time and time again that 20 percent of the people are generating 80 percent of the costs. As you see on Chart 5, 5 percent of the people are generating 50 percent of the cost. These are all valid and apparently sustained benchmarks. I don't see being incorrect in most markets. What I want to focus on in a consumer-directed environment is the 5 percent who generate 50 percent of the costs. We are not expecting that you're going to have a tremendous impact from a consumeristic point of view on these people's buying practices. If we do see some change there, I think it's icing on the cake, but it is certainly not the area that we're focusing on and it makes sense. You don't want someone who is on the way to the hospital to stop and check what the rates are at the hospital down the street. We want people to make informed consumeristic decisions up front about more of the day-to-day discretionary services.

At the other end, the lower end and the moderate expense people, we would expect there to be some considerable savings on the consumer-directed side. That's where many of these plans see initial savings. We already are already seeing some there, but that's not the primary focus in many of these plans.

The first question a lot of employers have is: What are we going to cover? Medical, drugs, dental? Most plans certainly will cover medical and drugs. The question on how to incorporate drugs, though, is the big one, and we'll talk about that in more detail. But there's a new evolution that I've been seeing. Employers, even though they're seeing some good results coming out of plans that have already adopted these consumer drug arrangements, want to take themselves slowly into this area. They are actually putting into place either a drug-only or a dental-only consumer-directed design, the thought being that these are relatively low-cost plans (drugs, at least, are temporarily at low cost). Availability of information is much greater than for medical coverages. It gives employees a rather easy way to get used to a consumer-directed design. Most employers that are taking this route are starting with these two. Then a year or so down the road we'll work in medical, once they're already comfortable and familiar with the concept. We are, however, seeing a lot of employers on the flip side of the coin deciding to abandon all of the current options and doing a complete replacement. I think we've seen that as a result of two issues—when the IRS came out the end of June 2002 giving consumer-directed plans effectively a green light and also, the savings that have been emerging from some of the earlier adopters have taken much of the concern away from many employers in jumping in with both feet. I think we're going to see a little more movement in these types of plans.

We see a range of deductibles for consumer-directed options, anywhere between $1,000 and$2,000 for single coverage. I don't think that's too remarkable. What we are seeing that's different is the deductible for family coverage. Most plans these days have a family deductible anywhere from two to three times the single deductible. For consumer-directed plans, we're seeing a much lower multiplier of anywhere from 1.5 to two. The reason is that the higher the family deductible, the scarier this type of plan looks to the employee. If you've got a $2,000 single

deductible and a three times multiplier in effect for family, that's $6,000. We are afraid that a lot of employees looking at family coverage will be scared away from this type of design as a result. Most employers are opting then for a much smaller ratio, so you may see a $2,000 single deductible and a $3,000 family deductible. That's a very different type of design than what we are all used to.

A big question revolves around the coverage once the deductible is met. Is it immediately at 100 percent or is there still some cost sharing? What we're seeing emerge is a concerted effort to match the out-of-pocket exposure to the current plans that are not consumer directed. For example, if my current option, a PPO plan, has a maximum out-of-pocket payment of $2,400, under consumer-directed design with a $2,000 deductible, we're seeing an additional $400 of cost sharing once the deductible is met before 100 percent coverage kicks in. One of the reasons is that this is easy to explain to employees as a financial protective design; they will be no worse off under a consumer-directed design because of this. It's a simplified statement, but from an employee's perspective, it does make a lot of sense and from a financial perspective it does model out closely to that.

How should the consumer-directed plan be designed to financially protect chronic patients? This is a big one. There was a *New York Times* article a few years back saying that the people who are going to be hurt the most by a consumer-directed design are those most in need of medical care. That is absolutely correct if that's the way you design the plan. However, you can design the plan such that these people who are most in need and who are, in fact, the biggest consumers of health care, are not financially disadvantaged. I'll give you a very simple example. Think about prescription drugs. Most plans today have drugs provided on a carved out copay basis. The sicker you are, the more scripts you get, the more you pay, because you're continually paying a co-pay per script. Many of these consumer-directed plans include the drugs under the deductible and the maximum out-of-pocket. Once you've incurred enough costs, you've hit your cap and you're paying no more out of pocket. Many of these employees, where drugs are now part of the consumer-directed plan, reach a maximum exposure and have a limited amount of out-of-pocket expense, whereas under the current copay design, they do not have such a limit. They are then financially protected under this type of simplified example.

Most plans are looking at putting preventive benefits outside of the consumer-directed design in that they are provided on the first-dollar basis and are not subject to the deductible. Finally, the big question is, should prescription drugs be included? I'm seeing a mixed response by employers. Half of employers are including it under the deductible and having it apply to the HRA and the consumer-directed design. The thought behind this is to get as much savings as possible out of these plans, and drugs are an area where we see some very early savings. The other half of employers want to provide some type of a provision that employees are familiar with. They're familiar with a copay design on their drugs, so companies want to continue that. I'm seeing that second approach starting to fall by the wayside. More

and more employers are jumping in and putting drugs in under the consumer-directed design.

There is a big question about the drugs though. When it's integrated in the consumer-directed design, can the insurance company actually accommodate that integration? We're still seeing some companies not able to handle drugs when it is integrated under the medical deductible. Some insurance companies have separate drug businesses that handle all of this on a stand-alone basis and getting those administrative systems in synch to be able to accommodate this is, I think, a critical component going forward, at least from most employers' point of view. It's an area where the typical employer doesn't even think that it could pose a problem, but it is sometimes a deal-breaker when an insurance company cannot accommodate that.

If we're not going to do a consumer-directed design on the drugs, will there be some savings left on the table? Absolutely. People have no incentive to become better consumers there.

There is a big issue on copays. We find among our employers that there is quite a bit of surprise surrounding the cost sharing under a copay plan. When you've got a $5, $10 or $20 copay, what's the equivalent coinsurance? In fact, a $15 copay on drugs is a much less rich benefit in many cases than is an 80 percent coinsurance for drugs. That can be a discussion point with many employers as they try to understand the cost of their drug plans.

The health reimbursement account is where we get a lot of new theories around how people are going to use these. What's the right way to design the plans? What's the funding level for the HRA criteria? I've not yet seen an employer establish an HRA where the funding level does not differ by tier. There's always some sort of tier relationship. It increases by tier, such as employee only, employee plus one, employee plus spouse and employee plus family. Very often that increase follows the deductible multiplier that we see.

How is the funding level determined? Thus far it's been a pretty unscientific approach. Typically it has just been setting a flat dollar amount that feels right to the employer. What does the employer think the employees will appreciate, but is a number not so high that the employer is going to be exposed to too much cost in the first year? We are starting to hear about more employers being a little more creative about this. Some are tying it to financial performance of the organization, such as profit sharing. Some are even basing each year's subsequent HRA accrual on how employees did the prior year. If employees roll over more in the year one than we expected, the year two will give them less into the HRA than they would have otherwise. I don't necessarily know that that's going to be an easy approach or strategy to communicate to the employees, but it is one that's being considered.

Other approaches have to do with how the rollovers are accommodated and I'll talk a bit more about that going forward. A big issue, though, has to do with how much is too much in the HRA. Just as you might think that a small HRA, say $200 or $300, is not enough to foster good consumerism, I would argue that if the HRA accrual appears too big, you're not going to foster good consumerism. If I'm giving my employees $2,000 in an HRA, this means for most of these people that in effect they have first dollar coverage. Do they have the incentive to become better consumers? If it's too much of an HRA, I would argue that they do not have that incentive and this plan might actually cost more in the long run. A careful balancing point needs to be found that works in terms of fostering consumerism, yet doesn't cost the employer too much.

Who's covered by the HRA? We use flexible spending accounts (FSA) as an example to describe HRAs to employers more often than we should. We take the tactic that it's just like an FSA, except that it's employer paid and it rolls over. Those two facts are true, but there are other differences that I think are critical for the employer to understand. For example, for FSAs, I can select single coverage, yet use an FSA to cover my spouse and kids. If I were to elect single coverage under a consumer-directed plan, can I use the HRA to cover my spouse and kids? Unless the plan design prevents me from doing so, yes, I can. That's a financial exposure to the employer that most, if not all employers, want to avoid, so most plan designs are writing in the plan document that you must be covered under the traditional catastrophic plan to get access to the HRA.

Another key difference, which is a subtle one but which can be a very frightening topic under the HRA, comes from the IRS's guidelines last June. It's best described in an example. Say I get $1,000 in my HRA each year and I have a $1,000 gap after that, so in effect I have a $2,000 deductible. In year one I incur $2,000 in expenses. What do I do? I go to my HRA and pull out my $1,000. I'm paying $1,000 out –of pocket. Year two, I get another $1,000. I paid $1,000 out of pocket last year, so I want my $1,000 from this year's HRA funding to pay for the out-of-pocket expense I had last year. The IRS has talked very subtly about the look-back approach, which is not something you would normally consider in designing these. Most employers and vendors have designed their plans so that you can't do that. That is a concern to the employer. They need to proactively address that in the plan design, but that is not an avenue that employees can take to reimburse themselves. In other words, once you've surpassed your first year, you cannot go back to continue to reimburse yourself for those expenses. It's also not something that most employees would think about initially, though once word got out, there would be no stopping it.

What's covered? This one is fairly straightforward. Most plans today are saying that discretionary services such as laser eye surgery, contact lenses and everything else that is typically considered a discretionary expense, is not covered under the HRA. If you want to cover it, use your FSA. Again, this is a limitation by the employers to limit their financial exposure. There are a few employers that are actually allowing

some of these discretionary expenses under the HRA. In many cases it's to sweeten the pot and to make these plans look more attractive. Other benefits, like dental and vision, are typically not covered under the HRA if there is a dental or vision plan provided.

Reimbursement order is a tricky issue that goes along with the objectives of the employer. Which comes first, reimbursement out of the HRA or reimbursement out of personal flexible spending account? Some employers have said they want to use these HRAs as a vehicle to accumulate funds over time for the employees to use, for example, for retiree medical. They say the FSA comes first. While the IRS specifically says you can't put the FSA first, the IRS also says that there's a loophole that allows you to do so. You can look on the IRS Web site to get the language to use in the plan document to allow that, so in effect it's a limitation that's not really there.

When the flexible spending accounts are used first, the expectation is that you'll get a little greater participation in these accounts if these are savvy consumers. I'd argue that they were not going to enroll in these plans in the first place unless they think they are savvy consumers. When the HRA, however, is used first, our expectation is FSA participation is going to plummet, if not disappear completely. It also means that some of that first-dollar employee payment that would otherwise come out of the FSA is going to disappear and it's an additional cost to the employer. Most of our clients are putting the FSA first to subtly increase employee cost sharing.

We're starting to see more sophisticated discussions around how you reimburse out of the HRA when a discretionary service is covered. For example, laser eye surgery is covered out of the HRA, but there's a $200 copay before you get a reimbursement. Or, with coinsurance, we'll only reimburse 50 cents on the dollar on what you spend. These are maneuvers by the employer to limit their exposure. I think it's because of fear from the employer's perspective on escalating costs.

There are other things that are being talked about. I haven't seen too many of these actually implemented yet, but allocated HRA dollars is one issue. For example, a plan may have $200 go just to dental, $200 go just to drugs and the rest goes just to medical. I think most vendors' plans can accommodate that, but the communication aspect is trickier from the employer's perspective. End-of-year HRA balance is balance for rollover. Most employers now are saying that whatever you have left over is applicable and usable next year. Some are starting to say part of it is allocated for retirement only.

As far as percentage of balance available, I don't know anybody that's doing anything less than 100 percent right now. Most are not allowing portability when you move, not only to another company, but when you move to another plan within the same employer that's out of the consumer-directed design back into one of the more traditional plans. In that case you also forfeit whatever is in your HRA.

Let me put forth a couple of ideas here about employee contributions. You don't want to set the consumer-driven plan contribution so low that people who have opted out of coverage in the past now opt back in. This can be a great plan, but if you're covering more lives, you're not going to save any money. The strategy that most employers are adopting is that the contributions for consumer-directed design are near the bottom range of all the other options, but not at that bottom range.

How are consumers expected to impact office visits? We'll talk later about the pricing and the experience we've seen thus far, but the question here is, do we expect there to be changes in utilization in office visits, lab and diagnostics, drugs and hospitalization? Do we expect consumer-directed plans to impact long-term trend? We talked a lot about how increases have played out in year one and year two. Is this a sustained savings? There is some concern that we're going to save in the first couple of years, but there's a bubble of utilization on the horizon five years out that's going to produce enormous increases in expense. Do I think those are there? I don't personally, but that's my opinion. I don't think we have enough evidence yet to know one way or the other what's going to happen.

Ultimately, how are people going to use the HRA? This is a savers-versus-spenders issue. We're seeing enrollment in terms of savers by and large, and the people getting into these plans are using them as we would expect them to.

You can spend a whole day talking about adverse selection. As an actuary I have long believed that concerns around adverse selection were overstated. I didn't think it was as big an issue as people thought it would be. But when consumer-directed plans came on the scene, adverse selection very definitely became an issue.

Termination is another issue. Are people going to try to accelerate their HRA utilization just to deplete it before they leave? You can control that with plan design.

The IRS has not given us any real guidelines on how to calculate the COBRA rates. If the COBRA rates are based on the full funding of the HRA, will that actually dissuade some COBRA participation? My contention is that it probably will. COBRA people cost 50 percent more than their rates dictate, and I think you're going to start to see that number come down.

Vesting is a scary thought for consumer-directed design. It's coming. I think there will be a few years before there's some sort of vesting required for these plans, but I do think it's going to happen.

These are more complicated plans. There are more areas where employees can get reimbursed. Will incurred but not reported claims (IBNR) liabilities increase correspondingly? My contention is, yes, there will be higher IBNR liabilities associated with these plans because you've got the HRA, the FSA and the insurance

plan itself where ultimately you're trying to adjudicate all these claims. There's a little more time in the pipeline.

Dave talked briefly about types of people that take these plans. I agree wholeheartedly. These are not the young, healthy people that take these plans; these are the folks who, I believe, want to be good consumers, and I don't think that necessarily ties to health status at all.

As far as migration in year two, we're not seeing many employees opt out of these plans after they've gotten in them. On the other hand, we're seeing more and more employees jump in in year two and in year three, so they are gaining in popularity.

There are not many numbers in the area of emerging experience. We'll talk about the typical design of a health reimbursement account, and what levels are out there. The $500 to $1,000 is common for single, with multipliers for the other tiers. Single plus one is usually 150 percent of single and family is typically 200 percent of single. The deductible gap usually matches the HRA. Most of these are built on PPO designs, given the full flexibility that a PPO design can offer to employees. It fits right in with the whole idea of consumerism. Preventive care is almost always on a first-dollar basis outside of the HRA. HRAs are unfunded. Eligible expenses tend to match exactly what's covered under the medical plan. We already mentioned discretionary expenses not being eligible for reimbursement. Rollover is permitted one year to the next, only while you stay in that plan with that employer.

There is limited availability of credible financial experience. Separate companies have issued their own studies on this plan. It has done well for our book of business. I don't know that any of those studies are robust enough that we can start to hang our hats on them. There is, however, a remarkable consistency among all these anecdotal studies and I think that's the most promising thing that we've seen to date. The programs have shown consistent reductions in the number of prescriptions and office visits. We're seeing decreases as high as 20 percent. Is that going to be sustained? I hope so. I don't know if it will be sustained at the high level, but I certainly think we're going to see continued savings there.

The first year health-care trend is in the range of 0 to 10 percent. There's no way that we are going to see long-term 0-percent trends under these plans. We've seen cases of 10 percent already, so three or four years into these, there could be some decent long-term trends.

Over 60 percent of the employees have HRA balances that they roll over, although their rollover amounts are not necessarily significant enough to accumulate over time to huge amounts. The average rollover is about $400. Most offer this as an option.

As far as emerging experience in employee response is concerned, 10 percent can be viewed as a successful first year. I would say that 10 to 15 percent is typical,

although we start to see double that for new hires, presumably because new hires have more one-on-one time with HR departments. If they have a better understanding of these plans in the first year, they're more likely to enroll in them.

We asked employees in focus groups what they thought of these plans. Ninety percent said they like them. It's easy for an employee in a focus group to say he or she likes the plan and to say that it seems to work well. I don't want to get down on focus groups, but I think the real indication of employee popularity is that they're voting with their feet. Over 95 percent of employees re-enroll in these plans, and that includes those employees that have depleted their HRA and are now in that deductible gap where they're paying out of pocket. Even they are saying that they understand why they're paying more out of pocket. They understand this stuff more so than we thought they would early on in the game.

More and more employees are using consumer tool kits. More employees are changing behavior as the result of the information that they see: 27 percent changed treatment plans, 22 percent changed providers, 33 percent chose facilities with better outcomes, 5 percent identified incorrect diagnosis and 10 percent discontinued unnecessary treatments. I think that's a key indicator on how employees are becoming better educated.

Participants with costs below the HRA maximum most likely will be winners. Of course, those with high utilization will probably be winners if it's designed properly. The losers are those with middle-of-the-road utilization. Will they be in that deductible gap area and if so, how much are they financially disadvantaged? Keep in mind that they may be disadvantaged this year, but next year they may be winners. The expectation is that over time they will come out ahead.

As much as I would like to think all the actuarial numbers and assumptions around these plans make or break the success of them, it is absolutely not true. The success of these things hinges entirely on communication. If they are rolled out properly and communicated to the employees in such a way that they understand them, this will be a successful plan. One of our clients is in heavy manufacturing. The employee population on average has a third grade education and half of the employee population has English as a second language. This is not your target population for rollouts of these plans. They had complete replacement, and they love it. Employees understand this stuff much better than we thought they would.

There are still some gaps. We don't know what impact this is going to have on hospitalization. We don't know if the high utilizers are going to change their consumption. Do we think that there is any reward for cost management efforts above the deductible? I would say yes, but not to consumer-directed plans. I think the traditional, large case programs benefit more. There is no mechanism for rewarding participant cost-management efforts above the deductible. It needs to be supported by a consumer-centric health management model.

Looking at next-generation CDHC plan design, there are more complicated designs. I think allocated funds in the HRA is going to be popular. Drug-only consumer-directed plans are going to be popular. There will be more consumer-directed options. It was already indicated that they have more clients that have more than one of these plans being offered. I think that's going to become very prevalent going forward.

I already mentioned opt-outs, but I want to make sure that you're not opting back in folks who had waived coverage in the past.

MS. LINDA CUSHMAN RUTH: First I'm going to spend a few minutes talking about some of the information that we get from our survey. We do a survey every year of both employers and consumers, so I have some information from that about opinions on consumer-driven health care. I am also going to talk about experience we have from seven employers who were put in the catastrophic HRA plans, and then I'm going to talk more specifically about one employer in particular.

In terms of statistics, there are 175 million people with job-based coverage. We believe there are 1.5 million people in some type of consumer-driven health care, and 500,000 of those are in catastrophic HRA plans. The point here is that there are still not many people in consumer-driven plans, but most of the people that are in one kind of plan are in the catastrophic HRA plans. The others are distributed throughout the other plans, so we'll see that the catastrophic HRA plans are certainly the most popular today, with others catching up.

We asked employers what their interest is in various consumer-directed health plans. We asked them about health reimbursement arrangements; customized design, which is basically a choice of different options with buyouts; multi-care networks, which are networks that have different copayments or deductibles depending on the cost and sometimes quality of the providers in those networks; the straight defined contribution plan; and, of course, open market purchasing, which is like what we're doing with laser eye surgery, in which we go out and can buy on the open market based on price. The bottom line was that there is a significant interest, not surprisingly from employers, if it would decrease costs by 10 percent, ranging from 80 percent who were interested in HRA plans down to 34 percent who were interested in open-market purchasing.

There was significant interest from employers if it were cost neutral. For the HRA plans, 41 percent of the employers were interested in the catastrophic plus HRA plan. If it was cost neutral, 37 percent were interested in customized design and 31 percent were interested in multi-tier networks. What that's telling us is that employers are so desperate to find some kind of solution to the health care cost crisis that they will try a consumer-directed plan, betting on the outcome. They are thinking that it may not work and it may be cost neutral to start with, but it's better than anything they've got. Most of the employers that we see putting in these

plans don't have better alternatives. As Dave and Dan said, there is no credible experience yet as to whether or not they are going to work.

We deal mostly with large employers, but this survey has some smaller employers. Fifteen percent are interested in the catastrophic plus HRA plan as a replacement plan; 53 percent were not at all interested in it; and 34 percent said yes, they were interested in it as an option. Our experience working with larger employers has been that all of them have put in this option as a choice.

Catastrophic plus HRA plans and other consumer-driven health plans are part of an overall strategy. Most employers are very comfortable dealing with drugs. They know what to do there and are out there raising contributions and changing plan designs. Employers are also showing a tremendous amount of interest in disease management. Consumer-driven plans are something that employers are strongly looking at, but they're doing it in tandem with other approaches. Of course, unless something is done about plan design, employees are not going to change their behavior.

Basically, employers are interested but not flooding into these plans. From an experience standpoint, employers that are taking these plans up are usually ones that have a severe cost problem. There is either some kind of burning platform or they truly want to be leaders in health care.

As for consumers, 48 percent of consumers believe they can influence the cost of health care. According to our studies, one of the interesting things is that the consumers who don't believe they can influence the cost of health care and believe it's the employer's problem are those who are paid lower. If those employees are making $25,000 to $30,000, their attitude is that it's the employer's problem.

One of the positives of looking at the tiered or narrow network approaches and the catastrophic plus HRAs is that it starts changing employee behavior. Surprisingly, there doesn't seem to be a strong opinion out there that the best doctors and the best hospitals charge the most. That is one of the issues with changing consumer behavior.

In one focus group, we asked 100 employees what they would do under specific circumstances, and consumers will change their behavior or change their attitudes given information. So this does underscore the point that Dan made, which is that communication is critical when we're putting in these plans. We asked the employees if they would ask their doctors questions about fees, and the universal answer was that there was no way they would bring up fees with their physicians. After an hour-and-a-half discussion in education, 61 percent of the employees of the consumer said they would feel comfortable bringing up the fees with their physicians. When we talk about communicating these plans, it's not just communicating them in enrollment. You're trying to communicate to employees how to change their behavior throughout the year.

I want to spend just a few minutes on what we call our "Trailblazers" group. This group is seven employers, many of whom are in the Dallas area, who implemented catastrophic plus HRA plans and banded together to compare data and experience to try to make this a success. The bottom line here was that all seven of them had very successful implementations: ID cards got there on time, communications worked, the phones were answered and those kinds of things. There were varied enrollment rates. The enrollment rates were anywhere from 5 percent to 34 percent. The biggest factor in the enrollment rate was senior management's attitude and approach toward the catastrophic plus HRA plan and the communications. We also did something called our "health need index," where we looked at projected cost for these employers.

We didn't have data on all of them, but again that's no surprise. The demographics are similar between plans, so if we're just using our traditional demographic adjustments and demographic projections, we're not going to predict adverse selection. Also, the HRA plans attract the highly paid. There were significant differences in pay for some of these plans, so I don't think it comes as any surprise to us that the HRA adopters are going to be more highly paid. However, this is pretty good proof that we are definitely attracting those who can afford it when they enroll in these plans.

For our health need index, we took these seven employers and we decided to develop a way of predicting what their cost will be given their enrollment. We came up with a proxy for the traditional risk-adjustment methodologies, and we used pharmacy cost data and demographics to estimate cost for these employees based on their enrollment the following year. Then we translated it into an index that stated the relative cost of these folks in the HRA versus the non-HRA, compared to a total average for the population. The result is that there was a big surprise with the amount of adverse selection. If we compared the difference in projected cost or health-care cost between those who enrolled in the HRA plan and those who didn't, we were looking at calling that adverse selection rate of anywhere between 23 and 40 percent. Our projections were more in the 5 to 10 percent range. The problem that we found with this was that the employers that were putting these plans in were hoping that they were going to be cost neutral. Based on the fact that they knew that they were losing some discounts because they were going to another carrier, they predicted some increase in adverse selection. They were going to make that up and the loss of discount up on utilization. Adverse selection is significantly higher than we expected it to be, and is the utilization change going to make up for it?

In terms of design and the way these employers approached it, they wanted to put in a design that was going to encourage people to enroll in these plans. So the typical bridge was about $500-$750-$1,000. That's a pretty low bridge. We found that those who had higher bridges not surprisingly had lower enrollment. Those who had the lower bridges had the higher enrollment. The idea here was to have a

low bridge. The pricing was about 15 percent less than the lower plan to encourage enrollment. If you eliminate a plan, and three of these companies did, they got significantly higher enrollment in the HRA plans. This again confirms that if something changes, they have to think about it, and there's more enrollment in the HRA plan. In fact, we found a company that eliminated one of their exclusive provider organization (EPO) plans, kept one and still had 17 percent enrollment in the HRA plan.

I am going to talk quickly about Baylor Hospital System, a 12,000-employee hospital system in the Dallas area. They're obviously one of the premiere, if not the premiere, health-care providers in the area, and health care is their business. What their CEO said is that health care is their business and they need to be a leader in health care. Not surprisingly, this organization was filled with health-care professionals, and they were savvy users of health care. They used twice as many specialists as primary care physicians (PCPs) and their use of technology was also stunning. What they wanted to do was to see if they could change behavior. They wanted to get people into these health plans and to start influencing physician behavior as well as consumer behavior.

The company decided not to eliminate an option, although they did make the PPO less rich and they did change carriers for the PPO. Their goal was to be cost neutral and they made the change there in the vendors. Again, here they wanted a low bridge, and their bridge was $500, $750 and $1,000 with a deductible of $1,000 to $1,500 in 2000. They wanted to maintain out-of-pocket costs, so they said they always wanted cost sharing up to the out-of-pocket limit. They didn't want to have a high deductible and then get right to the 100 percent coverage, so in all of their plans including the EPO, they still have cost sharing at 10 percent. What they've done is to continue cost sharing up until they hit the out-of-pocket maximum, which is $3,000, $4,500 and $6,000 in network. Then everything is covered in network at 20 percent and out of network it's covered at 40 percent. Preventive care was covered at 100 percent in network for the catastrophic plus HRA plan. Drugs were integrated so that the drugs are covered in exactly the same way as the inpatient/outpatient. The EPO has cost showing about 10 percent with copays and the PPO is a traditional PPO, but out of network it has no out-of-pocket maximum.

Again, this is a relatively rich design, designed to be cost neutral and gain enrollment. They just finished enrollment and they've had about 34 percent enrolled in this plan. The major things here were that they had mandatory employee meetings and an e-mail from their CEO that introduced and endorsed the plan and said, "This is our plan." I think those two things were the major elements behind getting the folks at Baylor to enroll in this plan.

The adverse selection is lower than some of the adverse selection we saw. It was in the 15 percent range as opposed to the 20s and the 30s, but again it was higher than they'd hoped. What they're going to do next is to take a look at the actual

claims of the folks who have enrolled in the HRA plan versus the non-HRA plan and get some hard figures on what the changes are in utilization. I think from the standpoint of where we are now, all of these seven employers are really trying to find out what's going on.

The other thing that most of the seven employers are going to do is to maintain their HRAs for the next year. Not increasing the HRA is one way of making sure that they keep costs lower. They're also looking at adding options, and I think Dan talked about this too. All of these employers had one catastrophic plus HRA option. They are going to put in a lower-cost catastrophic plus HRA option to try and encourage folks into the lower-cost plan. A third thing that some of them are thinking about is eliminating their PPO. This is always a big argument with employers. You want to offer choice, but certainly the numbers would show that adverse selection is a huge issue when you offer choice, so at least one or two of these employers are looking at eliminating their PPO.

Next year at this time the hard numbers will be available. We can find out then if all or some of the predictions have come true and what employers are going to be doing about it.

MR. DAN WOLAK: Linda, you talked about anti-selection of 22 to 39 percent and then a factor of 1.02 to 1.08. Is that suggesting that the overall plan cost prior to other factors is higher because of anti-selection? I didn't quite know how to interpret that.

MS. RUTH: No. What we did is we said, for instance, Company One's predicted adverse selection was 23 percent and the health need index for those in the HRA was 83 percent. The PPO was 1.4, so you can see that there was a huge swing in the health need index and between those in the HRA and those in the PPO. On a weighted average basis, you're coming up to adverse selection of about 23 percent when you look at the difference. When you divide the 0.83 by the 1.40, you get the 23 percent. Did that answer your question?

MR. WOLOFF: I think 0.83 divided by 1.4 would tend to be more than 23 percent.

MS. RUTH: Yes, thank you. When we're looking at the health need index scores, at the 83 percent, we're saying the average is 100 percent. So we're saying these folks are 17 percent less healthy than the average and we're saying the folks in the PPO are 40 percent less healthy than the average. So, on a weighted average basis, when you take the difference you get to the 23 percent adverse selection, which is what we're calling it.

MR. DAVE MAMUSCIA: When you make the experience comparisons (and I know they're based on limited data), do you take into account last year's experience and this year's experience under the HRA combined with any administrative expense changes in the unused or rolled-over HRA expenses?

MR. PLANTE: You have to. In fact we've seen most employers take it one step further than that. As they are booking expense, recognizing the HRA, technically they currently only need to book actual dollars utilized as an expense, until the accounting rules change some more. Most employers are saying that it doesn't matter; they're going to book as a liability in effect the amount that's also not been utilized, so they're taking into consideration as a cost comparison the full funding of the HRA. That on top of administrative change, costs additional administration fees for administering the HRA on top of an FSA. Change in discounts, change in network access and really everything you can think of as part of the comparison is being included in here with the one new element being recognizing the full HRA funding.

MR. TUOMALA: Our standard approach with employers is to do exactly as Dan mentioned.

MS. KRISTEN RUSSELL: Dave, regarding Definity Health, can you tell me who provides the high-deductible plan as well as the stop loss for employers? Does Definity provide any of that or do you partner?

MR. TUOMALA: We administer the plan ourselves, so we administer both an HRA or personal care account component fully integrated with a high-deductible PPO option. All of our cases are self-funded. We market stop loss through a variety of carriers—sometimes directly, other times indirectly through some other broker or consultant.

MS. RUSSELL: Dan, you had mentioned that you had seen a 5 to 25 percent decrease in both prescriptions and office visit copays. I'm wondering if that's calculated on the exact same population before and after they enrolled in the HRA, or is it on the total group versus the HRA group?

MR. PLANTE: Yes and no. In cases where we can get access to the data, certainly the preference would be to look at the exact same population. We have limited access to that level of detail and even when we do, it may not be credible. That, coupled with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), means that sometimes we can't even get access to that level of detail any more. Some of the early studies that we were able to do were based on the same people and now is more of an estimate based on the total population. How much are we seeing office visits change for the non-enrollees versus those that enrolled? As Linda has pointed out, trying to assess adverse selective impact of that to come up with an answer is not an easy thing to quantify, yet if we can get a very robust study put together, then I think we'll have more definitive results.

MR. TIM CLARKE: Although there are a lot of differences, one of the comments that Dan made at the beginning is that a lot of this may not apply to Canadian practitioners. We, in fact, have seen a small number of employers, probably

through the mid- and late-1990s, that have put in something with some similarity in terms of catastrophic plans with spending accounts associated with them. One of the challenges that employers face and what my question comes to is, what have employers planned to do or what have they communicated to employees with respect to indexing of both the HRA balances and the deductibles going forward? As you know, the deductible erosion on these large catastrophic plans is significant. I'm curious what U.S. employers are communicating around that.

MR. TUOMALA: Currently none of the 60-odd employers that we have worked with have done anything around that. Frankly, the position that they've taken is the expectation among employees to not have plan changes. Plan changes are often viewed negatively by employees, so until that becomes an issue where employees are demanding that they index that, they've skirted that issue.

MS. RUTH: From a Hewitt perspective, we've found that our employers are communicating overall that the plans in general expect changes in your health care plans, but in regard to the HRA plans specifically, they haven't really addressed that.

MR. PLANTE: The companies that I've been working with have been, as Dave has said, largely silent on long-term funding of the HRA, but the silent implication has been that if you get $1,000 this year, it will be $1,000 next year. Or they have not voiced that and are thinking, "If we can do better, great. We'll take whatever PR mileage we can out of that in the future." But there's always the concern about the need for an exit strategy, and they don't want to commit too much to paper just yet.

MR. CLARKE: Is the implication on the deductibles the same, which is that it wouldn't change over time?

MR. PLANTE: Yes.

MR. CHRIS HALL: Given the problems associated with calendar-year deductibles and coordination with FSAs, have you seen health reimbursement accounts activated other than on a January 1 effective date?

MR. TUOMALA: Certainly. We have several clients who do a non-calendar plan year where essentially all of their benefits run on a non-calendar year basis. A great majority of our clients use a calendar-year basis for both the personal care account and the deductible portion of it.

MR. HALL: Relative to coordination of benefits, at least from a theoretical perspective, an employer might define the health reimbursement arrangement as a reimbursement account as opposed to a health plan and thus avoid coordination of benefits. Can you give me some idea of what typical clients are doing in that regard?

MR. TUOMALA: We have a variety of approaches to coordination of benefits from a practical perspective. You have the exclusion method, the standard and so forth. Most employers that we work with adopt the same provision for their consumer-driven option as they have for their other plans as far as method is concerned. Currently they all treat funds under the HRA, the health coverage or deductible component similarly, for coordination of benefits (COB) purposes. They haven't done anything differently currently for the HRA versus the other part.

MR. IAN DUNCAN: Does anybody risk adjust their contributions either directly or using some proxy? I think Dan implied that there was some sort of back door form of risk adjustment through plan design, but I'm wondering whether anybody can do this explicitly or if it contravenes some regulation somewhere.

MR. PLANTE: I'm not aware of any regulations around it yet and I don't know of any employers that are doing any risk adjusting around contributions so early in the game. This type of design is different enough that they are, in many cases, having enough difficulty just communicating it as is to the employees, without adding an extra element on the contribution strategy. I do think that may come down the road, but I don't see it happening any time soon.

MS. RUTH: There are those of you who are old enough to have been around when we introduced managed care, point of service (POS) plans and PPOs. Remember, everybody priced the POS plans considerably lower than all the other plans in order to get folks into the plans. Then we found over time that there were certain problems with all of that. From a consumer-driven standpoint, what we're finding is that folks are trying to get people into these plans. The first step is to get people into the plans. The second step is to spend the next couple of years figuring out how to make this thing work.

MR. TUOMALA: We have one client that I am aware of—there may be more than that—that actually does a risk-adjustment approach across all of their plans, including the consumer-driven options. I'm not sure how sophisticated the approach is, but the client certainly claims to do risk-adjusted contribution strategy.

MR. KELLY GREBINSKY: Can you speak to the responses of fully insured plans to both the implementation of a consumer-directed plan and at the first renewal as far as how harsh their renewal responses have been, or if they've made changes to their renewal rates based on whether or not you implement a consumer-directed plan?

MR. TUOMALA: Not that I'm aware of. On some of the insured plans that we are alongside, typically those are HMO options that are insured frequently in California where their rating approach may have really no experience component to it at all, and so they're somewhat insulated from that perspective. We have heard some rumblings in the community that they were going to increase their rates dramatically because this was an option. We haven't really seen that happen.

MS. RUTH: We haven't seen that either, and a lot of the employers that are looking at this or doing it, at least on our side, have EPO, self-insured HMOs rather than the insured HMOs, which makes it a lot easier, obviously.

MR. DALE YAMAMOTO: I was taking a look at the network discount differences between CDHC networks and other ones like that relative to the discounts that they already have, and I did see a relatively big difference. I was having a very hard time financially justifying moving to your CDHC plan, to be honest. Dan, you mentioned some specifics on pharmacy and office visits, but overall what kind of expectation do you have as far as utilization savings, not just specific services, that might counteract the fact that we've got the differences in discounts?

MR. TUOMALA: Typically we would use a range of around 8 to 10 percent utilization change, depending on the plan design that we're looking at. Discount differences vary dramatically depending on what market you're in and depending on what other carrier you're competing against. Nationwide that can vary from parity in certain markets to a deep disadvantage, and it really depends on where you are. It's unfortunate sometimes, but I think we, as an actuarial community, as carriers and as part of this system, tend to hold discounts quite close to our vest frequently and often it's difficult to establish the true difference, at least on an objective or credible basis. If that's the case, we're forced to make assumptions sometimes and we normally would assume some disadvantage, maybe 5 to 10 percent depending on market, but that's a shot in the dark if we don't have data available.

MR. PLANTE: It can be an obstacle to the consumer-directed plans that those discounts may not be as rich as existing plans, but one counterpoint to that is that as the employees become better consumers and have better understanding of the costs, we're seeing an increase in in-network utilization. So even if the discounts themselves are not as rich, as more people go in network, we're seeing that disadvantage get offset. The savings that Dave mentioned (8 to 10 percent) is very similar to what we're seeing—8 to 12 percent, overall decrease in utilization. When you couple increase in network utilization against the potential decrease in discounts, I think in many cases it's close to a wash.

MR. MARK ST. GEORGE: Dan, you mentioned that employers in the HRA piece of the plans are basically either funding or expensing the full amount of their contributions. What is the implication of doing that for forfeitures that occur down the road? I assume that if they're expensing it currently, they're taking a tax deduction for it currently. I don't know if they're putting the funds in voluntary employee benefit associations (VEBAs) or not, but what is the implication for forfeitures that occur down the road and the tax treatment of those?

MR. PLANTE: When they expense the full amount of the HRA, they're not taking a tax deduction on the full amount. They can only take a tax deduction on the amount that's actually utilized. To the extent down the road that there are

forfeitures, it's considered an actuarial gain that these are funds that they had expected and expensed to be used up that ultimately returned back to the employer.

MR. BRIAN SMALL: Given what appears to be dramatic adverse selection, is there any thought on a fully insured basis that you'd need to load this for underwriting wear-off as these people gradually come up to the mean? Or, is that a consideration because most of these things are self-funded?

MR. TUOMALA: I'm glad you brought that question up. First of all, I would say that this represents seven clients, not all of which are even ours (in fact I'm not sure if there are any Definity clients included in that). We have actually over 60 enrolled clients currently, and certainly the picture that we're seeing here is not representative of the entire group. I think one of the points that was mentioned is that the contribution strategy was to be about 15 percent lower than the lowest option. That's highly unusual for our client base. Most of our clients actually offer contributions that are within a couple of dollars of one of the other options—typically the most popular one. So what we've seen in a lot of other cases is even the opposite scenario. Now, I don't have hard risk-adjusted data necessarily, but I have seen some anecdotal information and directional information that would suggest in that environment frequently you get the opposite scenario occurring. Also, the wage issue is not something that we've seen across the board. In fact, in some clients we've seen the opposite as well—that the low-paid people are the ones that gravitated to this plan. Again, there is a limited sample with limited data on that.

MS. RUTH: It will be next year or two years down the road before we can say for sure what's going to happen because our sample sizes are just so low now.

MR. MAMUSCIA: Have you had any clients with collectively bargained contracts enter into these arrangements? We have a lot of clients that negotiate with unions and I'm not sure that a plan like this would work with a union.

MR. PLANTE: Yes. The American Postal Workers Union has this plan as an option, and Textron was an early adopter. When they first rolled this out, it was strictly for the salaried population. They denied it to their collectively bargained group and the response was then that they wanted it. So there have been some in-roads in the collectively bargained groups as well. They're looking at this as well.

MR. TUOMALA: We have not seen a lot of activity directly with collectively bargained groups although we certainly have incidentally. Many of our clients have put this benefit option in. Clients who have the same set of options for both bargain and non-bargain employees typically will put it in as a choice for everybody. We do have the American Postal Workers Union that is a Definity client, and so certainly there are some, but we haven't seen a lot of activity specifically with that market.

MR. PLANTE: If we start to see some real increased interest on the part of collectively bargained groups in these plans, I think you will see requirements around vesting. If not legislative requirements, at least collectively bargained contracts will require vesting around the HRAs.

Chart 1

Plan Design Offerings

Number of Definity Health Options Offered to Employees	2002	2003
1 Definity Health Option	36%	52%
2 Definity Health Options	40%	34%
3 Definity Health Options	24%	14%
Amount of PCA Levels (Employee-Only* Tier)	**2002**	**2003**
$500 PCA	8%	16%
$700–$800 PCA	32%	26%
$1,000 PCA	60%	58%

* Please note that the typical benefit tier multiplier for PCAs and deductibles is 1.5xEE Only for EE+1/EE+Dependents and 2xEE Only for Family

Chart 2

Plan Design Offerings

Amount of Member Responsibility (Employee-Only* Tier)	2002	2003
<$500	20%	12%
$500–$750	56%	58%
$1,000	16%	12%
>$1,250	8%	18%
In-Network Coinsurance Levels (Employee-Only* Tier)	**2002**	**2003**
90%	28%	30%
100%	52%	44%
Other (e.g., 80% / 60%)	20%	26%

* Please note that the typical benefit tier multiplier for PCAs and deductibles is 1.5xEE Only for EE+1/EE+Dependents and 2xEE Only for Family

Chart 3

2002 Results of Analysis – Significant Variables

Variable	R-Squared
HR Support	86.59%
EE Access	57.13%
Contribution Rating	40.11%
Minimum PCA-Ded Gap	39.41%
Competing HMO	36.17%
PCA Level	33.48%
PCA Scope	28.43%
Packet Execution	27.82%

Chart 4

Key Enrollment Drivers Identified

23 Option Clients Assessed	Top 33% Enrollments	Middle 33% Enrollments	Bottom 33% Enrollments
Average Enrollment Rate*	23.2%	9.8%	4.3%
% of Employees Disrupted	18.5%	2%	1.3%
Meetings Per 1000 Eligible	8.3	4.0	2.5
Weeks Of Communication	16	14	11
Average Rate of Co-Insurance	97.5%	90%	90%
Minimum Gap (PCA to Ded)	$806	$743	$750
PCA Scope (Expanded Items)	7.6	3.4	7.0
Deductible Level	$1656	$1571	$1531
In-Network Co-insurance Max	$663	$1036	$1875
Average Web Log-Ins/Eligible	.6	.4	.3

*** Overall average, first year option clients: 12.6 %**

definity health

Chart 5

Plan Design Issues:
One Size Won't Fit All