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Developments in Consumer-Driven Health Care

Track: Health

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Summary: Panelists provide an update on recent events in consumer-driven health care, including the regulatory environment, results versus expectations and the implications for the overall group health marketplace. Attendees participate in a lively discussion, leave with an update on this market segment and are better informed on implications of changes in this segment for the group health marketplace.

MR. ROBERT GORDON COSWAY: We have three speakers today. The first speaker will be Steve Kaczmarek from Milliman USA. He's going to talk about federal and state regulatory issues related to these new kinds of plan designs. The next speaker will be Dave Tuomala, who is director of actuarial services at Definity Health. He has been there for three years. He joined the company about six months after it was founded. Our third speaker will be Dean Fiscus, who is now the national accounts actuary with Aetna, and is in charge of the design and illustrations for these kinds of plans for their national accounts. Dave and Dean are both going to provide their companies' perspectives on what they have seen in the last year or so and what they see for the future.

MR. STEPHEN J. KACZMAREK: You might think that I drew the short straw this morning by having to talk about regulatory issues, but unlike other health care products where regulations can sometimes limit time design, in the case of consumer-directed health plans (CDHPs) and health reimbursement accounts

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

(HRAs) in particular, the regulations are actually driving the plan designs, so it's important that we all understand what the regulations are and how we have to design these products to comply with them.

There are two primary pieces of regulation that cover HRAs. It is very easy to find a copy if you do an Internet search for "IRS Notice 2002-45" and "IRS Revenue Ruling 2002-41." There are three major provisions for an HRA.

I want to first point out that this regulation is surprisingly easy to read. Unlike state regulations, which we're all familiar with, the IRS has actually done a good job of making this readable for the practitioner.

The recent clarification on the use of over-the-counter drugs and making them an allowable expense for flexible spending accounts (FSAs) is at least an indication that regulators understand the issues that we're facing along with employers and consumers. I think the legislators are getting ready to do some things once they find the time. Unfortunately, world issues seem to have taken the forefront over domestic issues, but as the presidential race heats up, I think there's more to be said on the front of FSAs and the ability to roll those funds over in the future. That's something that should be on all of our watch lists.

Going back for a moment, to people who have been following this for a number of years, it won't be surprising that I point out that an HRA is not the same as an Archer medical savings account (MSA). You can make the argument that the Archer MSA actually was one of the first CDHPs in the way it was structured.

On the next point about FSAs, it's interesting that the order in which they are used with HRAs varies. My colleagues will be talking about this later. Two of the first CDHP companies actually fund this quite differently, and the use of the flexible spending account and how it's integrated can be a very important design element. There's clearly not a best practice, and if you stop and think about what should come first, the FSA or the HRA, you quickly start to understand that neither one works as you might want it to work. Clearly, the need to define which of the Section 213D expenses are going to be permissible under the HRA is going to impact where you're going to put the FSA. I would say that right now that's a very critical design feature, and understanding the regulations will certainly help employers decide which one they want to put first.

It is important to point out that all of these plans need to fit into the social and regulatory framework that is already in existence and that we're forced to deal with. In fact, the recent Revenue Ruling 2002-43 facilitates the use of debit cards with HRAs, and there are a lot of start-up companies that have that capability. That's an important design feature that plays well to the consumerism aspect of HRAs. These cards will do away the consumer's requirement to track and submit their paperwork.

There are quite a few regulatory implications if health maintenance organizations (HMOs) start getting actively involved with HRAs. In fact, the 2003 Milliman HMO Intercompany Rate Survey asked two strategic and directional questions of HMOs. What are they doing with HRAs and how are they going to respond? The findings are a little surprising. First of all, 48 percent of them have or will implement a high-deductible plan, so it looks like they are standing up and taking notice of what's developing around them. A few of those HMOs indicate that they're going to use tiered networks. Very few of them plan to share price information, but a number of them have plans to share quality information. Many HMOs are planning to provide information on treatment options, which is a bit of a different approach from what some of the first CDHP companies decided to present as the primary type of information for use by employees who choose these plans.

Without a doubt, though, HMOs are going to face an uphill battle, because a lot of their contracting doesn't necessarily lend itself well to a high-deductible plan. Of course, we're talking about capitation and other contracting arrangements. In addition, any cost-sharing limitations that are imposed by state regulation still have to be met.

Our office recently gave a CDHP presentation to a state department of insurance, and we posed some of these questions to them to find out what they were thinking about this issue. The bad news is that there weren't many answers coming from them, so clearly this is a topic that they're just getting started on as well.

Concerning the risk-based capital requirements, their initial thought was that there's enough subjectivity involved to allow for the recognition of the different type of risks that an HRA could represent. Because we still don't know, I don't think there are any definitive studies that really explain utilization and who selected HRAs. There's some information available. I think we're going to see that information play into the development of reserves and in the risk-based capital requirements. That's something else that should be on our watch list as we go forward.

Concerning credibility theory, we all know that credibility theory looks at the volume or the number of claims as one of the primary determinants for setting credibility thresholds. If we see numbers with fewer claims being submitted, then it could impact credibility, but once again, I think it's something that we have to watch and then look at the data once we get enough data to use.

The nice part is, because of the integration of HRA with the lean core medical program, we still should have claim information, even if all of it isn't being applied to the core medical plan.

Fund balances is a critical feature, as we all know. The consumerism aspect of HRAs is designed to make people feel like this money is their own. There's a lot of work that still has to be done to think through how these funds could be used for retiree

medical benefits. Certainly, with the mounting pressure being put on pension funds and some employers' inability to fund both a pension plan and retiree medical, the ability for people to use an HRA to roll balances forward into retirement could be a very desirable feature of these plans. Because the programs are so new, we're not seeing too many people who have gotten to the point where retirees are actually using those funds for that purpose.

Concerning the use of policy reserves, the age-old test of the present value of future benefits minus the present value of future premiums is still the gold standard here. I find that that thought process will allow anyone who is offering an HRA on an insured basis to determine those reserve levels.

One other issue that's worth bringing up is the use of consumer decision support tools. I'm not going to steal any thunder from my colleagues who follow me. They're going to talk about the types of resources available to consumers and how those are going to impact consumer utilization. In addition to those consumer decision support tools that might address provider cost, provider quality and condition treatment, there's one other type of consumer decision support tool that we're seeing crop up quite often, and that is the use of a consumer decision support tool to help employees decide at the point of enrollment which plan is going to work for them. That's critical because, as employees struggle to understand how a traditional HMO might compare with an HRA, the current spreadsheet method that many benefit managers provide to them is probably insufficient. More comprehensive models are now being used, and many employers are using those to help the employees make these important decisions.

As you can see, many of these topics are still developing. I think I have pointed out a number of things that are on our watch list. There are a few things that we have already seen establish themselves, but I think we'll be watching these issues develop as we go forward as well. Thank you.

MR. DAVID M. TUOMALA: Good morning. I'm Dave Tuomala with Definity. I want to give you a brief overview of some of the topics that I am going to talk about today. We've already covered regulatory framework and environment. I'll talk about results versus expectations, in regards to clients and enrollment, and some of our financial results to date. One new feature that we recently started to do, member messaging, is something I wanted to talk about, as well as some ongoing external studies in which they're looking at the CDHP experience globally.

Second, I have some implications for the overall group market, regarding product evolution and what I call "beyond the 80/20 rule." That's something that people frequently bring up about these plans, and I want to touch on the features of that.

As Bob mentioned, we enrolled our first client and have been in business since October 2000. Therefore, we are going into our third full cycle of renewals with external clients. Currently, we have over 75 companies enrolled with us or in the

process of being enrolled for January 1. Twenty-seven of those are Fortune 500 companies. We haven't included most of the 2004 clients because they haven't been announced publicly yet. Again, 27 are Fortune 500, seven are Fortune 1000, and four of those are Fortune 1000 "Best Employers." They represent a wide variety of industries, from long-haul trucking, retail and grocery to the Internet or you name it. We're the first plan to be an offering to the Federal Employees Health Benefits Program (FEHBP), and we started doing that January 2002.

We've had an explosive membership growth. We had about 5,000 total members in 2001 and about 48,000 total members in 2002. Currently, we have a little over 180,000 members and we expect to be well over 300,000 members starting January 1. We've had tremendous growth over the past few years.

One research report suggests that about 2.7 million members will be in some form of CDHP by 2005. There may be some disagreement as far as what the definition of those plans is and whether their assumptions are exactly correct. All of the pundits out there are suggesting that this is an explicitly growing market segment.

Chart 1 is a comparison of employee demographics for the first three years of membership, so the different bars are 2001 through 2003 members by age. Compared at least to a standard demographic mix for employees, we have seen a slightly higher age breakdown. It seems to be consistent across the three years, so there is more of a clustering in the age 45-54 category and slightly less in the age 25-34 category. It is counterintuitive to what most people suggested when we came out with these plans. Actually, what I've seen through the enrollments that we've done is that people enroll in these plans much like they do in any other plan. There's a mix among benefit design, contribution, offering, environment and things like that; they are similar to what we see with traditional plans.

I think we'll see some more about the rollover trend with the Aetna experience shown on Chart 2. We've also seen fairly high personal care account (PCA) rollover activity, what we call the HRA, throughout our history as well, including about 60 percent in 2001 and about 58 percent in 2002 for first-year groups. The last bar represents our second-year groups, 2001 groups in year 2; they also had about 68 percent who had a positive balance in their PCA at the end of the year. About 28 percent of the available balance was the amount that was remaining in this, but there was a fairly high amount of rollover percentage as well as the amount of dollars that were left. This is not inconsistent with what you would expect if you looked at claims distributions for the amount of dollars that were available.

We've also seen since the first day of this plan that prescription drug utilization has been toward the low end of the spectrum. If you recall the tremendous growth in enrollment that we've seen, we've seen consistently low prescription utilization on groups that were offered as a choice environment alongside other plans and the ones that were offered as a full replacement of all of the other options. Lower drug utilization seems to be a lasting effect, or at least an ongoing effect, of these plans.

It's not surprising. It's probably the lowest hanging fruit of a consumer-driven environment. It's probably the most advanced market in health care today, as far as the direct-to-consumer advertising, clear choices between treatment options and that type of thing.

One other thing that we've seen on prescription drug utilization is very high rates of generic utilization. We've seen that grow over time from about 36 percent for 2001 clients to about 43 percent in 2003 (Chart 3). These are just gross percentages for prescriptions dispensed generically. The substitution percentage measures the opportunities to substitute generic for brand drugs. We're up to about 95 percent substitution, year-to-date 2003. That's almost as good as you can get on that.

Mail order usage has not been super so far, but we do not require mail order usage. Some of the clients that we've worked with had previously required that. We have seen that growing over time as well.

Projections from last year overall were a negative renewal on average, about 0.5 percent lower. Full replacements were about 1 percent lower. Option groups were about 0.25 percent lower. If you look at that split by first- and second-year groups, the groups having their first renewal versus their second year, they're down again about 0.3 percent for the one and 1.1 percent for the other.

For 2004, of all of the renewals that we've completed to date, probably about two-thirds of our total book of business, we're up by about 3 percent overall. Our full replacement groups, those that didn't have another choice offered, are up about 4.5 percent. Option groups are up about 3 percent, so that is still fairly consistent, and still much lower than what the underlying trends are in the market.

If you look at those by length of coverage again, the first-year groups are down by about 5.8 percent. The second-year groups are just a subset of our groups that were midyear implementations as of last year, so those that started in mid-June, July, August, etcetera. Those have gone down by about an average of about 6 percent. The second-year groups are up by about 14 percent. We've done some analysis on that, and that's primarily a worsening of experience in the second half of the year. That was experience that we didn't have available when we did the renewal calculations for them, primarily inpatient and large claims. It's not something that we would attribute to a consumer-driven thing. It appears to be experience. Many of these groups are actually choice groups that have fairly limited enrollment. On average, we're probably about 10 percent to 15 percent penetration in most of these cases, so you will see fluctuations on those. Our third-year groups have been up 7 percent. Across the board, we've seen fairly positive results year over year in terms of experience.

As I mentioned earlier, I want to talk a little about member messaging. That's one of the things that we're just starting to do, and I think it's actually a core CDHP. If you get beyond the plan design features, the HRA or the HRA plus catastrophic is

really a type of CDHP. It's the tools and other things that you do that drives the consumerism. Currently we're primarily messaging on drug savings opportunities, including mail order, pill splitting and generic substitution. We are sending mammogram reminders, which isn't that unusual. We are also doing 50th-birthday messaging and health-coaching invitations, which are a little more unusual. I'll talk more about that later.

As a result of that, about one in four members has received at least one drug savings message on their home page. About 17 percent of the members who read the message and refilled the drug changed to mail order in the 3-month follow-up period. About 6 percent of members who did not read the message and refilled the drugs switched. Therefore, we found a statistically significant difference in behavior among those who read the message. People are motivated to change their behavior if you educate them about a relatively easy thing to do that can save some money. The financial impact of that was about $5.52, a gross savings per switcher of about $0.63, and that's across everyone. That's a substantial savings for something that doesn't require a lot of effort. I think we're just scratching the surface of the opportunities for that type of messaging.

As for some other research studies, there's quite a lot of activity in the academic community around these types of plans. Currently, six active studies are underway, including Parente, Feldman, Christianson from the University of Minnesota, one from City University of New York and one from Mercer Human Resources Consulting. These are all funded studies. The first one was actually funded by a Robert Wood Johnson Foundation grant. We have a number of other grant-based studies underway. We know of four other ones that are in development or awaiting funding. We can expect to see some results later in 2003 or early 2004. They're going to do a more in-depth analysis of what the experience has been for some of these early adopters. That will be interesting. As we all know, there have been limited data on some of these things.

Briefly, here are some implications for the marketplace. I touched on some of these already. I am referring to CDHP product basics, and I call them "basics," but I think these are the minimum things that are required in order to do what I would call a CDHP design. You can draw it in the market and you can offer a high deductible plan and slap an HRA with it and call that a CDHP, but I don't know how successful you will be with that. I think a lot of these other things are very necessary, and I think they define the product more so than the plan design itself does.

There are also 24/7 health coaching, outreach and case finding, health risk assessment integrated with coaching so you can put information in, incentives on disease management and health risk assessment. Web tools are probably the key feature of it—pre-member and member—so that you can educate. We don't have a market today in health care that people can at least access easily. In today's market we need to help the consumer understand how to access that care. We have our customized communication for education and support, and I already mentioned

member messaging. We need to integrate our customer service environment and our coaching environment with the members' Web site and the other information that they have available to them. You don't want to have someone call up for disease management or a coaching opportunity and get completely different information than what's available on your Web site. You have to have consistency there.

There are monthly member statements. For those people who don't have great access to the Web, they can receive statements about their use of health care to help them understand what the costs are.

A single explanation of benefits integrates all of those different pieces of health coverage, such as FSA health coverage and PCAs, and puts them all together so people can use them easily.

We are using a number of Web-based tools and content. As far as content, what we are talking about are health-related articles, the Healthwise Knowledgebase, the kind of treatment options that are available, what's appropriate for different conditions, decision support tools, articles and things like that. Our health coaches can bookmark and send health content directly to members' Web sites so that they can get access to that.

Our pricing is probably one of the more key components. What do different services cost? That is put in a consumer format so that people can use that information. The average person doesn't relate well to a current procedural terminology (CPT) code, so you need to roll that up into some sort of episode basis that the member can understand and use.

This is just scratching the surface of quality. As you're all aware, there isn't a lot of quality information available today. The health plans don't have the resources to develop a lot of that, either. We are using a few pieces of information that are available and getting started on that. We think quality is very important to this product as well.

There are the other health risk assessments, such as product design, and Steve touched on this a little as far as ordering of FSA. The way we view them, and again, with the integration of these products, it really looks at the PCA/FSA health plan. There are three different components that you can mix and match in many different ways. Anything on the spectrum, you need to consider a form of CDHP. What would make that a CDHP is integrating that with some of these tools and other assisted things to create a consumer environment. You can have the PCA/member responsibility health coverage, PCA followed by FSA, then member responsibility health coverage. Put the FSA first. Some of the players may want to do that. We've always had an option for employers to do FSA first or second, depending on their choice. Most of them have chosen to do that second, primarily because they normally will offer an unintegrated FSA that they offer to all of their plan

participants, which makes it impractical to try to do the FSA first because it messes up their administration of all their other health care benefits. That's a consideration there. Some of them have done it first, though, and had mixed results on that. The last ones are putting more of the traditional health plan together with an FSA to see if that would have some kind of overlay of those consumer tools as well.

Not directly included here is prescription drug only. That's a new product offering that we just rolled out recently. It's the same kind of plan design with the drug-only HRA and catastrophic drug coverage. We're just starting to market that.

A lot of people want to talk about the 80/20 Rule. The question is, with such a large percentage of claims being toward the high end of the spectrum, how do these CDHPs change enough behavior to have a real effect on cost?

There are a couple of other things that I want to point out, and they are related to where we are today in medical care. These are just a number of quotations taken from medical journals and other sources. "You have about a 50:50 chance of getting recommended care today." That's sad, but true. "Fifty thousand to 100,000 Americans die every year in hospitals due to medication errors." I think we're aware of that also. That's a sad statistic. "Sham authorization is as effective as the real thing." That's an interesting statistic.

There is one very important feature. "Widespread practice pattern variation increases costs but not quality." This is something that's been heavily studied over a long period of time. We have seen tremendous differences in utilization across the country with no discernible difference in quality. There is room for people to change their behavior and their care, and I think the patient is best suited to drive that change.

Here is another quotation about quality of care. "Thirty percent of all direct health care outlays today are the result of poor-quality care, consisting primarily of overuse, misuse and waste." You could argue with how they studied this and how they estimated it, but it could be as much as $1,700 to $2,000 per covered employee per year. That's real money, even with health care costs as high as they are today. There is a lot of opportunity to do better.

Another point I want to discuss here is evidence-based versus preference-based care. There are at least two different types of treatment out there. Evidence-based is clear-cut best practice, one best treatment. A good example of this is colon cancer. Every doctor you talk to knows what to do about that. There's no disagreement about how you should treat that. Good practice guidelines and chronic condition or disease management programs are available for that.

Preference-based care is another thing entirely, with a lot of different treatment options. A good example of that is breast cancer and mastectomy. There are a lot of different ways that you can treat breast cancer, with a lot of different possible

outcomes and tradeoffs. The best treatment for you may not be the best treatment for someone else, and so there are a lot of preferences that tie into that. We believe that shared decision making is the right approach to those kinds of treatment decisions, and that you need to provide consumers with support to do that.

My last quotation is, "Most surgical procedures are discretionary." I think that's interesting.

I want to tie in the clinical view of claim distribution. I thought Chart 4 was interesting the first time I saw it. One thing that people forget or maybe don't understand is that a lot of medical claims distribution actually consists of things that are significant medical decisions. Examples are hysterectomy, lower-back pain and cardiac care. Those are the red part of the chart. That's about 10 percent of employees, but probably about 25 percent or 30 percent of the cost. Both significant medical decisions and chronic conditions are the green area. Roughly, close to 50 percent of your costs are chronic conditions, chronic conditions and significant medical decisions, or just significant medical decisions. These are things where people have choices in treatment.

We don't think that consumer-driven care alone really affects most of these significant medical decisions. You need a little more to affect those. The bottom line is that there's a consistent amount of our claim distribution that is affected by the behavior or by patient choice. Not all things that drive up cost are completely up to the physician or to your health status.

One thing that is often overlooked when people talk about this 80/20 Rule—which is probably not strictly correct with health claims anyway—is that we're talking about the aggregate distribution. We need to remember that everyone starts off the year with zero claims and they accrue over time. There is a difference, at least from a behavioral perspective, of the first $1,000 of claims versus the last $1,000 of claims. The way I think about consumer-directed care is that even if I am a person with a chronic condition, if I'm someone who has a significant medical condition that happens at some point in the year, often I don't know about that or I'm not able to predict that. If I'm going to have a heart attack, I don't know that when I start the year. I still have the same kind of incentive as someone who doesn't expect to have a huge expense during the year. When you look at the distribution of claims, you look at all the claims. The first $1,000 of all claims is a fairly significant amount of the total distribution. There certainly is a lot of room for people to change their behavior.

To summarize, the CDHP market is growing rapidly. You could argue about exactly how big it's going to get, but who cares how big it's going to get? It's growing, and that's good. Financial and utilization results have been favorable and remain favorable. Basic CDHP product features—at least how I define them, and maybe I define them differently than others may—are not widely available from traditional carriers. People are just starting, particularly on the tool aspect of that, to fully build

a robust tool set to support consumer-driven health care. Many people have the product available, but not a lot of the support functionality. I believe that there's still much room for improvement in health care in general, that consumers can have an impact and that they're the only ones who can have an impact. Every transaction in health care is between a patient and a provider. The patient can have a lot more control over that than the health plan can, and that's why we're doing this.

MR. DEAN E. FISCUS: Thanks and good morning. My name is Dean Fiscus. I work at Aetna in Hartford, CT. I'm going to talk about what we have seen for CDHPs, but first I want to talk about what Aetna's products are all about. Then I'm going to talk about what we've seen in terms of enrollment and some recent results that we've obtained in terms of some analysis on an actual customer that has offered CDHPs.

The big thing, and my colleague has mentioned this as well, is trying to get the consumer involved with health care. In the past, HMOs have focused on co-payments and paying 100 percent of the benefit after the co-payment, and people don't necessarily understand the cost associated with health care. We need to start getting consumers engaged in the middle of the health care process, because they are definitely going to be there to help us out in terms of a solution. As the president of Aetna has said, "Consumerism is an attitude, not an event," which highlights that we want to somehow get the consumer in the midst of the health care.

Our product at Aetna is called Aetna HealthFund, and there are many facets of the product that I want to quickly review. One facet is the plan design, and I'll give a high-level overview of how our plan design generally works, but there are definitely many alternatives in terms of how the plan design works, depending on what the plan sponsor wants. I'm going to talk about network contracting. It's very important in terms of the product, in terms of making sure that the consumers as well as the plan sponsors get the discounts. I'm going to talk about medical management because many of the claim dollars that the plan sponsor pays are driven by large catastrophic claims, so you need to still have strong patient management programs. Then I'll touch quickly on the tools and communications that Aetna has to help that consumer in terms of support.

From a plan design standpoint, the way our plan designs generally work is that you have a fund balance of about $1,000, generally you have a catastrophic deductible plan and generally it's a preferred provider organization (PPO) product. Then you would have coinsurance if it was out of network, and preventive care generally would be covered 100 percent. Much of this depends on what the plan sponsor wants. If in year one a member in the family had an $800 claim, that $800 claim would go against the fund. There would be a remaining fund balance of $200 at year-end.

Going into year two, they would roll over that remaining fund balance, and the fund at the beginning of the year would be $1,200 that the plan, the member and the member's family could use in year two. This rollover feature will, I think, give the members the incentive to manage their overall cost associated with health care. That is generally how it works.

Some of the changes are continued innovation in terms of the plan design. When Aetna rolled out the product in 2002, we offered both a self-funded basis for a plan sponsor as well as a fully-insured basis. In 2003, we integrated pharmacy into this fund product, and we integrated FSA in 2003. We also have a stand-alone integrated dental benefit. In 2004, we are rolling out a stand-alone pharmacy benefit, so you could have a separate pharmacy fund with a plan design after the fund in terms of a higher-deductible plan on the prescription, so it could be a separate plan. We also have some additional features in 2004. If you have a fund balance at year-end, you could potentially use that excess fund balance for paying long-term-care insurance, about which we have seen a lot of customer interest, and, as was mentioned earlier, we're looking at retiree coverage. Many national account plan sponsors are contemplating what they can do for retiree coverage. We have seen in national accounts many plan sponsors contemplating eliminating retiree coverage altogether, and there's the potential for these funds. How can they accumulate fund balances and then when somebody retires use that excess fund balance potentially for paying for the person's retiree benefits?

A big part of Aetna's product is the networks and the providers. For a national account case, where you potentially have customers all over the country, it's very important to have strong networks and large networks all over the country. Aetna has almost 600,000 PPO providers, so we have very broad networks. We also have a fairly large pharmacy network.

As I was saying earlier, patient management and disease management programs that can support the members that we need to get in an appropriate program are very important in terms of this product. Aetna's programs wrap around this product. We use a lot of predictive modeling to try to identify people early on and make sure that it's the appropriate intervention program. This is fully integrated with our overall patient management strategy.

As was mentioned earlier, consumer tools are very important. Aetna has a Web site for a member portal called Aetna Navigator. On that tool there's lot of information for a member to access. A member can access where his or her claim is. Members can access enrollment information. They can look for a doctor who's in our PPO network. They can get a comparison of drug costs, or they can look at the price of drugs. They can also look at what the advantages are to a mail-order drug. There are also price procedures so a member can see what this procedure is going to cost on average within a certain ZIP code area. We also have a hospital comparison tool where a member can compare one hospital with another. We have information with regard to evaluating the health care provider and we also have HRAs, which is our

Simple Steps, as well as access to InteliHealth, where members can ask questions with regard to the course of treatment. Tools are extremely important in terms of what the member needs to be really involved with health care.

Let me talk about results and what we've seen at Aetna over the last couple of years. We now have 135 customers that are going to offer the Aetna HealthFund, and this includes 2004. We do have a lot of different business. More than one-half of our business is for insured. We also have a lot of option business. Generally, this is put out there as an option. It is not a complete replacement solution. For national account cases, they want to offer it to their members, get them comfortable with it and see how it works before they make dramatic decisions in terms of the complete replacement. For enrollment for 2004, we're anticipating somewhere in the neighborhood of 150,000 members. As Definity had mentioned earlier, we have a federal government account as of January 1, 2004. We will be offering to the federal government as well.

I have some additional results of surveys that we've done in terms of the members that we have enrolled in Aetna HealthFund. Generally, when you look across the board at these, it appears that we are getting 85 percent more concern about costs. Seventy-nine percent of people say that they are seeking healthier lifestyles and exploring options because they're in this product. We are seeing 67 percent saying that Aetna HealthFund provided them with a greater degree of control over their health care expense. Eighty-five percent said Aetna HealthFund provides access to information that helps them make intelligent health care benefit decisions and that they think, from the member's point of view, that people who enroll in this product are taking control of trying to manage their own health care.

What have we seen at Aetna in terms of enrollment? I would say that our distribution of the folks who are enrolled in Aetna HealthFund is very similar to what Definity was showing. We are seeing a fairly similar distribution to the overall book of business. We are seeing the average age is about the same, and we are seeing that the enrollees are in the middle range, between 40 and 50 years, who seem to have a higher percentage in Aetna HealthFund. We are also seeing that the actual folks who enroll are generally paid more on average, which makes sense, relative to the deductibles that are out there between the fund and the deductible of that quarter. Generally, those who are paid at a higher rate are willing to take on that exposure to the deductible. Since the majority of this is offered on an option basis, we are seeing a generally healthier population enroll in Aetna HealthFund as well.

What products are these people coming from? Based on our book of business, they're coming from a lot of different products. Fifty-three percent are coming from point-of-service plans, and 8 percent are coming from indemnity. We're getting folks from HMOs (11 percent) as well as PPOs (28 percent). It's not as if they're all coming from one product.

What have we seen for results? I'm going to talk about a study that we have done to try to get a better handle on the results. This is a 2002 case study that was based on a plan sponsor that offered Aetna HealthFund on January 1, 2002. This study is based on only 450 members so it is fairly small. We did an analysis of the individuals who enrolled in Aetna HealthFund, and then we went back and got their claim experience prior to enrolling in Aetna HealthFund. We took the utilization information and compared them to what actually happened in Aetna HealthFund. It was essentially a year-over-year comparison of these numbers. This was based on medical claims only. It does not include prescriptions, because this particular plan sponsor did not integrate the pharmacy benefits into the Aetna HealthFund. The members came from many different products in 2001, including HMO, PPO and point-of-service plans.

What did we see? In this population, we saw that the admissions were down. We saw the ambulatory cases were down, and we saw that emergency room business was down. Keep in mind that we were comparing 2001 with 2002 for the actual people who enrolled in Aetna HealthFund. Directionally, it appears that Aetna HealthFund, or this CDHP, is having an impact. We saw primary care physician (PCP) visits go down slightly. We saw specialist visits go up, and this could be because in the past, they would have had to go to a PCP for referrals. Now that there's direct access to specialists, we saw specialist visits go up when these members moved to Aetna HealthFund. We saw preventative care stay about flat and ancillary services go down.

On the fund rollover on the results, we saw a fair amount of the population that was enrolled in Aetna HealthFund roll over dollars. Fifty-nine percent of the participants rolled over some or all of the health fund. There definitely was rollover taking place. On average, the fund rolled over about $260, so members do roll over. We also saw a re-enrollment of 83 percent from year over year.

From an ongoing-study standpoint, I would say that this is based on only 450 members. With a fairly substantial enrollment on January 1, 2003, we are now in the process of doing the same type of study where we go in and look at the claim experience prior to enrolling in Aetna HealthFund and get an idea of what's happening to these members when they roll over. We have about 300,000 member-months, and we have probably about 50 percent of that membership who will have a history with Aetna. We will be able to really drill down and understand what was happening before and after.

Many of the studies out there raise a lot more questions around populations. How does it work when it's an option, who enrolls and how do the different plan designs work in terms of getting people to enroll? There are definitely a lot more questions out there with regard to whether this can effectively manage health-care costs and utilization, and whether there are particular populations that do it better than others. We need to continually look at the long term, including looking at one year over another year, at what happens to those same numbers in the following year.

You might see a one-year phenomenon where maybe utilization drops off, but over time it comes back up. You need to look at this over multiple years.

MR. COSWAY: Does anybody have any questions?

MR. WILLIAM R. JONES: I was intrigued by the use of fund rollovers for retiree health or even long-term care that Dean talked about. I wondered if there were any federal limitations on how much you could accumulate in a rollover status, and whether there has been any thought to the amount you could eventually keep that would be a significant amount to put a dent in retiree health-care costs.

MR. KACZMAREK: Since I was the regulatory guy, I get to answer that first. I'm not aware of any limitations on the volume or the amount of funds that can be rolled forward. It is clear, though, that the use of those funds for retiree medical is not disallowed, so I think many people are looking at using them as a possible coping strategy to help deal with retiree medical costs.

MR. TUOMALA: Just from a practical perspective rather than a regulatory perspective, we've had clients who have been doing that since 2001 on a retiree basis, both pre-retiree and post-retiree, and who have been allowing the active employees who were retired to carry over any remaining balance. We don't have any clients to date that have done a retiree-only product. Quite a few people have kicked the tires on that quite a bit, but really haven't done it yet. I would want to say about 25 percent of our clients actually offer the Definity Health product as another retiree option. It's not uncommon for them to do that even today.

MR. FISCUS: This money is still employer's money and from an employee standpoint, I think that there is a lot of concern if you have someone who's very young and starts accumulating a fair amount of money that's in this fund. Is it a segregated account? I think there are a lot of issues that could be raised in terms of employee relations about how these retiree funds are handled.

At Aetna, we recently offered a few more options for Aetna HealthFund to our employees, and it does raise a lot of questions around what the long-term strategy is and what happens if a plan sponsor suddenly says, "This isn't working. I'm going to pull the plug on this." When the sponsor pulls the plug on it, that's employer money, not members' money. The funds are trying to get the employee or the member to think that it's the member's money, but in reality, it's not.

MR. JOHN DUNN: You talked about a plan sponsor offering on a full-replacement basis and on an optional basis. Have there been any studies, or what's the evidence in the option replacement as far as selection goes? Many people are worried about that component. As for the total cost of the employer in the option or replacement, is the employer really saving in total or is it selection and so forth?

MR. FISCUS: I think much of it depends on how they have stacked the CDHP and what it's competing against, and whether or not it's the lowest-cost plan from a benefit-selection point of view or member-selection point of view, or the highest-cost plan in terms of selection. We have seen some customers who, on average, have gotten generally the same population in terms of medical costs enrolling in the HealthFund versus their other options. Much of it depended on how they stacked the contribution in the plan design. There are some plans we've seen where there has been positive selection in terms of the medical costs of the people who enroll in this product. I think it depends on the particulars of the account.

MR. TUOMALA: I would echo that. I think, certainly from our perspective, that we haven't had an opportunity to do a lot of explicit measurement of risk selection. I know of at least one example where we were able to look cross-sectionally at all the different plan offerings for an employer and determine what the explicit risk selection was. For that particular example, we were a dramatically higher-risk population, so it's not an all-or-none kind of a decision.

Among the results that I've seen, at least directionally, when you look at a group, it's at least evident that there's probably selection of one sort or another, very high or very low. We have cases in which their actual cost is much higher than expected compared with the rest of the group. Typically, those are groups that have had a very rich benefit with a moderate contribution. So if you have a very low out-of-pocket responsibility for the member coupled with a moderate contribution, it's not surprising that that would happen.

Similarly, you can have a fairly stripped-down benefit design or a fairly large out-of-pocket responsibility for the member, particularly if you have a low contribution. If you price it 15 percent or 20 percent below the other options that you have today and also have a fairly stripped-down benefit design, then—surprise, surprise—you get a positive selection in that plan design. I would argue that you could put any plan design in with those same kinds of parameters and produce exactly the same sort of selection. The employees aren't stupid. They're able to look at the options that are available to them and do the basic math to determine whether they're likely to be better off or worse off under a plan.

I would also suggest that you see very few examples of average selection. That's probably also true of any plan offering, but it tends to be hot or cold. We see a sort of bipolar distribution, with a lot of groups that are much lower than average cost and others that are much higher than average, but not a lot that are clustered in the middle. Again, I think the parameters of the environment that you're offering in have a lot of effect on what the result is.

MR. KACZMAREK: I think there are actually two questions there. The first has to do with adverse selection, the level that might be in the multiple-choice environment. The second directional strategic question from our Intercompany Rate Survey dealt precisely with that question. Respondents in a multiple-choice

environment with two offerings said that they were using in practice 1 percent to 4 percent adverse selection loads in their total pricing. If it is a modest adverse selection load that introduces itself, and based on the information presented today, it sounds like there's enough of a mix where there's not a pure segmentation of the better risks with the HRA and the worse risks with the traditional plans.

If, in fact, there is some sort of a mix, and we can estimate what that adverse selection component is, the next step of the process is, which I think is the second question, how do you structure that benefit so you achieve your financial objectives over a multi-year period? To answer that question, first, the data doesn't exist today so we're forced, as actuaries, to use something called "n-fold convolutions" of claim probability of distributions. You may recall that from the examination process. We're looking at a set of assumptions using claim probability distributions to derive the likely outcome over a 4- or 5-year period. To look at this for anything less than that length of time is not giving the subject adequate service, because this is a longer-term commitment that employers are making whenever they start signing the employees up.

One of the underlying assumptions you could make is your turnover rate, for example. To the extent that we're left using that sort of raw claim probability distribution data and underlying assumptions, there's a certain level of risk that we're undertaking. That's why I keep referring to wanting to get at the data over successive years. Since it won't be available until 2006 or 2007, we're left with dealing with the best that we have, which is the distributions we have today.

FROM THE FLOOR: This question is directed to Dave. It's with regard to your renewals and projected renewal increases. To what extent, if any, were there any assumptions made for the fund carryover and, if so, how far did your assumptions vary from the actual fund rollover that you had seen?

MR. TUOMALA: That's one reason why, for a consistent comparison, we look at the premium equivalent projections compared to expected as kind of a proxy for how the plan is performing. Normally in our funding rates, on both sides of the expected from the past year-end with the projected, we use 100 percent of the current year contribution as the PCA component or HRA component. We ignore the n-fold convolution part of that.

When you get into the ultimate usage of the PCA or the HRA over a 5- or 10-year period, it's going to be pure speculation on who uses that, and how much they use. You are going to have to resort to doing a lot of gymnastics with claim distributions. What we've chosen to do, and most of our clients actually account for it in the same way, is to expense the full amount of the PCA year one. If I have given you $1,000, we'll take an expense load for $1,000. If some of that ultimately gets forfeited when employees leave or whatever, they'll capture that at that point. From a projection or funding perspective, we'll just assume that 100 percent of that as available and used.

MS. SANDRA GIBSON: Does the employer record as an expense the portion that's rolled over each year from the HRA, or is that just money recorded in the employer's expense and it doesn't show up until the next year? How does the employer account for that in his own bookkeeping?

MR. TUOMALA: I'm not an accountant, so I'll qualify that. However, I have looked into the accounting treatment of this on behalf of our clients. There are two schools of thought on the accounting treatment of this. One of them is probably the minority view currently, as I understand it from discussions with our client base. This view is that you treat that rollover amount as expensed when it's used. You would establish an incurred but not reported–type reserve like you would with any other self-funded health plan. You would say, "I'll take an expense for the amount that has been incurred but not reported, but nothing so that the unspent balance is floating out there and not expensed." As I mentioned earlier, most of the clients are being very conservative in the accounting and taking an expense for 100 percent of those balances in the current year, and then they'll make an offsetting entry, if and when some of that gets forfeited ultimately.

We have done projections over a fairly long period of claim distributions from year to year, using independence, which is kind of a bad assumption, but necessary to some extent. A very high percentage, under almost any scenario that you look at, will ultimately get used because as people persist in the plan, they're more likely to use it. If you build up a big balance, you have to stay with the plan for a long period of time. If you stay with the plan for a long period of time, you're more likely to use it. The ultimate use of that might be north of 90 percent, so to use an assumption of 100 percent is not terrible. There's no explicit guidance in the accounting literature that would tell you how to do that.

FROM THE FLOOR: Obviously, the provider reimbursement arrangements would have a large impact on whether these CDHPs are meeting their employers' cost objectives or not. I'm interested in what these types of reimbursement arrangements are compared with, say, an HMO or a PPO product.

MR. FISCUS: From Aetna's standpoint, the HRA is in front of our PPO product, so the reimbursement arrangements are fee-for-service for physicians and probably per diems for the hospitals; they would not be capitated.

MR. TUOMALA: Definity Health is similar. Presently, we use about 35 networks nationwide. We've actually used a regional strategy where we've identified, in every area of the country where we have significant employer representation, the best available PPO network that we can rent. We have about 35 of those currently, and we're adding more over time, but we're using a traditional rental PPO network.

MS. EVELYN PENDLETON: We talked about it being the employer's money, but the employees think it's their money. Do you see regulations coming out later to

protect the employee? In reality, couldn't an employer decide in five years not to do it any longer and just take that expense off their books?

MR. KACZMAREK: That's a great point. I don't see anything that's addressing that risk or any attempts to using the safeguards that are in place for other forms of benefits. That's one area where, the first time someone gets burnt, we'll probably see a reaction.

MS. PENDLETON: I was in pensions, and I remember the pension plans, at one point in time, stripped the benefits and then put rules in to protect the employees.

MR. KACZMAREK: This may be one more time where history repeats itself.

MR. TUOMALA: That's certainly possible. Right now, however, I think it's problematic from an employer perspective. There's no way that an employer can, short of allowing them to participate in the Section 105 Plan for perpetuity, make that money the employees' money on a tax-qualified basis. It's kind of a chicken-and-egg thing. Frankly, I think all of us sitting at this table would love to see some sort of legislation that would enable a pure employee-owned account, but right now it's not available. That is possible in the future. However, I think the same thing could be said for a lot of retiree medical plans today; you could simply cancel that plan if you wanted to and the employee has no recourse

MR. FISCUS: Your question is important if we're going to start using these funds as they accumulate toward paying for retiree benefits when someone retires. If the plan sponsor is saying, "This is how you can save for your retiree coverage, so start accumulating now. If you accumulate enough money and then you retire, here's your $10,000 that you're going to have to pay to retiree benefits." It gets harder and harder for the plan sponsor to be able to pull the plug on this when the employer set the stage that this is what the employee can use the money for. I think there's more to come on this one.

MR. SETH KATZ: How much usage are you seeing for the Aetna HealthFund to cover dental expenses?

MR. FISCUS: In terms of an integrated plan where you have medical and then dental coverage is in?

MR. KATZ: Either that or on the stand-alone. It covers both, right?

MR. FISCUS: Actually, for the Aetna plan of benefits for the employees, we have an integrated dental and pharmacy. I would say that the product just rolled out. Customers have been asking how it works. You look into integrating both with a medical, so I would say we probably have very few customers right now that have that. It just started.

MR. CHARLES BROOKS: Do you have a high-deductible plan on how high that HRA balance can be in the first year? Then in subsequent years, do you do anything different in underwriting when you have these large account balances?

MR. FISCUS: Do you mean, on your first question, how much will the plan sponsor allow the member to roll over from one year to the next?

MR. BROOKS: In your example, you had a $1,000 HRA with a $3,000 deductible. Do you put any sort of limit, like 50 percent? Do you only allow the employer to put in about $1,500 out of the $3,000, or do you allow the employer to put in $3,000 in the HRA up front?

MR. FISCUS: We have both fully insured and self-insured business. From a self-insured standpoint, the plan sponsor can choose how to handle that. For example, where does the employer want that corridor between the HRA and the deductible? Some plan sponsors want the member to always have some skin in the game in terms of his or her HRA accumulations. If the employee's HRA accumulates $3,000 and the employee has a $2,000 deductible, that is almost a 100 percent benefit from the member's point of view. They might want to say, "Okay, we'll allow you to use $1,500 of that, but then you have to pay $500, and then the plan kicks in and pays 100 percent." It depends on how the plan sponsor wants to structure it and how the plan sponsor wants to encourage getting the employee—the member—involved.

From an underwriting standpoint, in terms of projections for the following year, was your question around how you project what the paid claims are going to be?

MR. BROOKS: If you're allowing the balance rollover, essentially you could be providing first-dollar coverage, so do you do any sort of underwriting adjustments?

MR. FISCUS: I would say on the underwriting projections, too, since it's a higher-deductible plan, there is going to be this accumulation period that takes place toward that deductible, and maybe the majority of people start hitting the deductible during the latter half of the year. If you only have a claim experience that you're analyzing, say, the first 6 or 8 months of the year, make sure that you're taking into account that you do have this high-deductible plan sitting out there in terms of projecting the claim into next year. I think these high-deductible plans change the way that you think about underwriting.

MR. TUOMALA: We have a handful of clients that have put some kind of a cap on the amount that could roll over. Generally, we discourage that. You have a notional account to begin with and you want the sense of ownership in that. If you put too many restrictions around how people can use that, particularly on the rollover side, it starts to feel less and less like it's their money. It's more like a fictional account that you have given me. We don't encourage that. The employers that have done it have put a very high multiple on it, upward of five times the annual contribution.

Actually, most of the groups that we've worked with have been in here for a limited amount of time. Most of them are single PCAs of $1,000 or $750 and double that for families. You're not talking about huge balances at this point.

One other point I would make is that most clients who have been in for multiple years started out the gate with multiple deductible options, so they'll have a buy-down deductible available for someone who's carried over a sizable balance. They might have a base deductible of $1,500. You could buy down to $2,500 if you have an account balance. There's still a gap, and it's a smart thing for them to buy down to that smaller deductible. Many clients that started out with one plan design have actually added another one in their second or third year.

MR. JOHN DAWSON: I've seen several sales presentations for CDHPs, and the salespeople are saying something that's kind of fascinating. They say that these underlying tools that help the patients become more intelligent and make better decisions are what will save the money. If we offer this on a choice basis, they want to see the sick people enroll in this plan, not the well people. I want to hear a bunch of actuaries say, "I want sick people enrolling in my plan," because that's really counterintuitive. Usually we want the healthy people, and we'll weed out the sick ones.

MR. FISCUS: Many of the tools that Aetna is creating are not just for Aetna HealthFund. They're for all products that we have out there. Whether you're in an HMO or a PPO plan, or an Aetna HealthFund option, put those tools out on a member portal you can access and get involved with that.

MR. TUOMALA: I have two reactions to that statement. I've been in an unusual position the last three years of advocating for the sick people. For the first 10 or 11 years of my career, I was always on the other side of that equation. That's been a new development for me, but that was to counter the risk selection argument that we'll obviously get the younger and healthy people.

From a clinical perspective, though I think our medical director and people who work in that area would actually agree with you, we would prefer to get at least a higher mix of the less healthy people, because, certainly, there's more opportunity for behavior change, education and consumer-directed care for a lot of the things that I've pointed out in my presentation. If you're someone who uses a lot of care, you might be getting 25 percent or 30 percent unnecessary care today, and if you have a financial incentive, you may change that. There's a lot more behavior change possible for that population.

From a practical perspective or from an actuarial perspective, in a perfect world, that would be great, because one of the things that we struggle with on an employer side is an employer who has absolutely no idea and no good data available on the 15 different plans that they offer, has no idea what their existing risk selection is or any way to measure that. If you have a CDHP design that

appears to be costing more than one of your other options, it seems like a bad thing. Now that may not be true, because you may have gotten negative selection in that plan. It just makes it more challenging for us, with no information, to try to sell that to the employer on renewal. From a selfish perspective, it makes things easier if you do get positive selection, because people are willing to ignore that because it looks like the plan is doing well.

MR. KACZMAREK: I think we want to see sick people in the most cost-effective, high-quality program. The question is, is that going to be an HRA offering or is it going to be a traditional HMO? The medical management, case management and disease management offered under an HMO are trying to get at managing costs and providing high quality in a totally different fashion than the HRA, which is relying upon consumerism. Which of those forces is stronger? I think the jury is still out, and that's what we're trying to get enough data to assess.

FROM THE FLOOR: I have two questions, primarily about the funding. The first would be a follow-up to Evelyn's question about the vesting of the fund. If there is no employee vesting, doesn't that act as a disincentive for a person to allow that to roll over instead of using it, because it's available now, but it may not be available later on?

The other question is related. One of the presentations talked about the coordination of this fund with the FSA. Under what circumstances would it be better to not use the FSA first because that clearly is a use-it-or-lose-it kind of an account?

MR. KACZMAREK: The answer to the first question is "yes." That point is one that an association of CDHPs has been lobbying to change. I think the point is well-taken. People are hoping that some sort of provision can be developed so that in the future people do feel like it is their money.

To the second point, you could think through the two different options. If the FSA comes first and you put money into your FSA for eyeglasses, but you go to the doctor and your cost-sharing gets paid for out of the FSA, you don't have any money left for your eyeglasses, and it hasn't served your needs. If the FSA comes second and you're putting your own money in there, but you don't use up your PCA or health fund, not only does a portion roll over, but you've lost your FSA contribution. When I said earlier that it doesn't work perfectly either way, that's what I was referring to.

MR. TUOMALA: I would qualify the "yes" with "not yet." I think that's a potential future problem. In the first few years of the program, I don't know that it has surfaced as an issue with any employer as something that employees have brought up. I think employees are conditioned to not have a lot of continuity in health plans, so they certainly haven't raised that as an objection that they need to be vested in these balances.

I would agree with what Steve said on the ordering of the FSA. I think one of the keys is what benefits are covered under each. If you have consistent benefits covered, identical benefits under FSA and HRA, ordering is less important. Then you can make an argument for using FSA first because it's use-it-or-lose-it, and letting it roll over in the HRA. Where you run into problems is if services are covered under the FSA and not under the HRA. That's where you find you've used money that you have actually earmarked for something and then you can't use the other account for it.

MR. FISCUS: Based on the studies that we've done, the folks that enroll in Aetna HealthFund enroll in an FSA account at a higher percentage than the overall population. It appears that you still want to offer an FSA with Aetna HealthFund because it seems that the members understand it and are using it.

MR. LESLIE STRASSBERG: I understood from the presentations that these contracts are all written right now on indemnity PPO-type paper. Given the underlying economics of writing on indemnity PPO paper versus writing on true managed-care paper, when do you see or do you see the industry moving toward being able to put these contracts on the more economical HMO-type paper?

MR. KACZMAREK: Some people out there are doing that already. There's a joint venture between Tufts in Boston and Destiny Health. I think that's an example of it being done on HMO paper just to start off.

MR. FISCUS: For Aetna, we write it off of our indemnity paper. I think it comes down to the contractual differentials between your HMO contracts potentially and your PPO contracts. One of the big differences is the capitations that are on Aetna's HMO product. We do not have capitations on our PPO products. If your fee-for-service arrangements are consistent with what your overall cap is, or equivalent, I'm not sure whether writing off of the PPO paper makes much of a difference versus the HMO paper. All of our patient management and disease management programs that we can, we overlay on our PPO-based product. You are getting the benefits of all of our patient management programs on our PPO paper and on our indemnity paper.

FROM THE FLOOR: What about at Definity?

MR. TUOMALA: At this point in time, we're doing self-funded business only. We're using PPO networks. We have no option to use an HMO mechanism. We have no desire to at this point in time.

MS. DANNA METTA: Looking at some of your graphs and charts, it appears that most of the people who have selected these programs are middle-aged and probably more affluent, and therefore more of the professional and thinking type of people. There has been good improvement in reducing the utilization. If there was some incentive devised so that the general masses are provided an incentive to

select these plans, do you feel that utilization would still be controlled as well? I'm thinking of our vast quantities of consumer goods out in this country and which people don't buy the best values that are out there, and that there are several optimal consumer goods that are purchased in vast quantities. What's the difference between that and purchasing health care in a very optimal manner?

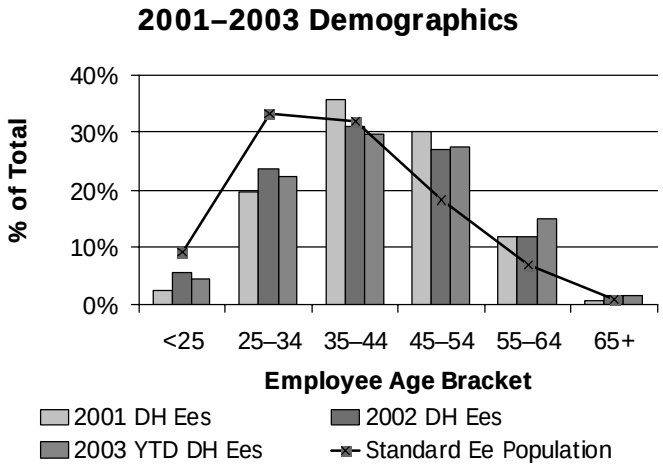
MR. TUOMALA: To clarify, we have not seen generally higher-income people enroll in our CDHP, and that may be a function of the diversity of the groups that we have enrolled. The industry that's probably most prevalent in our population is manufacturing. We have a lot of lower-education, lower-income, rural kinds of populations that seem to have no problem managing with this kind of a plan.

I didn't point out in my presentation that we offer all of the same content that we offer over the Web via telephone. We also offer the mail statements and things like that. There certainly is an ability for someone who is not that technologically advanced to access the same kind of information. We've seen the same kinds of results when we've been able to compare before and after experience, regardless of what kind of a group or population we were looking at. It doesn't seem to be highly educated, wealthy people only who can be served by this product.

MR. FISCUS: It gets back to the point around the plan sponsor and what the plan sponsor is offering. If more studies come out indicating that this product does manage utilization, then you are going to see plan sponsors pushing hard to get more members and more employees enrolled in this. Then it comes down to if they start eliminating options, employees will have no choice but to elect one of these options. Much of it depends on what the plan sponsor does.

Chart 1

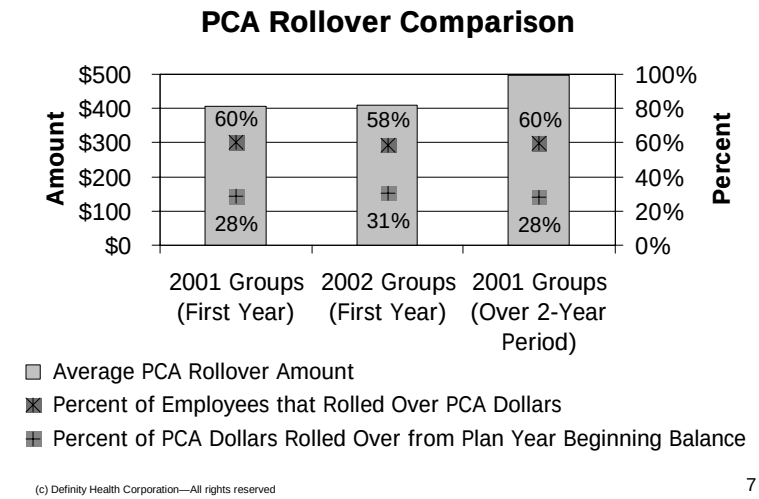
Definity Health Employee Demographics



6

Chart 2

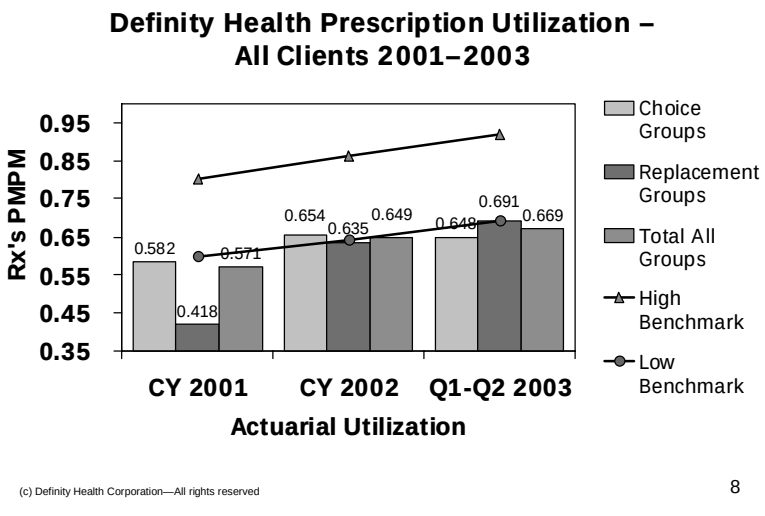
PCA Rollover Trends



7

Chart 3

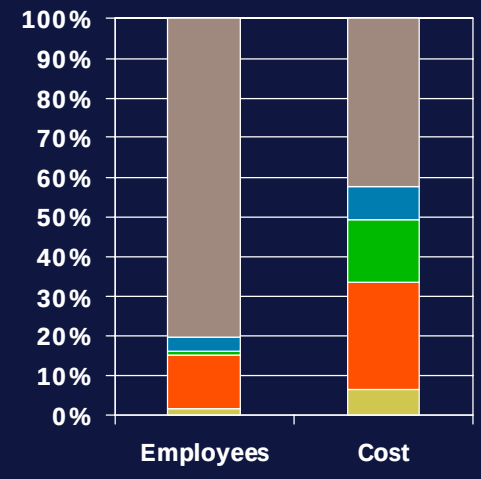
Pharmacy Results



Claims data through June 30, 2003

Chart 4

Claim Distribution - Clinical View



Chronic conditions

- Diabetes
- Asthma
- Cardiac
- Etc.

Significant medical decisions

- Hysterectomy
- Low back pain
- Cardiac
- Etc.

25