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Session 95PD
What's Happening with Consumer-Driven Health Plans (CDHPs)?

Track: Health

Moderator: LORI WEYUKER

Panelists: EMMA HOO†
NEAL OKTAVEC‡
SCOTT WELTZ

Summary: Panelists discuss consumer-driven health plans (CDHPs) and their impact on the marketplace: short-term impact vs. expected long-term impact, whether or not CDHPs are here to stay and risk-transfer implications. Attendees gain valuable insight into the performance and future of CDHPs.

MS. LORI WEYUKER: We have three interesting panelists with some interesting points of view on what's going on with consumer-driven health. I'd like to introduce them in the order in which they're going to speak. Scott Weltz is a consulting actuary at Milliman in Milwaukee, Wis. Scott has over nine years of experience at Milliman, and in the past three years he has been focusing heavily on consumer-driven health. He has a good level of depth. He's going to focus primarily on how to price consumer-driven health. Next we're going to have Neal Oktavec. Neal is senior benefits analyst at Wells Fargo Bank in the corporate office. Neal has over nine years of experience at Wells Fargo. His areas of expertise include decision support tools and the analysis using these decision support tools. He's been focusing heavily over the past couple of years on consumer-driven health. He's going to focus on a real-life example for a large employer. Last but not least, Emma Hoo is from Pacific

†Ms. Hoo, not a member of the sponsoring organizations, is director at Pacific Business Group on Health in San Francisco, Calif..

‡Mr. Oktavec, not a member of the sponsoring organizations, is senior benefit analyst at Wells Fargo Corporate Benefits in San Francisco, Calif.

Business Group on Health (PBGH), which is a large group purchasing coalition representing over 43 large employers in California. The company has some real-life examples of what's going on with consumer-driven health and some real data to show you what its experience shows the implications are for consumer-driven health at this point in time.

MR. SCOTT WELTZ: When I first saw the session title, I thought that this would be an easy topic to talk about. What's *not* new with CDHPs, since there are not many of them out there? I thought maybe I'd focus on health savings accounts (HSAs), being that they would only be six months old at this point. That went by the wayside because everybody and his brother are putting something out there on HSAs, and I'm sure you've been inundated with that information already. Instead, I'm going to focus on some of the work that I've been doing a lot of recently. Many health plans out there are starting to jump on the "consumer-driven" bandwagon. Up until this year, there has been a lot of discussion strategically that maybe we'll position ourselves to eventually go this route, but no active product development, plan design or anything like that was going on. This year there is a lot of that going on.

I'm going to touch on what's hot in the market right now and what health plans are doing. I'm going to focus a large portion of my presentation on pricing issues surrounding, specifically, high-deductible health plans. If you're a health plan putting out a fully insured product, that's going to be your risk unless you're doing one of these pseudo-types of health reimbursement arrangements (HRAs) where you also insure the account, which is not nearly as prevalent. With pricing, I'm going to focus on the utilization changes and the selection impact when you implement a CDHP, especially in a multiple-option setting. I'll touch briefly at the end with regard to communicating CDHPs to employers, from both an employer cost perspective and an employee's perspective.

Not sure about "a multiple-action signing" above.

What's hot? First of all, high-deductible health plans are hot. Up until this year, there hadn't been that many carriers, other than a handful of the large ones and the innovators in the CDHP arena that had gotten involved with this market. Now, like I said, we're getting many requests for high-deductible health plans. They seem to be going two routes. They'll either put together a high-deductible plan, which is compatible with HRAs, and/or HSAs. Right now we're seeing a lot of focus on HRAs because the legislation with regard to HSAs is still up in the air. The IRS continues to come out with guidance. In terms of the 2005 plan year, most employers, if they are opting for consumer-driven plans, tend to be going the route of HRAs.

Insurers, in turn, are offering products that they can pair up with those. That's an easy transition for most insurers, if you're just talking about offering the high-deductible plan and not all the additional support tools with it. Most plans have a PPO out there, so all you do is increase your deductible levels, perhaps your out-of-pocket maximums and office visit co-pays to some extent and away you go. You don't have to worry about all the things you do on the HSA side with regard to drug

carve-outs, not having any office visit co-pays underneath the deductible and things of that nature. Insurers are looking at that as a prime opportunity in the coming plan year. With regard to the long term, the viability of that product is somewhat questionable because HSAs could take hold in the future, so you could go through this whole plan design process and have a product out there that's viable for only a couple of years. However, in terms of maintaining your market share, it's better than nothing.

On the HSA side, there are a number of entities coming out with what are intended to be HSA-compatible, high-deductible health plans. There are still a number of outstanding issues with regard to state mandates and things of that nature. As many of you probably know, you can't offer any first-dollar coverage underneath the deductible except for preventive services. If there are state mandates with regard to things like behavioral health, where you'd have to offer some first-dollar coverage, insurers aren't sure whether or not those will qualify as high-deductible health plans. Nonetheless, some are coming out with those plans just in case they will pass muster. Again, in the long term, it's difficult to say but it appears, based on the tax treatment of these plans, that employees will likely demand HSA-compatible type products in the future, so it's definitely something to keep your eye on.

There's another group of insurers, a smaller subset of the ones I just talked about, that are taking a more active approach in trying to gain a foothold in the consumer-driven market. Those that are offering only a high-deductible health plan are taking a defensive approach. They want to maintain their current employer clients that they've had for a number of years but that are threatening to leave if they don't offer them an HRA- or an HSA-type of plan. The other approach is not only do you want to maintain your market share, but also you want to gain some market share in the coming years as these things potentially grow.

In addition to offering the high-deductible health plan, they try to offer the entire suite of services such as account management; pairing up with financial institutions so you can offer a number of different funding vehicles with HSAs in particular; and offering the decision support tools, including offering provider information on quality and potentially cost (although I think there are a number of contractual issues there if you're going to publicly show your provider costs), plan selection tools for the employee, self-help and self-diagnosis (WebMD-type tools), nurse help lines and things of that nature.

Some of the spending account products also are now being paired with tiered provider networks to get at the cost problem from a number of different angles. They'll offer tiered provider networks much like the ones that are out there today, where you vary the employee contribution rates or the employee cost-sharing based on the breadth of the network. That's not nearly as common, although it's somewhat attractive to some employers. You're starting to see more plans that offer financial incentives with the accounts, where the employer might make an

additional account contribution if the employee decides to participate in a disease management program. The thought there is that CDHPs get at the discretionary services at the lower cost levels, and you can't do as much at the higher cost levels, so you might as well try an approach such as that.

Let's transition to pricing issues. Like I said, I'm going to touch on both the utilization aspect and the selection issues involved with CDHPs. Most of you have probably heard this one. Relative to the typical products that are out there, CDHPs are expected to have reduced costs primarily because the discretionary services could potentially be reduced as people become more aware of what health care actually costs. They don't want to pay $100 for that office visit, whereas before they only had to pay that $10 co-pay. You have substitution of services and things of that nature. (Emma and Neal will have more to talk to you about there with empirical evidence and will tell you to some extent what that's worth.)

From what we've seen at Milliman—we have some of these data sources as well—the CDHP experience does support this. However there are some caveats. Many of the consumer-driven products that are out there have either been available in the individual market, where selection is still an issue, or in the employer group market, but on a dual-choice or a multioption basis, where again selection is an issue, so you're likely getting a healthier-than-average population.

What do you do as the pricing actuary? Do you ignore utilization changes? If you do that, with the competition that's increasing out there, you're probably going to lose a lot of market share, but you'll definitely be conservative. If you use the existing experience that's out there and don't adjust for selection, you might be somewhat aggressive, but you'd likely gain market share. The third alternative, and this is the one we tend to go with, is to make some educated assumptions. You have an idea of what the bounds are with regard to how the costs can vary. From there you have to adjust for the various risk characteristics that these types of plans present to you.

We've taken a look at utilization by type of service. You would expect that the nondiscretionary services, such as inpatient costs and things of that nature, would not decrease nearly as much as things like office visits, prescription drugs and emergency room visits. We've taken a look at some of our claims databases, which, granted, have underlying them more typical plans with $250 or $300 deductibles, and from there made assumptions on a longitudinal basis throughout the year to reflect the potential decrease in costs. Granted, these are merely assumptions at this point because there's not enough credible experience to justify them. What's valuable is to sensitivity test them to see what the range of the total reduction in utilization could be depending on how costs are adjusted.

We'll take an individual. Say the individual has had a $250 deductible in the past. Now we'll assume the individual has a $2,000 deductible and, based on the type of claim the individual has, adjust the individual's costs accordingly throughout the

year. We adjust them differently if they're underneath that deductible or above it because once you reach the deductible, the impact on your behavior shouldn't be nearly as great as it is underneath it. In addition, if you place an account with these high-deductible plans, for example you put a $500 account with a $1,500 deductible, which is a common type of HRA or HSA design, we'll adjust further for that first $500 of expenses to reflect the potential "woodwork" effect. You're going to bring people out of the woodwork if before they had zero dollars in claims, but now you're offering them some money to pay for services on a first-dollar basis. What we haven't done at this point is vary things by the type of conditions that are out there, such as chronic, catastrophic or routine. You could make varying assumptions for that, but again, there's just not enough data out there. It is valuable from the point of getting a sense for the range.

Having said that, if you're a health plan, you're likely not going to go through that entire exercise because it's time-consuming and it's still based on a number of assumptions. That kind of exercise becomes more valuable once we have more credible experience with which to populate that model. What we tend to do instead is look at the potential aggregate reduction in the utilization of services. What we focus on is not just what that number is—is it 5 percent, 10 percent or nothing—but how that impacts the distribution of claims. When you're dealing with high-deductible products, that's important in terms of determining the value of the deductible and the leverage. The other advantage to this is that it's much easier to do and much easier to implement, although it is somewhat less refined. In the future, you'll likely see more sophisticated models, but at this point we're at the beginning.

Let me give you an example of what I'm talking about. Let's say this health plan has a base claim probability distribution (CPD) underlying its experience. It comes to us and says, "We're going to implement this high-deductible health plan and don't think that utilization based on our plan design can go down more than 6 percent. How should we adjust for that?" We say, "Don't just take your insured costs and knock them down by 6 percent. What's going to occur is that you're going to get a shift in the distribution. The shift will likely come at the lower end of the CPD. At the upper end, you're not going to impact anybody's behavior who has a $50,000 claim. If you put in a $500 deductible or a $2,000 deductible, there's not much you can do about it. But at the lower end of the spectrum, you expect a general shift. That's what a utilization reduction is." That's what we try to get at. We talk it through with them and say, "What if you implemented a CDHP and put one of those accounts on a first-dollar basis? How do you expect the utilization to change? It's likely you'd get less at the zero-dollar level and a little more in the intermediate levels of $250 to $500." When we've done this, average costs went up roughly 2 percent relative to having a high-deductible health plan by itself.

We're doing this because once you calculate the insured costs for the high-deductible plan and remove the value of the deductible, that results in a 9 percent decrease, in this example, for the high-deductible health plan, not 6 percent, and a

7 percent reduction for the consumer-driven plan, not 4 percent. As competition increases out there, these are the types of things you might want to reflect to make sure you've evaluated the cost as well as you possibly can at this point. We also try to emphasize with the health plans that there's going to be a correlation between the deductible and the account funding level and the nature of the account itself. The real concern here is with HRAs. Most HRAs that are out in the market today have an unvested nature to them. If the employee leaves the company, the employee can't take it. As those account balances grow, the concern is that, for example, somebody has a $1,000 deductible but a $1,000 account. If the employee understands the nature of that and doesn't have a significant reason to save it into the future, you could see a significant increase in the utilization of services because that that's going to look a lot like an HMO with a $10 co-pay. That can be entirely different if you set up an HRA where you can use the account to pay for future retirement expenses, retiree medical or things of that nature, but that's not common at this point in time.

When we explain this to health plans, they agree with the concept, but at this point not many people are going to adjust their rates for it. It's one of those things to look out for in the future. Make sure you understand what the employer is doing behind the scenes. If the employer gives them a high-deductible product, that's fine, but if you have that $1,500 deductible and there's no employer funding it at $1,000, versus an account at $500, you're likely to see a different cost.

Let's talk about selection. The conventional wisdom out there—and I think it's valid—is that the young and healthy, if given this plan option in a multiple-option environment, will choose the CDHP, leaving the other health plans with the worse risks. Because of this, some carriers only offer options next to CDHPs if they are the sole carrier. I think that makes a lot of sense. You have some consumer-driven players out there, the innovators, saying that they have some experience that shows that's not necessarily the case. I think that that could happen. It depends on where you're starting.

Here's an example. Let's say a PPO had a $500 deductible in place, and now it implements a CDHP with a $1,500 deductible and a $750 account. From the employees' perspective, their costs are their premium contribution to the plan plus the cost-sharing that they incur, less any account contribution they receive from the HSA, in this example. Granted, at the lower claim levels, this is a no-brainer. If you haven't gone with the CDHP, you didn't look at this at all. But at the upper claim levels you're not losing that much because you still have a maximum out-of-pocket in place. The other thing to consider is to think about those people who have $15,000, $20,000 or $50,000 in claims. Those aren't exactly predictable claims, so you could likely have people in the CDHP who chose it thinking they would have a lower claim level, but then it resulted in higher claims.

In general, I would expect that you would see healthier risks. From the experience that we've reviewed, that's true for the most part, but it does depend on where you

start to some extent, and I can see why there's some experience indicating the contrary. The other thing there is the order of magnitude in terms of the risk selection adjustment. Is it 80 percent of what you would expect on a full replacement basis? Is it 90 percent? I don't think it's nearly that dramatic, simply because of the predictability of claims and the fact that when it comes down to it, costs aren't going to be all that different at the upper claim levels where you can see significant risk selection.

Finally, with regard to communicating CDHPs, we're getting a lot of requests from the various health plans asking us to help them communicate what this means to the employer. We're also getting a lot of requests from employers themselves. From the employer's perspective it's fairly straightforward, especially when you're dealing with an HSA. It's going to be their premium contribution to the plan, plus the account contribution. It gets a little fuzzier with HRAs because those are notional accounts. If you make a disbursement from the account, it's a cash cost to the employer. If you don't, it's simply a notional balance that carries over on their balance sheet, impacting only their income, not their cash, and that's important to them.

What you usually want to do there is reflect the payout from the account versus what balance is going to carry over, so they can evaluate that. Then you look at the complement on the employee-cost side. Employers want to understand two things. The first one is, on the average, how much more cost am I shifting to the employee, if any? The second one is to which employees and to how many am I shifting those costs? If I'm putting too much of a burden on a majority of my population, I probably don't want to go this route. To answer these questions, we show what the employee costs would be under the old plans and under the new plans, considering the premium contributions and things of that nature.

In conclusion, for pricing in the consumer-driven market, the competition is definitely increasing. You're not just dealing with a handful of players anymore. Everybody is coming out with something, so you want to evaluate the risks that these plans present and develop modeling techniques to adjust for the risks as much as you possibly can to determine where those margins exist so you can properly position the products. Good luck to everybody out there who is implementing these products.

MS. WEYUKER: Next is Neal Oktavec from Wells Fargo.

MR. NEAL OKTAVEC: We implemented a consumer-directed health plan in '03, and we offered it as a choice option. You can take that into context into what was said prior.

First let me give a little background on Wells Fargo. We've been around for a long time—151 years. We've got 135,000 team members, 15,000 retirees and over 250,000 covered lives. We're in all 50 states, but California, Minnesota, Iowa,

Arizona and Texas are our big states. We do have a strategy and want to give choice. We understand, as Scott was mentioning earlier, that the choice option has problems with it and have to carefully adjust for the contributions between the plans. We want to offer a range of plans, so we have a nationwide point-of-service (POS) plan. We've got HMOs in many of our states. We are beginning to tier networks for some of our HMOs, and we offered the consumer-directed health plan Definity in '03.

Again, we offered Definity nationwide as an option. We priced it to our POS plan, and generally our POS plan has become pretty expensive in a lot of states. It's competitive in other states. When we priced the benefit design that we have, because it's about equivalent to our POS benefit design on a full replacement-type basis, we priced it accordingly. We priced it conservatively, but we also understood that there was a network differential. We don't have discounts that are as good in the consumer-directed health plan as we do in the United Healthcare POS plan, so that was taken into account. We've got a typical design. Looking at the employee-only coverage, we've got a personal care account (PCA) of $1,000 and a deductible of $1,500, so we have a gap of $500. That's fairly typical, and it follows throughout the tiers. There is 80 percent in-network coverage after the deductible is met.

The first year was interesting. We got a fairly small enrollment. Again, we priced it according to the POS plan, which often is very expensive. We probably priced our consumer-directed health plan higher than maybe a lot of other employers did. We got about 1.7 percent enrolled in the plan in the first year. The highest enrollment states were Iowa, California, Minnesota and Montana. Iowa had the highest percentage. Our average age was 38.6, and the Wells Fargo average age is 38.7, which is almost identical if you look at it on an average age basis. We priced the plan to be fairly expensive, so the average pay of a person who enrolled in the consumer-directed health plan was $78,000, while the average salary at Wells Fargo is $43,000. That's quite a bit different. That was the first year.

They came predominantly from the POS plan, so the first-year adopters, the HMO people, were not willing to sign up with the consumer-directed health plan given the pricing that it had and given the risk exposure on the out-of-pocket side, so we did see a lot of highly paid employees sign up with the plan. By the end of the year, the first-time enrollees, predominantly new employees who were more willing to sign up, were signing up throughout the year. By the end of the year, we had 3,000 people sign up, so 3 percent of the total enrolled population was in the consumer-directed health plan.

Iowa, at 6.6 percent, had the highest enrollment in the consumer-directed health plan. That's much higher than the 1.7 percent we got overall. Again, we do a fairly sophisticated pricing for our plans in all the states. We look at the rates. We adjust it for, hopefully, diagnostic cost group (DCG) scores. We gather the drug data, have it run through a DxCG model and get the relative risk score for all the plans and adjust their rates accordingly. In Iowa, we weren't able to do that. We did age-sex

there because we don't have all the claims data from the insured products. The POS plan was relatively efficient there, so the consumer-directed health plan was only 5 percent more expensive. That was in the middle of the pack, so we got a lot higher enrollment in that state. Obviously the pricing made a big difference.

The average age is exactly the same as the whole Wells Fargo health plan population, but those people in the 35 to 55 range are the more likely ones to move and sign up for the consumer-directed health plan. While the average age is the same, there's a bigger hump in the middle of the Definity people than there is in the average Wells Fargo participant population.

It's interesting to look at the pay metric and how it was affected. If you look at it, you can see some of the things driving each state. In Iowa, we got only 16 percent enrollment of people who were participating in open enrollment. It's not everyone; it's only those people migrating. You can look at people who were participating in open enrollment and were migrating to another plan. How many of them chose the consumer-directed health plan? In California, for instance, where HMOs are competitive on a DxCG-score basis, the POS plan was the most expensive.

I categorized each state as to what was their least efficient plan and the most expensive plan in the state. Again, it's our own pricing because we didn't have any experience. It's a pie in the sky. It's priced again to the POS plan. In California, the POS plan is by far the least efficient, so the consumer-directed health plan is the most expensive plan and you got small enrollment. Only 5.2 percent of those involved in open enrollment went to consumer-directed health plan, but in Iowa it was 16 percent. In all these tiers in all these states, the consumer-directed health plan had the highest average salary in all the states except Wisconsin. That's an interesting fact. Even in Iowa, where it was priced in the middle of the pack, it was still the most highly paid people who signed up for the plan.

Let's look at it another way. Let's separate the states where the consumer-directed health plan was the most expensive plan for employees in the state from those states where it was not. The difference in the percentage of employees changing plans is 14 percent versus 10 percent, respectively, so there's a 4 percent difference. If you're in a state where it's not the most expensive, you do get higher enrollment in the plan for those people migrating.

In '04, we tried to change a little bit. We did want to advance consumerism and put in elements to make people think about their cost responsibility. Definity is a big proponent of this. It helps their model and also gets more enrollments. Our old plan became the Gold Plan. Then we added another plan, the Silver Plan, which created more out-of-pocket risk. We raised the annual deductible in the Silver Plan up to $2,000, but had a PCA of only $500, so that's a $1,500 gap there. That's a lot more risk, but if people had signed up with the Gold, banked their money and did not spend it, then they could sign up for the Silver Plan, pay the lower premium and continue on. That would be a measure of success if they were taking into account

they were being rewarded for banking their dollars. They were seeing the advantage of doing that.

In '04, we're halfway through, so we can talk about the enrollment. We did increase our enrollment in the Gold Plan by 3,000. That brought us up to 4 percent of total enrolled being enrolled in the consumer-directed health plan, the Gold Plan. The Silver Plan gained 1.9 percent of employees. We had 2,600 re-enrollees. We had 3,000 consumer-directed health plan enrollees at the end of '03, and 2,600 of them re-enrolled, so 400 didn't. Then we had 1,700 of them carry over PCA. The average PCA was $500. As you might expect, families carried over less than single coverage.

There are some other characteristics. We did see some continued patterns from the first year. We did see that higher-paid employees continued to enroll at higher rates in the Gold than lower-paid employees, but enrollments in '04 were fairly evenly stratified. I thought that was interesting. People making less than $25,000 were more enticed by the lower premiums of Silver, so we got a higher percentage enrollment in the Silver Plan of the people in that category, which I found interesting. I wasn't expecting to see that, given how in the first year we had seen so many highly paid people sign up for the plan. All salary ranges did favor Gold Plan over the Silver Plan. They still like the idea that they got a significant amount of money put into their PCA. That's an important aspect for them. What we were hoping to see, a migration from the Gold to the Silver Plan, we did not see in most states. There was a relatively small migration, but there were some exceptions and we'll go through that a little.

In the under-$25,000 in the pay range, we got 2.7 percent enrollment in the Silver. That is higher than all the other pay bands. The total enrollment in each pay range in the consumer-directed health plan ranges from 7.4 percent for the under-$25,000 to 6.8 percent for greater-than-$125,000, so it's all in a similar range. I thought that was an interesting characteristic given that our first year, again, we had so many highly paid people signing up for the plan. We got more people with lower pay signing up for the Definity Silver, and on the greater-than-$125,000, we still have some of the highest enrollment in Definity Gold.

If you look across all pay tiers, we're getting it from all pay ranges. Iowa continues to have the highest percentage enrollment among the larger states, so we're still getting a large enrollment. We now have 13 percent of the population in Iowa in the consumer-directed health plan. States that had spotty network coverage by other plans in the state also showed higher penetration to consumer-directed health plans. We know that east Washington has spotty network coverage. Idaho has spotty network coverage. You can see higher enrollments in the consumer-directed health plan in those states. That was interesting. We also looked at the indemnity areas of the POS plan. If you look at the indemnity areas of the POS plan that have obviously no network coverage for the POS plan, 13.5 percent of those people in those areas were enrolled in the consumer-directed health plans. We have 5.9 percent overall across all states in all areas.

In California, most of the people in Definity Gold and Definity Silver came from the POS plan. A small percentage, under 20 percent, of the Definity Gold people moved to Definity Silver. In Texas, it was the same thing. About 10 percent of the enrollment of Definity Silver migrators came from Definity Gold. That's small. Most of the people, again, came from the POS plan in '04. This is the same thing we saw in '03. Iowa is a little different. Remember, this is the one state in which we had a huge population. We had it priced in the middle of the pack. We got a lot of people moving from Definity Gold to Definity Silver. Above 30 percent of the people are migrating. We also got a more even distribution of people coming from the HMOs, the POS plan and Definity Gold. This gives us an image of the actual impact of employees responding in a consumer-directed way. We still have to look at the data more, I think, to see if it bears out to be true.

Let's look at some of the projected costs. Definity does its own projections of what the costs are going to be in the first year. Obviously its model must take into account what kind of population it expects to get enrolled in a consumer-directed health plan given our costs in all our other plans. They were accurate. Again, what is due to risk selection and what is due to actual utilization decrease is still a debate. Basically, Definity's projection of the '03 costs were $2,559. The actual costs were $2,332. At Wells Fargo, we budgeted a higher rate.

Of course, it's probably better for us to do the conservative estimate because if there is a real selection bias, our trends are going to go up in our other plans. If all the healthy people are leaving the POS plan, our trend will be much higher, so we made a conservative estimate of the cost per member per year (PMPY) in the consumer-directed health plan, but the actual was close to Definity. The actual was 9 percent below the expected as Definity projected before '03. Again, we don't know how much of this lower cost than our budget projection was due to the first-time enrollees and the lower risk of that population and how much was due to reduction in utilization.

Let's talk about some of the risk scores. This is interesting. We're not able to get the risk scores for '03 because we don't have the full-year data in our data warehouse yet. We'll be getting that shortly, but we can look at the people who migrated. If we look at Definity migrators (again, those are all the people who were in a self-insured plan and moved to Definity), we could track their costs in '02 and follow them to '03. That's what we did. We were able to get their DCG score. The DCG score in '02 of these migrators was 64 percent of the POS population. You can take that same '02 data and do the prospective score for the following year, '03.

Again, it's a prediction. It's taking the '02 experience and predicting '03 costs. There's a big jump to 80 percent. Maybe some of you know why that happens. The actual risk of this population on an age-sex basis, if you look at the '02 PMPY costs by age-sex, is 84 percent of the POS plan. The age-sex predicts that it's going to be higher, but their actual '02 DCG score based on the illness burden, and the claims

data was only 64 percent. Obviously their prospective score matches closer to their age-sex expected score. We've seen this over and over again. We have a new HMO. We offer the HMO. The year prior to the year people move from the POS to the HMO plan is generally a risk-free year. It's often a year in which they don't have a lot of costs, so that may be a reflection. Maybe this score is an anomaly and we won't see that happen. These people have a greater inherent risk in the long run, but that year that they moved they were low risk.

Their '02 age-sex expected score is 84 percent, their prospective score for the next year is 80 percent and they spent 71 percent of the POS people in '02. The '03 costs under the consumer-directed health plan went up to 84 percent of the POS expenditures. Are the increased costs due to people spending more? They might be saying, "I can go sign up for the consumer-directed health plan. I can get 100 percent first coverage on the first $1,000." It's hard to tell what's happening, but it does appear that there's some underutilization or little risk in the year prior to moving to the consumer-directed health plan.

We tried to follow the population and look at its per month per member (PMPM) cost. We have paid data through the full year only. We have incurred data through the third quarter of '03, so we're doing annual estimates based upon that. We take the cohort of all the people who were enrolled in a plan in September '02, follow them back and follow them forward. We're taking the POS-plan people as they migrate to Definity, and if they were enrolled in a POS plan in September '02, then we follow that cohort forward and back.

There were 610 of them that we were able to follow back to '01. There were 872 of them at the point in '02, and we followed them as they moved to Definity. We did that for all self-insured plans too. The POS plan, again, has most of the people who migrated to Definity. The numbers go up slightly for all the self-insured migrators to Definity, with 739 of them in '01, 1,104 of them in '02 and 1,097 of them in '03. As a benchmark comparison, the counts for all our other self-insured plans were 48,496 in 2001, 56,247 in 2002 and 45,592 in 2003.

On a total cost basis, the POS plan migrators' costs went up 32 percent from the prior period. All self-insured plans migrators' costs were similar, up 31.7 percent. If we look at the continuously enrolled in all of our self-insured plans that aren't Definity, we had only an 11.4 percent trend. That's not a wonderful thing to see, but again, looking at the DCG scores, we understand that there's more happening here. We probably have to wait more years to see what's going on.

Looking at the employee's cost, the average PCA expense in '03 for both populations of these two different cohorts was $51 PMPM. The company's cost, which includes the PCA amount plus any portion of coinsurance that the company has to pay, went up 37 percent for the POS plan migrators and 32 percent for all the self-insured plan migrators. We made the benefit design less rich to do some cost-shifting in our other self-insured plans, so our costs went up only 8 percent on

the company's side and all the self-insured plans.

As far as employee out-of-pocket expense, because we did some benefit design changes, all self-insureds got a 30 percent increase, but the people who moved to the Definity plan managed to temper their increases well below what they would have if they had stayed. The POS migrators, in particular, gave an indication they were thinking about what they were going to spend and what they get in their account. They got only an 8 percent increase, while all the self-insured plans in Definity got a 21 percent increase, which is closer to that 30 percent. It does show that people, at least the first-year adopters, are making careful decisions.

We ranked clinical conditions according to total payments for Wells Fargo. Our top condition for the Definity people is preventive/administrative health encounters, which is probably the top one for most. It was number two if you look at all other plans, not including Definity. The CDHP shows the same utilization pattern that you see in all new HMOs, where it's going to draw some of the healthy risk. People who have high utilization are going to be a little less inclined to go to a new plan like this, where there's potential out-of-pocket risk. Things like pregnancy, which was number one, moves to number five. A lot of other pregnancy things move down.

There are some unexpected potentially expensive conditions that end up in the middle of the ranking. People don't think they are going to have any health problems, sign up with the plan and then find out they do have health problems. There are some categories of clinical conditions where there are a lot of discretionary expenses, like back disorders. Those seem to be moving up a little in the categorization. If you look at the number of patients per 1,000 in the Definity population compared to the self-insured, you see that the consumer-directed health plan may be favoring people who have back problems and some other general, unspecific conditions.

People with obesity are coming in for more care. The people signing up for Definity, compared to the rest of the other self-insured plans, are less likely to sign up for pregnancy. If they expect to have a delivery soon, they're not going to sign up with a consumer-directed health plan. You do see what you would expect to see if you're expecting to see a favorable risk selection for the consumer-directed health plan.

Looking at the dollars-per-patient Rx, the consumer-directed health plan is showing signs of tempering costs for drugs. If you compare the trend, in cardiovascular agents you're seeing a -2 percent trend when you look at the Definity people, following them year to year. This is comparing '02 to '03 expenses year-to-date. We're comparing the self-insured plan people to the Definity people and looking at their trend. On a dollars-per-patient Rx, the trend is lower in general for the Definity population compared to the all self-insured population. In talking to employees, we found that if they were very upset about anything, it was about the expense of drugs and how much they had to pay for drugs under the consumer-directed health plan. They became 100 percent aware of that. There is some

indication that they're looking at this and that it's affecting their utilization patterns.

There are some conclusions I think we need to make. We're committed. We believe that consumerism needs to be an element of our benefit design, but we're not sure what place it's going to play in the end and how it's going to be structured. It's too early to say the way costs are tempered when it's one option among many for employers. We're still not certain about that. There have been proponents of and there have been nay-sayers to consumer-directed health plans. We think the story is a lot more complex. It might be a battle of the risk selection issue versus the ability to temper trend. We've got to plan our benefit design well and our options well to get that proper balance.

The utilization patterns do show positive selection bias toward the consumer-directed health plan and higher cost in the postperiod of migrators, but it cannot yet be determined. Is it simply the same pattern seen in new HMO offerings, or is it the unique impact of the benefit design? In year one, the CDHP shows signs of tempering the trend in Rx, but not in the medical plan. Pricing consumer-directed health plans competitively with other plans appears to advance consumerism. I always saw that it helped consumers, to the extent that people moved from Gold to Silver, which I think is something that we want to see. We need to spend more time looking at that. Let's look at Iowa and see what the utilization patterns are in Iowa. Let's compare that to a state like California, where the consumer-directed health plan is expensive. Are we getting more consumerism impact in Iowa than we are in California, for instance?

We're going to hold off on pricing the consumer-directed heath plan based upon our normal DCG score or age-sex score. We're going to have to make a philosophical decision in '05 on how we want to price the consumer-directed health plan because we do see this element where Iowa might be a better strategy for getting consumerism in the plan, lowering trend and lowering utilization. We're probably going to have to wait until '06 to price based upon DCG. We'll have to judge going forward.

MS. WEYUKER: Next is Emma Hoo of PBGH.

MS. EMMA HOO: I'm going to talk today about some of the experience of some of our members, like Wells Fargo, as well as the perspectives of a couple of the health plans that are in our marketplace. I first want to give a little background on where we came from and how we ended up moving down the path of endorsing a consumer-driven plan a few years ago. PBGH is a coalition of nearly 50 employers that have been in the large-group market for a number of years looking at how they could improve quality, improve the efficiency of health plans and obtain tools to better engage consumers. We are also in the small-group market, where we operate a purchasing pool, formerly the Health Insurance Plan of California, and manage the plan offerings for groups that are two to 50 as well, where we see different types of selection issues and benefit design challenges.

What's Happening with Consumer-Driven Health Plans (CDHPs)? 15

Back in '00, at a PBGH board retreat, a lot of our members had been faced with double-digit trends and were trying to figure out what they could do with our health benefit designs. There were those in the camp that were looking at exit strategies, and others that wanted to totally turn their offerings upside down because the concept of managed competition wasn't working to the degree that they had hoped. We defined a series of components of what the ideal health plan would be and then went out to bid.

We had responses from a number of the traditional carriers in the marketplace and some of the national carriers, as well as some of the fledgling e-health plans. There were about 12 fledgling e-health plans, most of which are no longer in the marketplace, but our finalists at the time were Health Market, Lumenos and Definity Health. Ultimately we endorsed Definity Health as an option for our members as a vehicle to work with the new health plan, design benefits and focus on how to measure the effectiveness of those programs.

At the time it was new in the marketplace, and nobody had any idea of how some of these options would play out. We have continued to evaluate these plans and focus on the core components, whether they're delivered through a PPO, HMO or CDHP, and try to benchmark the effectiveness of plans in capturing some of those competencies. Today we are continuing to work with our plans in developing and designing narrow networks as well as incentives that could function in an HMO environment to engage members, whether it's filling out health risk appraisals or other types of activities in educating members in choosing their providers wisely and so forth.

There is a construct with which PBGH approaches its efforts to support value purchasing. As part of our efforts in looking at health plans, we are part of a national process and conduct a request for proposal (RFP) in conjunction with other business coalitions and large national employers to use a common device across multiple plans in the marketplace. We also have entered into a lot of activities involving measuring quality and performance, at both the medical group level and individual provider level. More recently, we have been looking at disease management vendors and focusing also on the disease management programs of our health plans.

In capturing the value of these, we use a lot of analytic tools to try to understand how the programs work and how the outcomes are measured, as well as ROI. We hope to translate that value into products that our members implement and can roll out to their employees. Ultimately, as Neal described, where we want to see change is enrollment in the higher-value plans and engagement in those activities that generate some of the returns, whether it's shared decision-making, treatment option support or other types of activities that could drive behavior change in the long run. These are some of the components of our continuing evaluation of health plans in looking at the core competencies, best practice and so forth. It's important to note that the best practices that we see are spread across a wide variety of

health plans.

Even as we talk a lot about shared decision-making and treatment option support, and those are attributes of many of the CDHPs, there are a lot of health plans that have had these programs in place. Highmark has used Health Dialog for a number of years and found that to be effective in influencing consumer behavior with the type of support regarding information and treatment decisions that are preference-sensitive. We also have focused a lot of our efforts with health plans to better measure some of the outcomes beyond the typical Health Plan Employer Data and Information Set (HEDIS) scores that you see in the marketplace, but try to capture the value of disease management programs or other interventions.

Arnie Milstein, our medical director, on behalf of the business roundtable, did some work to try to quantify the impact of potential interventions (health promotion, health risk management, shared decision-making/treatment options and provider options) that could cut across all plans. These were elements that were attributes of many of the consumer-driven plans that we looked at. In some cases, they're core components of the traditional carriers that we also work with. A few years ago, if we asked the health plans what they did in health promotion, it consisted of sending a postcard out to members. There wasn't much measurement of uptake.

One plan, for its asthma program, sent out postcards, invited people to be part of a survey and then those people got a secondary notice. Some people did the survey, but by the time that they were done, they had 43 asthma members in their registry for California. This is a plan with about two million members. Ultimately, we want to drive toward better understanding those components that can be differentiating features in understanding the value that the health plans deliver. The return reflects what could be achieved potentially with low-effect interventions to high-value interventions.

In health risk management, it's possible that the investment that you make could cost more than what you get. We have certainly seen for some members that they spend far more in Rx once they start investing in disease management programs, so the savings on the medical management side are used up on the pharmacy side. At the same time, over the long haul, they potentially can see more savings in the behavior change and better compliance that is adopted ultimately. The area of provider options is where we think that in the future the long-term gains are to be achieved, both in changing provider behavior and in better engaging members in their treatment choices.

Circling back to the question at hand about the consumer-driven plans and selection, our perspective has been that it's all about benefit design, though it was hard to convince many of our plan partners in the early days. One plan even threatened to put a load on the premium for any employer that offered a consumer-driven option as part of the array of options they offered. Scott said earlier that the expectation was that all the young and healthy folks would sign up with the

consumer-driven plans. Our perspective was that it would be the old, rich and healthy because the young weren't even looking at their benefits, tend not to look at much beyond price and will tend to stay in place because they're just not focused on it.

We also have seen information about contribution strategies and other components that drive behavior far more than just the presence of a consumer-driven plan. It's gratifying to hear people talk now about consumer-driven plans as they are intended to be, as opposed to a few years ago where everybody was talking about skin in the game and defined contribution. As Scott said, if you're an employer looking to save money off the top, the easiest thing to do is raise your co-pays and increase the deductibles. I think a lot of employers have already done that over the past several years because that's the low-hanging fruit in achieving some credits based on the benefit design itself, but there's only so far you can go.

There were some recent studies on pharmacy benefit design, one just published in *JAMA* and one that came out in *The New England Journal* last December, where employers that made some rapid increases in co-pays in pharmacy ended up with compliance issues that ultimately cost more in the long run. That's a huge concern for employers because they have to also better measure issues like productivity and absenteeism in the workplace. I can't emphasize enough that it's about benefit design. Whether you're offering a high-deductible option in a PPO or an HMO with a $30 co-pay, that's going to drive selection as much as anything else. In any situation where you have a new plan offering, you're going to get selection. The people who have a chronic care condition or an established relationship with a physician are least likely to move, whereas the people who don't have a commitment to a particular provider or who aren't in the midst of treatment are more likely to migrate.

Over time, you see a pattern emerge that makes some of the mix in the consumer-driven plans, or any new offering, much like the existing plans. At the time we launched some of our efforts, nobody knew what the effect would be. We worked with some actuaries, both at PricewaterhouseCoopers and at Watson Wyatt, to try to model the effect. One actuary had an interesting way of looking at quadrants of your population. People on the high end were not likely to move, and people on the low end were not likely to move, but for completely different reasons. It was the people in the middle. A lot depends on contribution strategy, communications and a lot of the "soft" components of benefit design. Early on, many of the employers were considering having added benefits like acupuncture coverage, LASIKS or other types of complimentary care, those types of services as part of the potential covered services that an employer could "save" money to spend on.

Over time, what we've seen is that many employers are crafting more traditional benefit designs and aren't opting in for those added benefits in the same way that they might have early on three years ago. They're finding some of the same behavior happening around saving of dollars to look at the long term or to roll over.

With the potential changes in legislation, I think there will be more energy in looking at these designs. To reiterate from an employer perspective, we've got to look at the total picture, not just the particular premium, but the impact on consumers' behaviors, their health care and their long-term benefits, because most employers have these employees for eight to 10 years as opposed to one or two years with a given health plan.

I want to drill down on a few of the areas within the set of breakthrough competencies by example to demonstrate what we are trying to evaluate and the types of programs that we hope to see across all plans. There was another session yesterday on what's happening outside consumer-driven plans. This is exactly the type of activity we want to encourage. In measuring disease management, for example, a lot of health plans have invested resources, either internally or through outsource programs, to invest in chronic care conditions. I think there is an established set of metrics for the degree to which plans can effectively identify people, stratify them and use interventions, but the key differentiators for us are how they intervene with the providers and how they quantify the potential net savings, as well as program effectiveness.

We made a chart for scoring the plans that participated in our survey. The 10 plans included HMOs, PPOs and CDHPs. There is a huge gap across all these measures that were part of this evaluation last year in that "net savings and cost-effectiveness are quantified and continuously improved" was not there. Of the actuaries in the room, how many of you are involved with premium pricing? How many of you have been involved in measuring the effectiveness of disease management programs? Far fewer. This is where we hope that there will be greater engagement in health plan processes, so that the information that can be captured on the medical management side can be similarly reported to employers, not just cost and utilization, but understanding the impact of health management interventions as well as quantifying their effect.

These is some research out in the community on potential premium value from some of the interventions, as well as case studies from several large employers that have published reports on this. For example, for health-and-wellness promotion, we've seen a few employers reintroduce these programs in recent years as a way to better engage their members. In some cases, they are reporting dramatic results in finding ways to capture employees in a process that starts with filling out a health risk appraisal, getting that information to the health plan and working with the health plan to better communicate some of the opportunities to participate in the programs.

Some of this has also been a challenge around implementation of the Health Insurance Portability and Accounting Act (HIPAA) and coordination of information, but if there is a commitment by the employer, there's a way to work through the communication efforts to have the appropriate disclosures in place and have the appropriate sign-offs to create and foster information-sharing that allows for

coordinated care. Some of the direct activities that employers have undertaken also have been in selecting plans that offer particular programs. Neal focused more on the Definity offering, but in California, Wells Fargo also offers the PacifiCare narrow network. With some of its offerings this year, there will be opportunities to introduce "health credits" associated with participating in a Web-based behavior change program and information reporting that we hope to see specific incentives designed around by employers. The plan has also put monies on the table in the form of a premium credit for employers that are putting out the incentives. Those are innovative opportunities in which to jointly develop programs that better engage the members in reducing risk and changing behavior.

Speaking broadly about the health risk management area, there's a lot of effort in the community now to improve the measures that are used for looking at ROI. I think half the presentations that you see use regression to the mean in looking at the net results, and there's a strong interest in trying to standardize some of the methodologies, to come up with better definitions around pre- and postanalyses and understanding baseline performance. Again, this is where we hope more actuaries become involved in the processes at the health plans to measure the impact of medical management programs.

One of our members, Hughes Electronics, had a combination of activities that involved engaging members with completing an HRA. If members did that and also complied with the recommendations, such as participating in a disease management program, they got a $300 reduction in their contribution for their insurance. They have realized significant savings in both the health plan premium as well as coordinated services in an integrated disability program, where they've seen reduced absenteeism. We have seen efforts to reward physicians as well. I think that the measurement challenges in that area are still significant. Working with physicians to engage them in pay-for-performance type programs represents a huge opportunity downstream.

American Healthways, and its implementation with Blue Cross/Blue Shield of Minnesota, has demonstrated significant improvement not only in costs but in quality outcomes as measured by some diabetes measures. They were able to report savings in PMPM expenses, emergency room use and admission rates.

Let's move on to the next area of shared decision-making and treatment option support. A lot of plans have started with general communications, such as newsletters. Some have information and Web-based tools available, as well as telephonic support, but, again, the ability to measure the impact of these is difficult, and there hasn't been an investment in resources to try to understand what the impact is. I think many people have probably seen the studies by Wenberg of supply-sensitive care and the variation in care in different marketplaces. If we can influence consumers at a point in time before a decision is made to have a particular procedure or before they're in the hospital, that can have a huge impact, not only in member satisfaction, but in understanding and mapping the types of

services to their preferences. Again, this is an area with potentially a small return on premium savings. This is based on some of the work that researchers have done, as well as the information from a couple of vendors that are in this marketplace.

To reiterate the point concerning supply-sensitive care, a graph from the Dartmouth Atlas project shows the volume of admits for hip replacement surgery and congestive heart failure in conjunction with the availability of beds. In the marketplaces where there are more beds, the volume of admits is higher. People don't voluntarily break their hips. They just go in once it happens, and there isn't much variation in terms of the supply of beds. Those are huge opportunities on the provider side, as well as the member communication side, to assure that people get the appropriate interventions before they land in an emergency room or before they land at the hospital.

This leads into the next area of looking at some of the opportunities in reducing trend and changing some of the overall orientation of the marketplace in focusing on cost-sharing and benefit design components that don't necessarily change behavior in the long run. A key component to long-term savings is changing how people choose their providers. Some of this starts with the health plan and who the providers are that you put in the marketplace within PPOs or other types of health plans. This is not an area that's unique to consumer-driven plans. I think where the consumer-driven plans started off to try to be somewhat unique was to lay out more information, with more transparency in the cost of particular providers, the cost of particular procedures and quality information where it was available.

Since the introduction of some of these early tools by some of the CDHP vendors, we've seen all of the health plans in California, for example, adopt hospital measurement tools that are available on their Web sites. This information wasn't available several years ago, and it is now. Again, this is an area where there isn't enough measurement of the impact. We have started to see some plans develop cost calculators so that people could understand differences. We've also seen plans develop tiered networks, narrow networks to better differentiate their providers. In California, we have a huge challenge with large provider systems that are also trying to negate that ability by having contract clauses that prohibit it. More recently, we have legislation in play that would prohibit the tying of hospitals that are in a common system.

Again, to better understand the impact of provider networks, narrow networks, I think often employers are caught in a position where if they lose a particular provider in the community, they're afraid of the noise they'll hear from the members, and they're reluctant to do it. Sharing more information with purchasers by saying, "If you made this decision, here's your premium effect," has much greater impact for them to take that business case back to their CFOs or their vice presidents to say, "A little bit of noise is going to happen, but here's the impact."

As far as a few of the options that we've seen in our marketplace of narrow networks, Pitney-Bowes and Union Carbide did direct contract networks in their communities that resulted in huge savings over a small period. There is a recent effort by Pacific Business Group to develop efficiency measurements at the individual doctor level. A lot of our measures today are based on proxies of health plans' overall utilization numbers, days per thousand, and we don't have a sense of episode-based efficiency. Some carriers are using episode treatment groups (ETGs) to better understand that. You can look at specific specialty areas and individual doctors to understand how varied their practice patterns are.

We did an early study with a health plan in California and are in the process of rolling out this effort to look at performance at the medical group level. We're working with Blue Shield and several pilot medical groups to help them develop tools that they can use for internal quality improvement. The upshot of the study is that if you look at the variation in efficiency across individual California cardiologists, there's an opportunity for saving 15 percent of the cardiology costs for this particular population. To the extent that a consumer-driven plan or traditional plan can get the information out there about their providers, that can influence behavior.

Right now, most employees have no idea about their providers. I think that many health plans know who the good utilizers and who the high-quality-performing providers are. Many of the medical groups have internal quality in utilization committees that know patterns about their providers, but none of that data sees the light of day for the consumers. My point is that the more information that can be put out there in consumer-driven plans or other plans about provider information and provider performance, the more we can educate consumers about their choice of treatments and their choice of providers, and, in turn, influence the overall medical trends in the long run.

FROM THE FLOOR: Is it that the more cases that providers see, the more cost-effective they are?

MS. HOO: No. It's not based on volume. It's the relative efficiency based on a set of episodes. We looked at internal medicine, family practice and cardiology in this pilot study. For people who want to better understand the scope of the study, it was supposed to prove the case that the efficiency measurement could be done at the individual doctor level, as well as understand what size volume of claims was necessary to come up with credible results and so forth. There is additional information on our Web site; you can pull down the full study and the methodology for that.

I want to move into some specific discussions of health plan results in terms of how this all ties together. Earlier I talked a lot about the features that we're looking for in health plans and how we hope that adoption of those features can influence behavior change, cost trends and overall consumer engagement in the long run. I

want to acknowledge both Aetna and Definity for sharing information for use in this context. I'm going to give a quick run-through of some of the demographic results that they've seen, as well as some of the measures that they have for consumer engagement and utilization experience.

It's important to acknowledge that these are early results. As Neal said, this still needs measurement. The challenge, of course, is looking at the long term and understanding how these project out. With respect to the information here, Aetna launched a health fund a few years ago. I don't know the overall enrollment off the top of my head today, but it believed in this program so strongly that it launched it for its own employees. It created three different plan design options in addition to its existing HMO and PPO offerings and eliminated its POS. Today it has 78 percent of its own employees nationally that are in a health fund product.

When we graphed its early nine-month results of the distribution of the population in the programs, we found that the overall average age is similar to its other book of business, but it's a slightly different distribution of the mix in the middle buckets of age from 40 to 50. Interestingly, there's a much higher percentage of male enrollment. Like we've seen from other carriers, the family ratio was high. Both Definity and Aetna were surprised at the degree to which families enrolled in the respective products.

Let's talk about some of the measures that Aetna has reported of the members that are part of their consumer-driven option. Aetna reported a higher utilization of some of the consumer tools. Some of this is in partnership with employers communicating this information and promoting use of this information, but it's noticeable that it is better able to engage consumers through this program. It's a challenge to all of us to learn from this process and get this level of engagement across all plan designs.

As I think all of you know, so many of the employees have an entitlement mentality and believe that $10 is all they should pay for any of their health care forever. This is the start of a path to get that level of engagement to a higher point, to have information that rolls back to the members that is actionable and for them to take better information to their providers as well. They also shared some data of the overall PMPMs. As I noted, this is nine months of data, so it's early, but it is seeing some changes relative to its overall book of business.

In both of the designs that we've seen for Aetna HealthFund, as well as our members who have opted into various programs, whether Definity, Lumenos and others, preventive care is part of the covered benefits. In the case of Definity Health, the design is such that there's first-dollar coverage of the preventive services. We don't want people to be saving up and not using services to avoid the types of diagnostic tests that would be age-appropriate or condition-appropriate. It's interesting that there are fewer PCP office visits, but notably fewer in the specialty office visit areas also.

There is a reduction in both emergency room visits and inpatient admissions. These are relatively small numbers, but the cost savings add up. I think Humana has presented some of its results in a variety of settings where it has far more dramatic results in the reduction of emergency room visits, as well as reduction of inpatient admissions. Often providers harvest patients out of the emergency room, and most of those admits end up costing not an insubstantial amount. In many cases, if you can get the intervention on an outpatient basis or earlier in the process, that whole hospital cost can be avoided altogether.

As far as changes in pharmacy utilization, there's a significant increase in generic substitution. In the case of many of these plans, the larger the population they have, the more like a general bell curve or the general population these tend to become. They also have reported some low utilization in terms of hospitals as well as days per thousand. In looking at prescription utilization, they're seeing not only high generic use, but also an absolute reduction in the utilization relative to what their clients report on their other health plans. Some of this has to do with the transparency of information that's available through their Web tools. They use Medco Health. Some of our employers use Caremark in conjunction with Definity Health as a separate carve-out. The point is that the more information that can be had about costs and substitution opportunities, the more education that members get about substitution opportunities they can take to their doctors.

Ultimately, from an employer perspective, as Neal was describing, you want to understand the total cost, not only with respect to a consumer-driven option, but across all plans. Earlier I mentioned that it is all about benefit design. From a purchaser perspective, it's less about selection because you're footing the bill for the entire health cost benefit, so overall you want to see that reduction in medical trend across the board and in your net cost outside of cost-sharing, but looking at behavior change and engagements that can sustain long-term savings.

In their pricing model, they have conservatively modeled some of the pricing. Many of our employers in adopting these plans have been pretty conservative as well, largely mapping PPO or POS plans to the initial plan design. While I think a lot of our health plans feared that employers would be offering high-deductible plans from the outset, that wasn't the case among our members. In the employers that have offered this program, many of the overall trends have been significantly lower than expected. That not only supports the initial pricing model that they adopted, but also reflects some of the impact of behavior change and use of services.

To conclude, we think that it's a huge opportunity to improve the measurement mechanisms that are in place in looking at these plans. We hope that as more plans adopt various attributes of the consumer-driven plans and better engage the members, we have more effective ways in which to reduce our overall trend and improve the quality.