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Session 43 PD
Consumer-Directed Health Plans (CDHPs)

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Summary: This session compares and contrasts consumer-driven health plans (CDHPs) pre- and postenactment of the new Medicare legislation and provides a marketplace analysis of these plans and reserving considerations for the CDHP plans. Reserving issues discussed may include methodologies for new products and the impact of new plan designs on incurred claims seasonality and plan mix shifts of individual book of business. The issues involved in these plans are discussed from a managed care company, employer and consumer perspective.

MS. STEPHANIE HURLBUT: I am the product development actuary for CIGNA HealthCare. I have spent approximately the past two years working heavily with our CDHP offerings, high-performance networks and some other product development activities. I've been with CIGNA for 15 years, 14 of which have been in health care, and within that 14, I've had about a 50/50 split between pricing responsibilities and product management responsibilities.

With us today is Jim Galasso, a consulting actuary and the president of Actuarial Modeling. Jim has over 25 years of experience in health insurance and managed

Note: The charts referred to in the text can be downloaded at:
http://handouts.soa.org/conted/cearchive/valact05/043all.ppt

care. Prior to incorporating his company, Jim served as chief financial officer for MetLife, MetroHealth and BlueCross BlueShield of Florida. We also are fortunate to have, in place of Mike Thompson, Dan Plante from PricewaterhouseCoopers. Dan is the director of Global Human Resource Solutions for PWC in Chicago. Dan is PWC's national lead actuary for health-care consumerism. Prior to joining PWC in 1993, Dan accumulated 10 years of experience in group, health/welfare and benefits with a major national consulting company and a major national insurance carrier.

Here's what we're going to go over today. With a small group, we would love to keep this an interactive session, so feel free to jump in any time. I'm going to talk about plan design, give a quick review of the mechanics, talk about how these plans work and go over some pricing considerations. Then I'm going to turn it over to Jim, who is going to talk through some of the reserving implications. Dan will close this out this morning with a look at what has happened in the marketplace with consumer-driven plans and a view of the future.

We will start with an overview of the product itself. If you read a lot of the industry articles on consumer-driven health care, there is a popular sentiment that these plans are benefit buy-downs in sheep's clothing. I want to start by telling you why I don't think that that's the case. I want to highlight some differences that are associated with consumer-driven plans that make this much more than a giant benefit buy-down.

One, consumers are in charge. Consumers are going to spend their own money more wisely than they spend somebody else's money. Think about how often you've taken a rental car through a car wash. Consumers are going to own their fund money, and the features of these plans create that ownership.

Second, cost transparency is a big feature within a CDHP product. This cost transparency is going to create a situation like any other good in service works, where the consumer knows how much something costs. If you think about the environment we're in today, people think everything costs $10. I go to the doctor; it's $10. I go to the pharmacy; it's $10. Consumer-driven health care is going to change that dynamic. Providers are going to need to operate in a free-market economy, and that is going to lead to better cost and better quality. An example of seeing this dynamic work is LASIK surgery. LASIK surgery is a benefit that is not often covered as part of group insurance. It is a medical procedure that has operated in a free-market economy. If you look at what has happened to LASIK surgery over the past five years, trend has been flat to negative, and providers are getting more efficient in delivering that service, with higher quality associated with that.

Third, consumers are engaged, and they're continuously engaged from the features of the consumer-driven plans themselves. What you've got is behavior change and information that is proactive instead of retroactive (occurring after a service happens).

Last, all consumers can win in a CDHP. Healthy people for decades have been paying premiums into a service from which they have derived no value. Consumer-driven plans give consumers an opportunity to derive value from these plans now. We'll see that as we get into the features a little bit. For the chronically ill, consumer-driven plans now provide a support network, tools and outreach that will help better manage their health outcomes. These plans create a win/win situation for these consumers.

Let me give a quick overview of the mechanics of these plans. We'll start with health reimbursement arrangements (HRAs). You can't talk about these plans without drawing rectangles, so here is my rectangle (see slide 6). Very simply how these plans work is that an employer will seed money into an account, typically money for singles and then a higher amount for families. You can do two-, three- or four-tier arrangements; there's a lot of flexibility in these plans for employers. The basic mechanics are that consumers will use services, and the full cost of those services will come out of this account. When this account is exhausted, the deductible comes into play and then the underlying plan coinsurance. One important dynamic to keep in mind is the relationship between the fund and the deductible. As you spend your fund, it counts toward that deductible. As a simple example, think of a $1,000 fund with a $2,000 deductible. By the time that fund is exhausted, the out-of-pocket cost facing that consumer is only $1,000, which is the difference between the fund amount and the high deductible for the underlying plan. There's an important relationship between those two elements, and we'll see how that plays out when we get into some of the pricing components.

The message is that there is a ton of flexibility for employers to design an HRA to best suit their needs and their population. You can see down at the bottom of this rectangle that there are all kinds of different funds that we can offer. Most customers that we've had to date have kept it simple, which I think is smart. They have one fund, and all of the services that they cover under those plans come out of this one fund (medical, pharmacy, etc.).

We do have the ability, however, to earmark funds differently. If a customer wanted to put a spotlight on the importance of preventive care, for example, that customer can seed money into a preventive care fund. It is similar with pharmacy. Again, the message is that there is a lot of flexibility.

the other key feature to an HRA—and luckily this is now the case with health savings accounts (HSAs) as well—is the importance of incentive programs. An incentive program could take the form that if you, the consumer, complete a health risk assessment, your employer will put more money into your fund—$25, $50 or $100 (it's up to the employer). To help drive behavior with the chronically ill, if you are in a disease management program and complete that disease management program, more money will be put into your fund. You get the idea. If you use Web-based tools to get information on costs of services, more money can go into your

fund. The incentives are a big part of the behavior change that's inherent in the consumer-driven design.

Contrast that then with the HSA, the health savings account. The key differences here are from a fund perspective. Both the employer and the employee can now contribute money into that fund. From an employer's perspective, there's a little less plan design flexibility in an HSA because the government stipulates the nature of the design. For an employee, however, there are a lot of key features and advantages to an HSA. It creates a multiyear mentality; think 401(k) when you think of HSAs. You can now put money away during healthy years to pay for high health-care costs in later years. You get the tax "triple play"—money goes in pretax, it can accumulate without tax implications, and it can come out without tax implications. The fund money is instantly a consumer's asset. It is also portable, so if you have an account balance and leave your employer, that balance goes with you. It also goes with you into retirement. That fund money can earn interest. Often, there are investment options associated with HSA funds that are available. The funds are always 100 percent rollover (we typically see that in an HRA as well). Last, consumers have flexible use of those funds. There's a lot of flexibility from a consumer's perspective in an HSA design.

Let's go into pricing levers. I would categorize pricing levers into four main components (see slide 8). The first component is core fundamentals. These are provider discounts and effective care management at the core of them. You can have a consumer-driven plan that has all the bells and whistles in the world, but if you're not leveraging good provider contracting and or effectively managing care, those plans are not going to be effective at managing cost and quality. Those are core fundamentals.

The second component is the plan design. Obviously, there is a big buy-down component here, and the benefits themselves deliver two advantages. Obviously in a high-deductible environment you get a cost-benefit reduction from that higher deductible, but there's also a behavior change component to that plan design. It goes part and parcel with this notion of consumerism, which is the third component. The incremental behavior change that is generated from these plans by the outreach, by the engagement and by the cost transparency goes part and parcel with the plan design. Last is selection (we'll spend a little more time on this later). Most customers right now are adopting consumer-driven plans as a choice, so we do need to look at and manage effectively selection dynamics from that choice environment.

How do these levers play out? Here's a quick pricing example (see slide 9). Let's start with your run-of-the-mill PPO plan. There's a $250 single deductible and 90/70 coinsurance. Let's say our starting point is a blended per-employee per-year (PEPY) cost of about $6,000. Let's look at how one HRA plan design walks through the pricing mechanics relative to this current traditional PPO plan. You see that

we've got a $1,000 single fund and a $2,000 family fund, with a $2,000 and $4,000 deductible respectively. We've kept our 90/70 coinsurance.

Now let's walk across the columns. In the Plan Cost column, that $4,285 represents two things. It represents the buy-down (the cost reduction you get simply from moving from a $250 deductible plan to a $2,000 deductible plan), but also in that number is that value of consumerism from the other plan features above and beyond plan design. You can see that relative to the current PPO plan, we get a nice cost reduction.

Move over one column. From an employer's point of view, the fund itself is a big cost component, and it's something that we need to communicate to our customers. That $1,390 represents the single/family blend of the $1,000 fund and the $2,000 fund, based on expected use. There's an important point here when we're talking about fund liability or fund cost. There are two views you can take. You can take a cash view, which is what is shown here, or an accrual view. A cash view would say that singles in a given year, depending on certain plan design features and depending on the size of the fund, will use 40 percent or so of their funds. Families will use 80 percent or more of their funds. It's how much of that fund spend (dollars out the door) that happens in those first 12 months. That's the cash view, and that's what this $1,390 represents. Data would suggest that typical fund spend is about 60 percent. Obviously that varies a lot by the plan design features and the amount of the fund, but that's a common result to date in the industry.

The other view to take is an accrual view. Remember, an important feature of a consumer-driven plan is the fact that you can roll over those unused funds into the next year. A lot of our customers ask us to model for them a percentage higher than what we expect will go out the door from a cash perspective, so that they can account for that rollover that happens in future years as a year-one liability. Jim will get much deeper into that.

An additional cost component would be any additional fees that are associated with the fund dynamics, fund management, the tools, the reporting and the touches that go around these plans. Altogether they present the total cost picture to the customer. That's how you go across the columns.

I have a couple of comments on going down the rows. You can see as you change different plan design features how that impacts the pricing. I'll highlight the next one. You can see in the next row that we've lowered the fund amount to $500/$1,000, but we've kept the same deductible. You might wonder why the plan cost is bigger if you've still got a $2,000/$4,000 deductible. The answer is that that's the relationship between the fund and the deductible. In the first row, you had your $1,000 fund, and when you exhausted your $1,000 fund, you, the consumer, had a $1,000 deductible for which you were responsible. With a $500

fund, when you exhaust that $500, now you have a $1,500 deductible facing you. That will change utilization patterns and, therefore, the cost equation.

The other thing that I would highlight on this slide, if you look at the last column, is that, again, there's a ton of flexibility with these designs. We have customers who come to us and say, "I want to adopt a CDHP, but I want a plan design that is equivalent to my current one." You can design these plans to be equivalent, you can design these plans to be richer, and you can obviously design these plans to put forth significant cost savings (we have customers who are looking for that as well).

If there are cost savings to be had with a CDHP, you can't get the cost savings if nobody enrolls. We spend a lot of time working with our customers on how we can successfully position a consumer-driven plan so that you can drive enrollment. My fear is that if we continue to see only 5 percent or 10 percent enrollment, these plans aren't going to have an opportunity to succeed. We message and help consult and strategize driving enrollment. There's no better way to drive enrollment than go full replacement, and we're seeing more customers who are willing to do that. However, the majority of customers are still adopting this as a choice offering. In a choice environment, there are three key levers on which the customer needs to focus to get good enrollment into these plans and, therefore, get those savings.

I want to share with you one case study that we've done on a first-year adopter of an HRA plan who got good enrollment into the plan (see slide 11). It had a traditional PPO and introduced two HRA plans, kind of a high and a low, if you will. It drove two-thirds of the population into these new designs. Remember, this is first year. There are a couple of highlights on how it was able to achieve that enrollment. First is communication strategy. We can't emphasize enough how critical this lever is for successful adoption. These plans are new and, obviously, the communication strategy is "early and often." You can see some of the approaches that this customer used to communicate its new plan.

The second key is plan design itself. Inertia is a powerful phenomenon. When you're adding an HRA or an HSA plan design, what we recommend is that customers also make changes to their existing product offerings. That then creates an active enrollment environment so that consumers can now take a fresh view of all of their product options, rather than stick to the comfort of the devil they know.

Last, contribution strategy is a hugely critical lever, as I'm sure you can imagine. Typically, if customers are looking to generate good enrollment into their HRA design, we recommend that they set their contribution strategy in a manner that makes the HRA or the HSA design cost-effective for the consumer, and traditional plans are then typically positioned as a buy-up. Just taking a flat contribution strategy approach across the suite of offerings is going to serve to dampen the value across them, so we recommend either a differentiated contribution strategy or even a flat-dollar contribution strategy that's set at the HRA or the HSA design.

Let's talk about navigating a choice environment. Customers who do not go full replacement and do go choice, which, again, we still see a lot, do need to be cognizant of choice environment dynamics. Again, if you've read any industry articles about consumer-driven plans, you will hear a common fear that consumer-driven plans are going to stratify our risk pool; only the healthy are going to adopt a consumer-driven plan, and that means doom and destruction for traditional plans as we know them. Does that sound familiar? Does anyone remember when HMOs hit the scene? We heard the same argument then. "These HMOs are going to skim the best risks. PPO plans are going to implode, and doom and destruction will occur." The headline here is that risk selection is not a consumer-driven phenomenon. It is a choice phenomenon, and it has existed since the dawn of multiple-option offerings. The keys are recognizing that selection is present; effectively managing that selection with enrollment strategies, plan design strategies and pricing strategies; and also knowing that the selection is likely most acute in that first year when you do only have 5 percent or 10 percent enrollment into these plans. As these plans grow in their membership, that risk selection dynamic will dampen.

We've taken a look at some of our cases and the nature of the employee population who has enrolled in various plans (see slide 13). You can see three of our customers here, of varying sizes, who have adopted consumer-driven plans as part of a choice offering. You can see how the enrollment is shaking out across these plans. For Company B, I will tell you that the contribution strategy favored the HRA. From an HSA perspective, the employer in this case did not seed any of its money into the fund, so it was an employee-only fund contribution dynamic into the HSA. Therefore, it appealed to the top executives who were looking for those tax advantages, and hence there's the small enrollment.

From a demographic perspective, we found across these three cases that the demographics weren't materially different across the different product offerings. Similarly, contract size (our proxy for single-versus-family mix) looked similar across the different options. What you do see, however, when you look at the claim costs for these populations for each of these products is that your one-selection dynamic is indeed alive and well. The first adopters into the consumer-driven plans were the lower-cost employees, so that is bearing out.

From a renewal perspective, as we begin to renew CDHPs, there are a couple of considerations. One is that we believe that the consumerism, or the value of the behavior change above and beyond the benefits themselves, is a multiyear variable. It's not a "big bang" theory. You're not going to get all the behavior change there is to be had on January 2 when you put one of these plans in on January 1. If anybody has ever been on a diet, you know that that's the case. Behavior change happens slowly, over time. How we've set our pricing variable is that the incremental consumerism starts in year one, grows in year two, grows a little more in year three, and then you reach a point where you can only change somebody's behavior so much, and that levels off. It's an important renewal

dynamic to consider that now as people get comfortable with these plans, they've used the tools, they've started to see that cost transparency and they can now touch those rollover dollars in their fund, that that behavior change will be even more pronounced.

The second consideration is that the selection dynamic will dampen as you drive more enrollment into the consumer-driven options, just like any other choice dynamic. With a high-deductible plan, deductible leveraging is a consideration. From a renewal perspective, we'll see a starting trend on the high-deductible plans about a point or two higher than a typical, or normal, PPO plan. However, when you weigh all the ups and downs, what we're seeing as we renew these cases is that net/net, you've got good trend mitigation of several points. Again, with so much flexibility in the design, there's a wide range here, but trend is lower on these designs than the traditional PPO counterparts.

The one other consideration to think about as we move forward in these consumer-driven designs is what I call a cohort-based view. This becomes important from a pricing perspective. If you look at a super-healthy person, a nonuser, you can throw all the tools and all the cost transparency in the world at them but we're not going to change their behavior, because they're nonusers. There's no behavior to change. On the flip side, if you take a chronic employee and do outreach and tools and transparency and incentive programs, you're going to see a meaningful behavior change with that group. What we're looking at, as our data emerge, is potentially moving to a cohort-based pricing approach, so that we're not underpricing for an overly healthy group and vice versa, depending on the dynamics of the population at hand.

With that, I will turn it over to Jim, who will take us through some of the reserving implications of these plans.

MR. JAMES P. GALASSO: These are the items I'm going to go over today. I'll start with looking at some of the reserving implications with respect to HRA and HSA balances (the fund balances in those accounts). Then I'll be going into reserving implications of high-deductible health plans, selection considerations, communications (I'm talking about your internal communications between the valuation actuary and other disciplines within the organization) and some Health Insurance Portability and Accountability Act of 1996 (HIPAA) considerations. I think Stephanie's presentation focused largely on the large-group segment, where HRA plans, I believe, predominate today. In the smaller group, I suspect, it will be virtually all HSA-type plans. Then we'll sum it up with the claim reserves and contract reserves. We'll be going through those as we go through the various steps.

With regard to HRA balances, I think it's probably somewhat self-evident that as we sit today, the notional balances that sit in those HRA accounts—there's usually not actual cash sitting there—is held by the employer. I have no prohibitions against the insurer assuming that role. In fact, I found out just today that there was an

insurer that tried that but has abandoned the concept, so I think that for the most part we're talking about the notional balances sitting in employers' make-believe accounts.

One of the things with those accounts, as far as HRAs' concerns, is that there are no plan restrictions—back to Stephanie's point—in terms of the flexibility of HRAs. They can dictate what is and what is not an eligible expense in an HRA account, unlike an HSA account, where the government dictates what is and what is not a deductible expense.

One of the real complications for the valuation actuary is, What do you do with those balances? For HRAs, again, we're assuming that it's sitting with the employer (the notional balances). But even that employer, especially the largest of the employers, is going to want to have some help in understanding what liability is building up over time as the employer continues with this concept. It's not an easy concept to get your hands around, in terms of the vesting provisions of the HRA and how much is going to ultimately become an ultimate payout from the contributions to the HRA.

As far as the vesting considerations, as I understand it, employers, especially the large employers, do usually vest into real money that does have to get funded at some point in time for the employees. The typical, easiest consideration is age and length of service. They might also vary by employee classification; the salaried versus hourly workers may have different plan designs and different funding requirements. Then, in terms of the valuation actuary, other considerations are how he or she might discount the vested and funding of the reserves, including terminations that may occur in the future and the interest assumptions that he or she might use. It's a fair game in terms of open-ended possibilities of other vesting parameters that may come to pass, assuming this product continues to expand.

Let's talk about the claim reserving techniques that the valuation actuary might use. In terms of the "pay as you go," we're now talking from the insurer's standpoint about the actual claims that do get incurred and paid by the insurer. We'll talk a little more about this later, but I assume for the most part that the actuary will be using traditional completion factor and trend methodology-type techniques in developing reserve. I call it "IBNP" or "IBNR," or "incurred-but-not-reported," which is the more common term. The "P" is just a little more generic—"incurred but not paid." Presumably, they'll start with some assumption that is treating it almost like a standard, high-deductible health plan. It gets a lot more complicated than that when you start thinking about the HRA in terms of the impact that is going to have on the actual liability of the insurer. It is going to have some. There's going to be some incentive or decentive on the part of the employee to spend the money below the deductible level, depending upon how the HRA account is set up and what restrictions or lack thereof there may be on the account itself.

As we talk about the contract reserve for the vesting of the HRA balances, I've seen two basic methodologies. One is a true seriatim analysis, where you look group by group, member by member, at the actual vesting parameters in an actual analysis and study going forward. Most insurers, though, will not have the wherewithal or the information to do a lot of that analysis in terms of the parameters that may be involved to which insurers do not have access in a standard member file. So it could get tricky in terms of the assistance that the insurer and the valuation actuary may have, in terms of providing the employer with information. I'm assuming that there are going to be a lot of generic assumptions that have to be made in terms of length of service and things such as that, unless it really gets complicated and you try and get all that information from the employer, load it onto your system and do a true seriatim analysis based on all available data.

Another approach is to do a more high-level-type analysis, and perhaps over time something like this will add some credibility. That is doing something like X-percent of the gross contributions to the HRA, plus Y-percent of the payments attributable to the HRA. Use a high level or detailed level or any variation in between.

FROM THE FLOOR: Is this contract reserve just for providing to the employer? It's not something that the insurer would hold on their growth?

MR. GALASSO: Yes, that's the thinking here, unless there is an insurer out there that's going to try to assume the responsibility of the HRA account itself, which I understand is not taking place right now.

Going over to HSAs, it gets simpler from the insurer's standpoint and for the valuation actuary. The HSA is real money sitting in a real account somewhere (you may not know where). The deposits, though, are not premiums, and the expenditures are not medical costs. If you read financial magazines and financial planners, what they're suggesting to all their clients that have HSAs already—and this pressure is only going to grow as HSAs continue to grow—is to not use the fund at all for medical costs and to just use it as a tax-advantage savings vehicle ad infinitum into the future for retirement for the individual. Then it's going to get tricky for the insurer and the valuation actuary. This is going to be one complication, I think, that's going to get significant.

The HSA is going to be integrated into the actual administration of the health-care plan itself because you don't know whether people are spending the HSA account on medical costs, or whether they're just saving the money and spending out of their own pocket, which, again, is what their financial planners are saying and doing. They say to leave the money in the HSA, and spend your deductible dollars out of taxable dollars instead of funds that can grow tax-exempt. How that's going to play out to an ultimate liability to the insurer is going to get tricky, and only time will tell what the implications might be.

The HSA balance, as I said, could be held anywhere; there are certainly no legal restrictions of which I'm aware. It could be held in an insurer's general account, an insurer's separate account or by a separate institution altogether. As these funds grow, I know the Fidelitys of the world are already considering this type of situation. Right now I don't believe that they're really in the game, because the dollars aren't all that great. When those dollars start to grow to $5,000, $10,000, $15,000, $20,000, then $30,000 and up, in other words when you start seeing real money in these accounts, which will happen over the next several years, you're going to see everybody going after it to try and get their piece of the action in terms of controlling and managing those funds. Administratively, that's going to be a challenge for all of us. As Stephanie mentioned, the portability of HSAs is there. You can move your HSA account with you from employer to employer, and you don't have to worry about that.

I think that HSAs, as I may have mentioned earlier, will be the only game in town for the small employers. I can't imagine a 10- or 15- or 25-life employer opening an HRA, or at least an insurer being willing to open an HRA for those small accounts. I'm not aware of any; there may be some, but it wouldn't seem to make sense to me.

Let's look now at the insurance element of the CDHP. By the way, when we say "consumer-driven health plan," we're talking about a plan—at least for this presentation's purposes— such as an HRA or HSA, with a high-deductible health plan. There are infinite variations on the theme. There's also a fair amount of activity in the marketplace where we're not talking this kind of design; we're still calling it "consumer-driven," but it's more trying to get people to select the right provider and have copays and coinsurances vary based upon if you pick the right hospital or the right doctor, and then you have copays and coinsurances go up and down. That's another version of a CDHP that we're not talking about right here. We have enough to worry about with this particular design.

Stephanie covered a lot of this, but selection is a huge issue in my mind, as far as how it's going to play out and how it's going to be controlled by the insurer. It's going to vary from insurer to insurer and from employer to employer. It's going to be ongoing studies and keeping and monitoring of actual results that are going to help the valuation actuary looking at what's going on with selection. We'll talk a little about the communication between the valuation actuary and the pricing actuary, in particular in terms of what are the initial assumptions and then the monitoring of actual results against those assumptions.

Let's talk about the phenomenon that actuaries have always worried about since choice began. That is, you offer a bunch of people either a high-deductible plan or a low-deductible plan, and all the healthy people do, in fact, go to the high-deductible plan and the less healthy stick with something else. What you've done now is move a whole bunch of healthy people over to a high-deductible plan who, in the extreme in one of Stephanie's examples, had no claims at all, so all you have done is reduce

their premium. In the aggregate, you're getting a lot less premium, but you're keeping the same amount of claims as an insurer. That's the concept that you need to most guard against.

Then there are inherent pricing difficulties. We, as an industry, have not been that great at pricing deductible plans in the first place. We haven't priced $200-deductible plans well, let alone $3,000-, $4,000- or $5,000-deductible plans. The uncertainties increase as the level of the deductible increases. Then, of course, you have the leveraging impact with high-deductible plans, as well as just trying to understand the pricing implications themselves.

Assuming there is selection in the first place, which is hard to dispute, you will see the durational wear-off. This is one product in particular where the valuation actuary cannot afford to leave the pricing actuary behind or build a wall between them. All these issues are extremely important to the valuation actuary, who always ends up getting into looking at per-month per member (PMPMs) and such and developing his ultimate reserve analysis and his reserve estimates. That's why I'm going through these. As much as a pricing actuary needs to know about this stuff, so does the valuation actuary.

We talked about the high medical cost trends that the leveraging of high deductibles result in. As far as seasonality, almost every session that I attended the past couple of days talked about these intracalendar year reserves. There seem to be three camps: yes, you have to do it; no, you can't do it; and maybe you should do it. I'm not sure whether we've reached agreement. My opinion on the subject is that it's probably the appropriate thing to do and that it's a thing that a company needs to do if they want to understand how their product is working. A company needs to adjust for the seasonality of high-deductible plans, recognizing that the initial months are going to be more favorable than the later months and adjust reserves accordingly, so that you can track actual versus expected on a month-to-month basis.

As far as CDHP selection considerations, group fragmentation is a problem in and of itself. It's an especially difficult problem when rather than one insurer controlling the whole group, there are multiple insurers. At least when you have whole case, you can get into employing actuarial equivalence, and trying to manage the risk is infinitely easier when you're controlling the whole population. When you're one of two, three or more carriers that are offering coverage to a given employee population, controlling that risk becomes extremely difficult. From my perspective, you better hope that you're the one with the high deductible and not the low deductible, as far as selection is concerned.

You still need to monitor the duration, and the selection wear-off has to be considered. Do these plans inevitably favor the young and the healthy? I have just been reading about this and only now, in talking with the other panel members today, am finding out that these kinds of things are going on. As far as adjusting

the employer contributions by medical condition (less to the healthy), income level or disease management participation, or replenishing HRAs and HSAs for "evidence-based" medical costs, I thought that the HRAs and HSAs were complicated enough in and of themselves without getting into this kind of stuff.

FROM THE FLOOR: With respect to adjusting employer contributions, what are the other legal restrictions that will not allow you as an employer to do those things? If there are, do you think that there will be a push to try to change regulations?

MR. GALASSO: I'll let the other panel members speak to that, too. I'm not aware of any specific legal restrictions, other than discrimination. But I'm not sure that the government will worry about discrimination here. Lawyers can make a case out of anything, I guess, but the discrimination would be in favor of the lower paid and the sick people, to the extent that any of this is going on. I don't think there's any company who is going to try and reverse that and give even more contributions to the healthy people or the richer people. That would tend toward suicidal, so aside from that, I'm not sure if there are legal restrictions.

MS. HURLBUT: At CIGNA right now, we are not administering different contribution strategies by these factors. We have seen this kind of approach manifest itself in two different ways. We have had employers who are looking to put different vesting requirements on the fund money by certain things, which can be a proxy in some cases for some of these. But right now the most popular way that these items are getting addressed is through incentive programs, so it's not the employer's contribution to the premium, but the contribution or the money that they seed into the fund. For example, if you are in a disease management program and complete it successfully, you get more money into your fund. For now, that's how we're handling it. With respect to Jim's point, the administrative complexity would be significant to vary premium by all of these different factors.

I know that Dan has some thoughts on the HIPAA point of it.

MR. DANIEL R. PLANTE: I have not seen any sort of interest on the part of employers or carriers or even Washington on changing the regulations around things like this. Even if there were some talk about this, I cannot imagine that it would go forward. I think that all the carriers are operating within what they can legally do now under the regulations, and the designs that they are producing are innovative enough that they address some of the underlying desires that are laid out here without running afoul of the regulations. I don't see it going in that direction.

FROM THE FLOOR: Maybe this is what you were saying, Dan, but I don't know how a lawyer could change an employer contribution based on medical condition. Wouldn't that be a violation of HIPAA? He would have to know your medical condition to ding you.

MR. GALASSO: No, no, it's not dinging; it's rewarding people with a medical condition. Say someone has cancer, and now that person has exhausted his or her fund. The concept here was that the employer would say, "Let me replenish that fund for this sick individual." I don't know if that runs afoul of regulations.

FROM THE FLOOR: I would think that it would run afoul.

MR. PLANTE: I've seen plenty of designs that do provide additional funds for prespecified conditions. Diabetes is the example that's thrown out there frequently. "If you have diabetes, we will give you additional funds from your account, if you follow these protocols so that you live a healthier lifestyle." We've not seen any HIPAA issues related to that thus far. Maybe I'm being a little naïve about the issue, but I would think that if there were HIPAA issues on that, they would have been challenged long ago. I can't speak for the details of HIPAA, but so far I've not seen any problems doing so.

FROM THE FLOOR: That gets into a subtlety. I think that if the employer is actively looking for information, that would be in violation of HIPAA. But if they structure a benefit—effectively what you're talking about, Dan—so that the employee is, in recognition of HIPAA, now granting the employer or insurer relevant information to make that decision, it's not getting around it.

MR. PLANTE: It may well be permission on the part of the individual to do so. That could be the semantics that allows it to go forward.

MR. GALASSO: As far as communications, we talked about the need for the valuation actuary to communicate with others. Maintain consistent, understandable, communicated and documented pricing strategy to save yourself from Sarbanes-Oxley. That's just good business practice.

There are complications that HIPAA brings in, not the ones that have just been raised now, but the rating issues that have been causes for the small group marketplace. Pre-existing is limited. Guaranteed issue is required. Will guaranteed renewability end up a requirement for premium deficiency reserves? There are issues such as that. There are limitations on the rating bands.

It goes back again to setting up the claim reserves. Claim adjustment expenses certainly should be talked about. I don't know whether people are putting aside more, but these are certainly more expensive to administer, and that should be considered with the straight to claim adjustment expenses.

MR. PLANTE: Mike Thompson in our firm was supposed to talk today. Mike is one of our partners who spent a lot of time on consumerist issues. He is focused on strategy and producing healthier lifestyles. Once Mike leaves the room, I'm the guy that goes in and mops up what he tells clients to do. I'm going to bring a more pragmatic view to some of Mike's slides. I've not changed any of his slides. I might

not necessarily agree with all of them, but I've left them in there. I have added a few slides that you won't have in your printouts, but we're going to try to post those to the Web site, so you will have access to them afterward.

You've probably heard the definition of consumerism any number of times. The ultimate idea is straightforward: get the individual more engaged in this process. We've had everybody else under the sun calling the shots on health care, including the government, the providers, their insurers and the employers. Finally we're saying, "Let's let the patient decide some of these issues." Beyond this being the last person to get involved with this, I think consumerism is the best choice going forward. Certainly, individuals have got the most vested interest in making this work.

Let's talk about providing financial incentives. Ultimately, the best way to get any individual to look at something is to show some dollar signs. How is it going to impact me financially? This is a valuation topic, so the financial aspects of this are important.

Consumer-directed health care to date has not had any impact on the uninsured, as far as we can see. This doesn't represent a PWC comment; it's just an editorialization. What we have seen is a shift within private coverage. It's weeding away some of the nonconsumer-directed employer-provided coverage and replacing it with consumer-directed-type plans. That's not to say that down the road it's not going to start to impact the uninsured. It's certainly going to impact the government coverage of people. It has to, at some point, and I think that's part of the ultimate goal.

I mentioned that there are going to be some slides in here that Mike produced with which I don't agree. Slides 29 and 30 are two of those slides. Way back when 401(k)s and PPOs hit the market, there were different adoption rates by the general population. 401(k) plans slowly gathered some steam, whereas PPO plans picked up popularity fairly quickly. The postulation has been that consumer-directed plans, the HRA plans, have been picking up quickly, like PPO plans. Certainly that raises more selection issues in valuation. The question is, Are the HSAs going to look more like 401(k) plans? I disagree with that. I think that the HSAs are going to look more like the PPO and the HRA consumer-directed lines. Adoption rates are going to start to escalate, and we're starting to see that already. HSA business that's being written today is starting to eclipse HRA-type consumer plans. Ultimately, we're going to see a lot more people in these plans, and that's going to raise more valuation issues quicker than we might have anticipated earlier.

On the demand side, what are our goals for consumerism? You've seen all these things before (see slide 31). Some of this is the marketing approach. How do we get people to buy into consumerism? I'm an advocate of these plans. I don't believe that these are a mechanism to shift costs to employees. These are a way to provide

incentive to reduce unnecessary utilization. The demand side is just that: give the individual more desire to want to be involved with the decision-making process.

The supply side is a little different. If you look at the mix of cost efficiency versus quality (see slide 32), obviously we want everybody to be pursuing the upper right corner of the graph, where you've got good cost efficiency and high quality, and you're weeding out those health-care providers that don't provide good cost efficiency and high quality. We're never going to get everybody up there. We're going to try to get more people focused on that and, at the least, give them the value decision to decide, Is that what we want to go to? Six months ago, I would have said that there are some great measures out there on quality already; you are not going to get cost information in the hands of the consumer. The current insurer contracts make that difficult. That was six months ago. What has happened since then? CIGNA, for one (and another carrier for another), is putting concrete information out there to individuals on cost and quality mixes, so we now have the start of information going into the hands of the consumers to give them a value basis on choosing their health-care providers.

It's starting to sound more like adverse selection again. The more information you give the individual so he or she can make an educated guess, the more likely that the individual is going to pick a plan that allows him or her to capitalize on that. We have introduced layers of adverse selection with consumerism. Prior to the consumer-directed movement, I never thought that adverse selection was as big a concern as a lot of people thought. I've had to eat my words time and time again under consumer-directed plans. These vehicles do promote adverse selection. The issue, then, is to account for it and try to anticipate and control it.

The disease management process is part of not just a consumer-directed plan, but any plan. It is a retrospective-type process. After someone with a disease has been identified, they kick into these types of programs, and appropriate interventions can be applied. What we're seeing in the entire market (not just the consumer-directed market) is that there are a lot of lost dollars spent on these plans for populations that may never have a need for this, so there's more interest in focusing dollars in programs toward the specific underlying populations. Why is that important? Stephanie already talked about this. Going forward, the incentive programs—getting people to start to adopt healthier lifestyles and better courses of treatment for existing conditions—are going to ultimately, we hope, change lifestyle and long-term health costs.

Let's talk about improving health-care quality. We are seeing that people are still not pursuing recommended care to the extent that the provider community would like. You look at some of these statistics, and this is sad stuff (see slide 34). We would certainly like to get a higher score on recommended care. With good consumerism, we're going to get that. What does that mean? Will costs go up? It's possible in the short term that they'll go up, but in the long term, as people are focusing their treatments more appropriately, I think that we'll see trend decreases.

Let's talk about the evolution of health-care consumerism (see slide 35). There are a number of generations of consumerism floating around out there. To date, the first generation, discretionary spending, has been fairly well-documented and fairly well-adopted. When you talk about all of the unnecessary services that people pursue, isn't consumerism going to help them understand the costs associated with that? Absolutely. The great examples are prescription drugs, if you understand the cost of a generic versus brand, and going to office visits that are unnecessary. You can easily peel away these low-hanging fruit off the health-care spent.

Health savings accounts have popped in. Mike has put these at the upper end of the first generation or early second generation. I'm not convinced that I'd say that they're far along. I almost view them as slightly anticonsumerist because of their tax attractiveness; I think that they appeal far more to people's tax sense than health-care consumerist's sense. That's not to say that they're not going to catch up. I think that they will, but I don't think that they're there yet today. We'll talk about these different generations in a little more detail.

There are valuation issues around the discretionary, first-generation, consumer-directed plans. As far as IBNR, or IBNP, as Jim said, when you look at experience during the course of a year, obviously you would expect that early in the year, the HRA would be tapped at a greater rate than it would be at the end of the year, when it's probably exhausted. On the other hand, the high-deductible plan is not going to be tapped into until the end of the year, once you've met your deductible. The interesting thing is that when you look at the two things combined, regardless almost of the size of the deductible gap, they track closely to a uniform utilization of this plan during the course of the year. From an IBNR perspective, that has told us that these are fairly easy animals for which to use midyear data to do overall valuation work. Nobody that I work with has said, "That's great. Do it all together. Don't disassociate the HRA with the high-deductible plan." When you do so, you have to use the more traditional methods to come up with separate valuations. I'm not going to get into any of the IBNR intricacies beyond this. This is fairly straightforward stuff, and Jim has done a great job in talking about some of the details there.

What I want to focus on here in the first generation is what's left over in the HRA at the end of the year. Is it a liability? You're an audience of valuation actuaries, and I think that actuaries in general would say that this is a liability. This is a promise made to the employees that they will have these funds at some point in the future. Unfortunately, there's no official guidance that tells employers that, in fact, they have to recognize that as a liability. Most employers to date have been prudent and said that it's a liability. They don't know what the heck to call it, but it's a liability. There are some, though, that say, "Until we are told that we have to recognize this as a liability, we're going to go kicking and screaming. We're not going to put something on the books." That is a shortsighted approach. Is it an IBNR? Not really. Nothing has been incurred yet, but what else do you call it? I don't know what to call this yet. One of the things we're going to look for is the SOA to give us some

guidance in how we value and some guidance that it has to be valued. Prudence would dictate that we want to recognize this liability.

Now it gets interesting. What is the liability of the unused HRA? You'd think that would be easy. If you get $1,000 during the course of a year and use up $900, the liability is $100. Unfortunately, it's not that easy. Many of these plans are starting to say, "As you are good consumers and can roll these funds over into the future, you can take them into retirement or postemployment (move to another employer)." A lot of those issues are the same between postemployment and postretirement. I'm going to focus on the retirement side, which is the Financial Accounting Standard (FAS) 106 side. Now we start to get interested in some of the minutia of how to value this.

Does having a rollover HRA introduce a FAS 106 liability? If you can take this into retirement, I would argue that this is absolutely a part of a FAS 106 liability to an employer. That is the easy question. The tough question is, How do you value this thing? How much of the rollover do you treat as allocated to retirement? For that matter, there's an expectation that some part of the beginning-of-year allocation, of that $1,000, for example, is going to be carried all the way into retirement. How much? How do you value it? One thing to keep in mind is that it is not an additional liability. It is an allocation of the existing end-of-year rollover amount, so at the end of the day you know the total answer; it's just parsing it up into the components that is the tricky part.

Do you assume that people are going to continue to get the accrual year after year? Under FAS 106, the substantive plan design approach would dictate that you're going to continue to get that annual accrual, and you're going to continue to tap into it as an active employee. That's where this becomes a difficult valuation. Under traditional plans, you are not too focused on what the employee does while an active employee. Sure, you look at the employee's experience to get an idea of what he or she is going to spend in retirement, but you're not concerned individually on how the employee is using his or her active employee plan. Now we've got a design that ties those two together closely. You have to understand how they're going to use these accounts while they're active employees and how much is going to last into retirement.

Think about that for a moment. You could have two people that have identical health-care spend habits. Say that Stephanie is far more forward-thinking and does not tap into her HRA. She opts, instead, to pay out of pocket so that she can accumulate the HRA. Say that I am not foresighted at all, and spend, spend, spend, using my HRA up as I go and accumulate far less. Our utilization patterns are the same, yet our valuation issues are entirely different. As actuaries, you have to start to recognize that people are going to react differently to these plans, based on personal, nonhealth-based preferences. This is a new issue that we have to deal with as actuaries in the valuation of these. That is one of the things that makes these so difficult to think about.

The usual array of valuation assumptions that you'd want to throw in there, such as mortality and termination, are there. In addition, there are flexible spending accounts (FSAs). You can coordinate HRA and consumer-directed plans with the flexible spending accounts. What does that design do? Does the FSA pay first, or does the HRA pay first? That has an issue on the valuation. What about changes in future utilization? To date, when we do a FAS 106 valuation, we're not making assumptions about changes in future utilization, other than for the fact that as people get older, they use more services. Suddenly, we're going to start to look at how people change based on the amount in their account and how engaged they are in a process that we've developed to make them so engaged. That makes this more complicated.

We did a little example of a closed group with existing accounts. People could use these accounts or save them over time. In fact, in this particular scenario, people are in the "Stephanie" camp. They save, save, save so that they have this available for retirement. For this employer, this maps out over the next 50 or 60 years until the expected current population has all used up its accounts. The aggregate balance is pretty big, from the perspective of the employer, for what is in essence a pretty small population. This underlines one of the key issues of the importance on valuing these types of benefits: There is a significant liability out there through just these rollover amounts.

It's a difficult plan design to value, as I said, given the way that it's tied to the active plan. We've talked about this inside PWC a number of times. We've got a lot of accountants in our firm. I've asked them how they would deal with this. Unfortunately, the answer that I've gotten back generally is, "We don't know. We look to you to tell us." I've talked to some of our national gurus on FAS 106. I didn't initially like the answer that one of them gave me, and I'll tell you why in a moment, but the answer that he gave me was, "Let's make it easy. Let's say that you assume none of these dollars ever make it to retirement. It's a difficult thing to value. Assume that people are not going to be good consumers; they're going to be in the "Dan" camp and spend, spend, spend. If, in fact, some do have some dollars available when they retire, it's an actuarial loss, because now the employer is paying more."

I didn't like that idea initially because as an actuary, I want to do more valuation number-crunching rather than less. But it does have an elegance to it because it does fairly closely map out the impact on most employees. Most employees are not going to have much of a balance when they get into retirement on HRAs. I think HSAs are a different issue. There's more of an incentive from the tax perspective for them to save these dollars. On the other hand, those are actual dollars going in, and the liability is just the current dollar outflow for that. In this time now when we don't have any guidance on how to value this, I prefer this approach. It keeps life simple, and certainly those of you who do FAS 106 valuations can try explaining to

your clients an approach other than this. You're going to find that it's a difficult concept to get across to them.

That was just first generation. Second generation is where we get into some health risk assessments. The initials to that are "HRA" as well, so we're going to call it a "health assessment" so that we've got some different letters. The key issue to second-generation consumer-directed plans is health assessments. Get people to understand their lifestyle and give them some incentives to start to change it. I would love to take a personal health assessment to understand better what my return on investment is going to be.

Now let's look at this from a valuation perspective. Typically these health assessments are related to specific conditions. An employer will provide these in advance. Usually the insurer, the underlying consumer-directed vendor, will specify these in advance, but we'll keep it fairly limited to a dozen or so conditions. Diabetes and asthma are two very commonly included ones. Typically these health assessments involved in incentive awards involve three steps. The first is agreeing to complete the health assessment. "Dan, complete this assessment online, and we'll give you $50 or $100 to your account." Who wouldn't do that? That's the idea behind this. What employee wouldn't do that for, in essence, a free $100 in his or her account? Then you get to the second stage. "Okay, Dan, we've identified that you have this condition according to your responses. We will give you $200 more in your account if you agree to begin a program to address it." I have to go to Weight Watchers and work out twice a week.

After six months or after three months or after some period of time that's specified in advance, I get another award, say $300, because I've successfully completed that program, the idea being that I have become engaged and desirous of changing my lifestyle and my health habits. There's a reward associated with that. It varies in a market how big these dollar amounts are. It varies in the market whether these are provided per employee, per adult or per member. Most employers today are saying, "Yes, I can see the value of giving these to all members, but we're most concerned about our employees. We're going to limit our exposure by only providing these to the employees." Whether that's going to change in the future, I don't know. I think that that's the right direction in today's day and age.

What does this mean? Apart from being an additional amount in the HRA to begin with, you now have more dollars that can be left over at the end of the year. You now have people who are more engaged in healthy lifestyles, so maybe they're going to be accumulating more dollars because they're incurring fewer claims. Guess what? From a valuation perspective, that makes it more complicated. We're going to be looking to a lot of experience studies down the road to help us understand the return of investment of these programs for valuation purposes.

Let's look at third generation. Luckily, things are not getting successfully more complicated with these subsequent generations. All the third generation does is

say, "Take all of these things that we've already talked about, and be far more judicious in applying them to individual members." Stephanie mentioned stratified looks at pricing. This relates to stratified looks at plan design provisions. What does your overall population look like? If you've got the UAW population, which is an older, mostly male population (ignoring the spouses for a moment), are maternity interventions and healthy-mom benefits the best use of dollars? Maybe not. Maybe the dollars could be better spent with other lifestyle issues. Employers are starting to be careful in which programs they apply to their populations to get the most bang for their buck. The third-generation consumer-directed plan focuses on just that issue. From a valuation perspective, that is the same thing that we've been talking about. As you understand more of how individuals are going to react, you'll understand how their lifestyles and health-care consumption are going to change.

Let's look at fourth generation. You take this to the nth degree and say, "I have got this so focused and so personalized that it's down at the member level. Each member has a different consumer-directed package." That's a full-employment act for all of us, as far as I'm concerned; we need individual, personal actuaries for every one of these plans. Mike Thompson will say that we've already got a fifth and sixth generation out there. I can't pin him down to tell me what those generations are. I personally don't see fourth generation arriving here any time soon. I think that we've got quite a way to go before we get this. One key reason is that we have to get more of the population to the point where they believe in consumer-directed plans. Until then, we're not going to have enough critical mass to do individual types of programs.

From a valuation perspective, again, it's the same thing that we've been talking about. It's just on more of a micro level and understanding how individuals are reacting to these plans. What does that say? It clearly says to me that we are moving to seriatim-type valuations for these people. Group models, aggregate and continuous table models are not going to work for the role of our accounts. I've tried building models to do this; they implode fairly quickly. The seriatim models work fairly well at developing some of these short-term and long-term projections of costs, savings utilization and so forth. We can, as a group, value this. We need some guidance from the SOA to point us in the right direction on some of these open questions.

Ultimately, we've got a "sweet spot," which is consumerism. It's simple. Get people, based on their own interests and their own lifestyles, to focus health care on achieving those goals. I think that consumerism is the best shot at doing that. How long will it take us to get there? The studies that we've seen thus far have shown that even with lifestyle changes, you're not going to see any change in health-care consumption for three years. This is a long-term prospect. Again, that's a different health-care animal. We've been dealing with one-year-term health benefits. I have a deductible this year, and next year, the clock starts over again. With consumerism, this is whole life health. That is new stuff.

As for an open discussion, the first and only point that I want to throw out there is to say that there are many unanswered questions from the valuation perspective around consumer-directed plans. I would look to the SOA, which means you, to start providing some guidance. First up on the list is this rollover amount at the end of the year. Please make a pronouncement that this is a liability and needs to be recognized. That's important. Maybe that's the AICPA that needs to make that pronouncement, but certainly we can influence that by coming up with our own guidance on that.

MR. DAVID TERRY: I have a couple of observations. One is that consumerism has been around for years. I don't think that it's new. In the 1950s and 1960s, deductible plans and base major meds were all a fashion, and they didn't succeed then. We all had to go to managed care. My personal feeling is that there will be some short-term impact from this, but just giving people information is not going to change that observation significantly. In terms of consumerism, we've said the people are going to change behavior. I believe that's true, but I think that some of the behavior that's going to change, which will be impacted by the valuation, is that some of the people are going to hoard their money. They're going to do it at the expense of getting care, which means that they're time bombs. Time bombs are going to be more expensive when they happen and will offset any savings, so that has to be taken in to the valuation consideration.

MR. PLANTE: I'm going to jump in first because those are great comments. We've heard those issues raised with consumer-directed plans in the past. The early generation of consumer-directed plans swept those concerns under the rug, hoping that no one would notice, to be honest. The subsequent plan designs are more focused on addressing that, and I can give you two examples right off the bat. Preventive benefits are almost now universally provided outside of the consumer-directed plan, so it's first-dollar coverage. You don't pull the money out of your HRA, and you're not subject to the deductible. The idea is, don't avoid the preventive services where you might want to hoard the money. You can still hoard the money, but get your preventive services. Today, when under 40 percent of people take advantage of wellness programs, it's free money. As coverage that's provided on nearly a first-dollar basis, less than half the people take advantage of it. Consumerism in terms of plan design is not going to change that. Communication is going to change that, and communication applies to any plan, not just consumerism.

The other issue around hoarding money for nonwellness issues is an important one to recognize. Look at the other end of the spectrum, which is chronic conditions. We're seeing far more plans today—you can do this in the HSA environment as well—that are carving out specific conditions and providing first-dollar coverage on those as well, so, you're not using up your account to treat diabetes, for example. You don't need to hoard your money to address some of the costlier conditions.

Those are the bookends; now you've got that population in the middle. Are people who don't have chronic conditions and who have taken advantage of their wellness benefits going to hoard dollars? I'd be lying if I said that they're not going to hoard dollars. You're going to get some people who hoard money. You're going to get some people who are going to be engaged consumers. I don't know how to reduce the number of dollar hoarders other than through more communication. One of the things that I've seen so far that has been more effective and completely unexpected to me was word of mouth on the part of other employees. As more employees enroll in these plans and tell their office mates about how this plan works, we're seeing some change in hoarding mentality. It's slow, but we're seeing some.

I don't think that answers your question. I'm sure it doesn't reassure you that this is going to be fixed. I don't think that there's an easy answer to that. If you're healthy and max out that deductible gap, there's a $2,000 deductible, you've got a $1,000 HRA this year, you don't use any of it next year and you've got the whole $2,000 deductible, you've got first-dollar coverage next year. Are you going to spend, spend, spend, because you don't have to pay anything out of pocket? You will get some people like that, but I think that you'll get more people who will say, "I did what I did the first year because I want to have a healthy lifestyle. I'm going to continue that in the future." I think that time is going to show that we don't have that many hoarders of dollars at the expense of necessary health care.

MS. HURLBUT: We hear that concern from our customers as well. Relative to coverage of preventive care, we recommend doing one of two things. One is to cover preventive care at 100 percent in the underlying plan to make sure that the hoarders aren't avoiding care and that preventive care is an important part of total lifetime health. Second, some customers have taken advantage of this idea of having a separate preventive care fund within an HRA. That fund has no rollover attached to it. This is an employer's way of saying, "We're going to give you $250 this year on preventive care. Use it, because it's use it or lose it at the end of the year." So there are a couple of approaches.

Also, I think one of the differences between old deductible coinsurance and these plans is that it's not just information; it's incentives. It's dollar incentives for behavior change, and that's a little different from just throwing information at people.

I have two other points. The integration of the medical management programs within a consumer-driven environment is critical. It's outreach. It's touches. The touches that happen in a disease management program and an incentive around complying with those touches go together to make sure that people are managing their health on an ongoing basis and that there's not going to be some horrific, catastrophic event down the road.

The last thing I'll point out is a number of carriers have done a number of studies on their consumer-driven book of business. A couple of studies that have focused specifically on that issue. They've looked at employees with chronic diseases, and they watched their office visit utilization and their drug utilization before they enrolled in a consumer-driven plan and then after they enrolled in a consumer-driven plan. They found not only has that maintenance of care stayed, but in some cases it has improved. Some of the emerging data are suggesting that people are not avoiding care to hoard money.

MR. DAVID M. RUIZ: I'm not a health actuary, so I thought I'd join this one to see something new. What I'm seeing here is frightening me quite a bit. As an actuary, it sounds like a great opportunity to get in on a new field that's exploding. For an employer, it sounds great. Costs would be a lot less for the employers. But going back to the first slide showing a comparison between a PPO plan with an extremely low deductible versus an HRA plan with a much higher deductible, I'm worried about the consumers. We can talk a lot about how it gives them more options and more control over their own health care, but I don't see how it becomes affordable for the consumers to go from a $250 deductible to a $1,000 deductible. I don't see how it helps to control the rising costs of health care in general in the market by just changing the way the employers can fund it.

MS. HURLBUTT: One thing to remember about the high deductible is that there is a fund that exists before that high-deductible plan kicks in. That fund provides first-dollar coverage for people, so in some cases it's a richer plan because you've got that first-dollar coverage, where in a $250-deductible PPO environment, you don't. That first-dollar coverage is a benefit. The second point I'll make relative to controlling trends is to go back to the LASIK example. The value of the cost transparency is going to grow. The value of that first-dollar coverage and that fund rollover is going to grow. Just as consumers who go out and buy a car spend infinite hours researching the safety features of the car, whether they can afford the car and the different car options out there, that consumer mentality is going to start to seep into health care. As we the carriers and the rest of the community come forth with the actual cost information, people are going to be empowered to make better decisions. We're going to have to operate in an environment where those costs of services are finally known. People are going to need to compete on those costs of services, so I think that there's a lot of opportunity for long-term trend mitigation.