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Consumer-Driven Health Plan Effectiveness Case Study: State of Indiana

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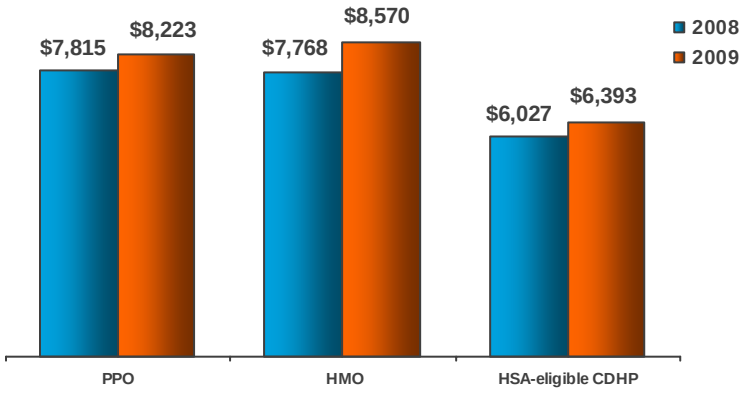
Executive Summary

In 2006, the State of Indiana joined a small group of pioneering employers that were adopting consumer-driven health plans (CDHPs) as a strategy to control the cost and trend of their health programs. At that time, only 11% of employers with more than 500 employees and 5% of employers with fewer than 500 employees offered a CDHP. Among public entities, the enrollment was far lower. By 2009, those percentages climbed to 20% and 15%, respectively. Interest in CDHPs, which are high-deductible account-based plans, has been strong, but many employers have held back from deciding to offer a CDHP. They have been waiting for feedback from the early adopters, such as the State of Indiana, to validate results about how CDHPs saved cost.

One of the attractions of CDHP plans is the lower cost and/or lower trend that they have been able to achieve. Mercer's 2009 Annual Survey showed that the average expense for a CDHP plan with a Health Savings Account (HSA) was considerably lower than the average PPO or HMO cost. In response, human resource executives have astutely asked why and what are the possible risks.



Source: Mercer's 2009 Survey of Employer-Sponsored Health Plans

The State of Indiana sought an independent assessment of the CDHP strategy that they began implementing in 2006. At that time the State offered two PPO options and two HMOs to 30,000 employees and their dependents. The legacy plans were very generous and shielded employees from the actual cost of healthcare. Newly elected Governor Mitch Daniels placed a high priority on reducing several areas of state spending, one of which was healthcare benefits, and was a strong advocate for getting consumers more engaged in their healthcare decisions.

The State introduced the first CDHP offering in 2006 along with the existing health plans. This plan was positioned to be the option with the highest deductible level and highest funding to the Health Savings Account (HSA) feature. A second CDHP, with lower participant cost sharing, was introduced in 2007. The two PPOs were consolidated to one PPO plan beginning in 2007. The primary HMO with almost a third of the State's enrollment was terminated at the end of 2007 when M-Plan withdrew from the market place. Thus, within two years the State had reduced the number of very generous plans from four to two, and replaced them with a new concept.

Mercer was asked to validate the sources of savings and overall experience of the two CDHP Plans compared to the remaining PPO. The CDHPs have achieved significantly lower cost than the PPO.

- The total average cost for the PPO was $12,317 compared to $5,462 for CDHP1 and $9,444 for CDHP2
- The two CDHPs had combined savings of 10.7% per year and are projected to save $17-23 million for the State in 2010
- Additionally, state employees and their families enrolled in the CDHPs are projected to save $7 to $8 million in 2010
- Both CDHPs had lower than average age populations, but a higher average family size compared to the PPO
- The actuarial values[1] of the CDHP plans were somewhat lower than the PPO plans, meaning that employees would pay more out-of-pocket than if they enrolled in the PPO. But, the CDHPs were not significantly lower in value:
  - CDHP1 to PPO: .926 to 1.000
  - CDHP2 to PPO: .996 to 1.000
- Individuals who moved to either CDHP option had reduced utilization and intensity of services

[1] actuarial value includes State-funded HSA dollars spent on medical claims

A critical question is whether the savings happened because of delayed care. Did participants avoid using services because they lacked an adequate amount of funding between the high-deductible plan and their HSA?

The State's strategy was to fund an employee's HSA in the amount of 55% of their deductible, with half of the state's contribution being prefunded in the first paycheck of the year, and employees could contribute their own pre-tax dollars to the fund. This amount would allow employees to build up a reserve, yet they would have access to a safety-net of funds to pay for services if they were needed.

The majority of employees enrolled in CDHPs in 2009 have significant HSA balances averaging $2,072 for the CDHP1 and $1,196 for the CDHP2. 20% of employees have HSA balances exceeding $3,500 in CDHP1 and $2,000 in CDHP2. Employees were not reluctant to use the accounts—82% of employees accessed their accounts to make tax preferred payments. Mercer's conclusion was that Indiana did not overfund the accounts and individuals stand a reasonable chance of increasing their accounts over time due to consumerism.

There is no evidence that participants in the CDHPs are avoiding care. Sources of savings appear to come from better use of healthcare resources and more cost conscious decision making.

2009 Healthcare Utilization	PPO	CDHP2	CDHP1	State of Indiana average
Emergency room visits (per 1,000)	308.1	210.4	163.0	238.6
Outpatient visits (per 1,000)	3,242	1,841	1,182	2,253
Physician office visits (per 1,000)	5,012	3,612	2,701	3,936
Generic dispensing rate	65.5%	68.4%	75.2%	67.7%
Average cost per prescription	$65.20	$53.89	$40.25	$59.04
Hospital admissions (per 1,000)	113.9	64.3	36.2	77.2
Average length of stay	4.9 days	4.1 days	3.8 days	4.6 days

Among the major factors leading to reduced cost were:

- Substituting generics for brand drugs
- Avoiding unnecessary visits to the emergency room
- Going to a primary care physician instead of a specialist, when possible

Potential savings for the remaining PPO population could be significant if the behavior changes could carry over to that population as well. Furthermore, there is significant opportunity to fine-tune strategy over time by focusing on provider performance, treatment alternatives and cost transparency.

Mercer's findings are consistent with other studies that suggest that savings are due to a number of factors:

- Increased consumer accountability and responsibility in healthcare decisions made by participants
- Increased knowledge of personal healthcare options and the associated costs and quality impacts
- Increased awareness of personal health status and factors impacting that status
- Increased dialogue with providers and interest in alternative treatments

The above factors are interrelated and believed to leverage one another. Healthcare cost can be positively influenced if patients are motivated to be better consumers, empowered with information about provider quality and treatment options, and given access to the tools and support required to understand and improve their health status. Obviously, these individuals and their employers also benefit from improved health status, energy and productivity.

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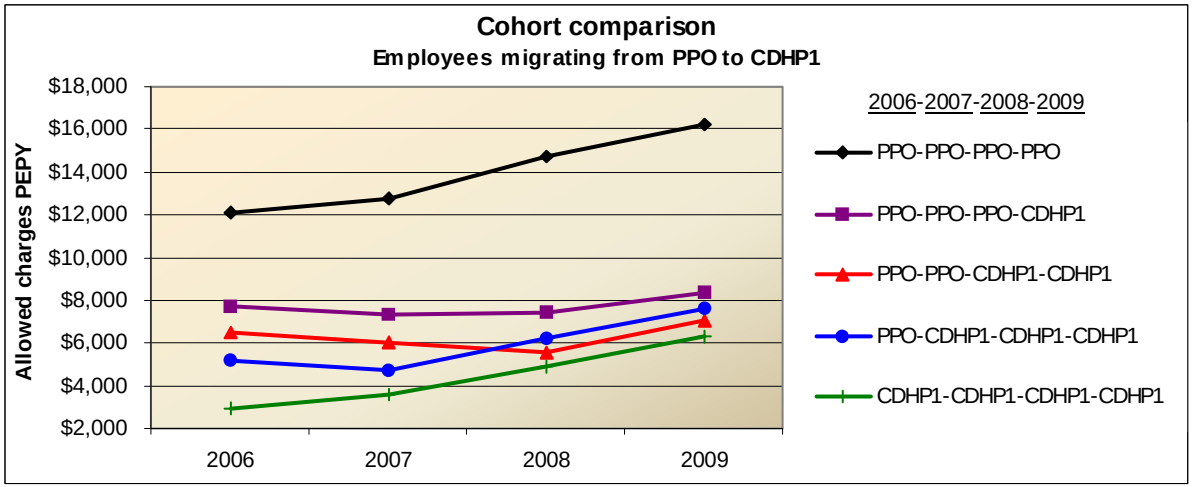
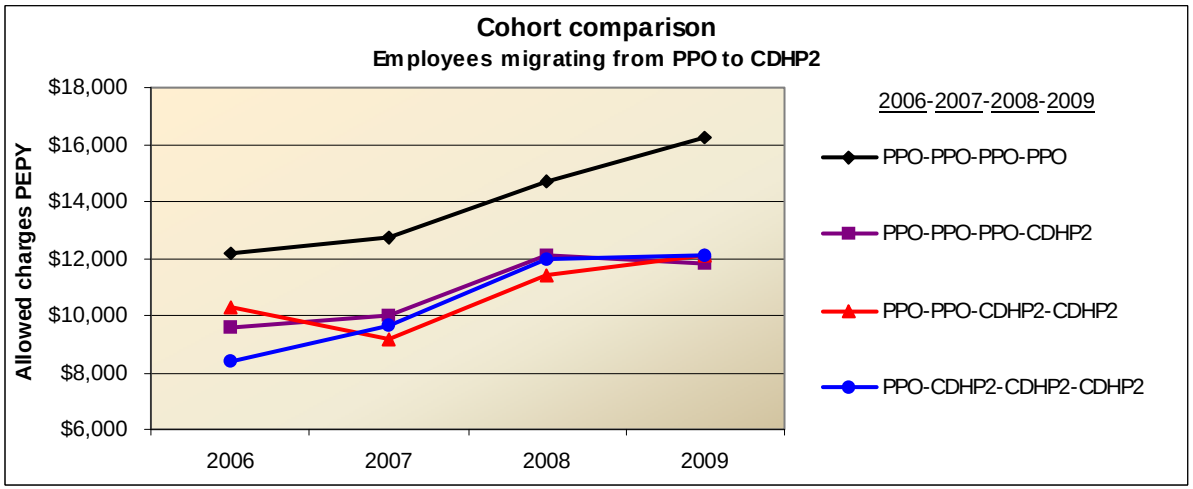
State of Indiana Case Study

In early 2010, Mercer completed an actuarial study of the State of Indiana's (State's) consumer-driven health plans. The results were very encouraging; however, Mercer believes that the State of Indiana's favorable results to date are largely the result of excellent plan designs and strong account funding. Improved information regarding provider cost and quality, as well as treatment alternatives could leverage these positive results further in the future. This will become increasingly critical as the enrollment moves beyond the current level (approximately 70%) within the State's population.

2006 was the first year the State of Indiana offered a CDHP to State employees. In the inaugural year approximately 1,400 of all State employees enrolled in the plan—now called consumer-driven health plan 1 (CDHP1). In 2007, a second consumer-driven health plan (CDHP2) was introduced, replacing one of two PPO plans. 2007 enrollment in the two CDHPs totaled 6,300. By 2008, enrollment in these plans reached 12,100. In 2009, the enrollment was 15,500 or 49%, and in the most recent open enrollment (November 2009) for the 2010 plan year, enrollment in the two consumer plans topped 70%. In just five years, consumer-driven health plans have gone from a new plan concept to the dominant choice among State of Indiana employees.

While the popularity of the CDHPs among State employees has been excellent, a critical question was raised by the State. Has this dramatic shift from traditional health plan enrollment (PPOs / HMOs) to consumer plans dampened the trajectory of healthcare costs for the State of Indiana, positively impacting affordability both for the State and its employees? Two charts on the following page outline the average allowed charges per employee per year (before employee out-of-pocket costs) for state employees enrolled from 2006 through 2009. The average cost for employees that have been enrolled in the PPO from 2006 through 2009 is significantly higher than those that have migrated into either CDHP1 or CDHP2. Over time, the difference in costs between employees that remained in the PPO and employees that migrated into either CDHP has increased over time.





Adjusted for pooling claimants in excess of $250,000

Over the last six months of 2009, the country and its political leaders were engaged in a debate about how to slow the rate of growth in healthcare expenditures nationally. One point of agreement that emerged was the need to "bend the healthcare cost curve" as critical for the U.S. to remain economically competitive on a world stage while maintaining the world's most sought after healthcare. The high level findings of this report are very encouraging and validate that consumer-driven health insurance plans have the potential to be one of the foundational components of strategies to "bend the healthcare cost curve". One of the critical flaws with the current U.S. healthcare system is the lack of engagement and accountability by consumers of healthcare. Employees and dependents have historically been largely insensitive to and shielded from the actual costs of healthcare services. Consumer health plans increase personal accountability for making informed healthcare decisions.

Over the study period the value of improved consumer behavior by participants in the CDHPs has been material. For the CDHP1 (the plan design with the most consumer-engagement features), the average annual savings over the study period has been 12.5% per year. The savings for the CDHP2 consumer plan participants (which have a lower participant out-of-pocket cost responsibility) were lower than CDHP1, but still impressive, averaging 7.6% per year. **Overall, the State has saved 10.7% through both CDHPs combined.**

Further proof of the CDHPs' impact is the State's health risk scores have improved since the CDHPs were implemented. This improvement is contrary to expectations of an aging State population. **Assuming the CDHPs continue to save 10.7%, Mercer projects the State to save $17 to $23 million in 2010 as 70% of the population has enrolled in the CDHPs.** The above savings reflect appropriate actuarial adjustments. Specifically, these are net savings after adjusting for plan design, all demographic differences as well as the underlying health status of the members**.**

Additionally, State employees and their families enrolled in CDHPs are projected to save $7 to $8 million in 2010. While these savings figures are impressive, participants that have already shifted to the CDHPs have lower costs than those that remain in the PPO. Therefore, going forward, the potential savings from increased consumerism for the remaining PPO enrollees is even larger (on a dollar basis), since their historical claim costs are much higher.

Details of the key drivers of these consumer savings are summarized below.

2009 healthcare utilization statistics[1]	PPO	CDHP2	CDHP1	State of Indiana Average
Emergency room visits (per 1,000)	308.1	210.4	163.0	238.6
Outpatient visits (per 1,000)	3,242	1,841	1,182	2,253
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Average length of stay	4.9 days	4.1 days	3.8 days	4.6 days

[1] Statistics are not adjusted for any differences in demographics or health status

As the table details, participants in consumer plans have less frequent use of the emergency room, fewer physician office visits, fewer outpatient visits, greater use of generic drugs, shorter hospital stays and fewer hospital admissions. The utilization differences are very consistent across the continuum of plans. PPO participants have the highest healthcare utilization rates. CDHP2 (the less strong consumer design) has lower healthcare utilization rates than the PPO, and CDHP1 (the stronger consumer design) has the lowest healthcare utilization rates. Generally speaking, employees have migrated from the PPO → CDHP2 → CDHP1 during 2006 through 2009. This migration flow has primarily been in one direction with few participants moving "upstream" in subsequent open enrollment periods to less consumer oriented plan designs. This provides strong evidence that participants are attracted to the consumer plans and have a high likelihood of staying in these plans.

The following table summarizes the total costs (including account funding) for the three plans studied (PPO, CDHP2 and CDHP1). The cost differences are detailed into five explanatory categories:

1. Plan design – including account funding
2. Demographic differences (age, gender and family size)
3. Health status (beyond those captured by global demographic factors)
4. Consumerism or behavior change
5. Unidentified

State of Indiana average annual claim costs (net paid claims) Includes State HSA contributions (2006 – 2009 per employee per year)			
Plan Type	**PPO**	**CDHP2**	**CDHP1**
Average net paid medical + prescription drug claims[1,2]	$12,317	$7,682	$3,399
Average HSA withdrawal	$0	$1,762	$2,063
Total average State claim and HSA value	$12,317	$9,444	$5,462
Difference vs. PPO	N/A	($2,873)	($6,855)
Categories of difference vs. PPO			
▪ Plan design – including account funding		($51)	($917)
▪ Demographic differences (age, gender and family size)		$89	($1,118)
▪ Health status (beyond demographic factors)		($555)	($3,058)
▪ Consumerism or behavior change		($940)	($1,535)
▪ Unidentified differences[3]		($1,417)	($226)

[1] Adjusted by pooling claimants in excess of $250,000

[2] Claims have been trended to calendar year 2009, assuming an underlying medical trend of 8% annually

[3] Actual experience varies from actuarial factors, resulting in some irreconcilable differences

The remainder of this report will detail Mercer's findings which utilized data provided by Anthem (claim, enrollment and health risk score data), Tower Bank (HSA transaction and balance information) and the State of Indiana (census data and various reports). Mercer would like to thank Anthem, Tower Bank and the State of Indiana for their strong efforts to produce the data in the requested format. Without their assistance this study would not have been possible. Mercer would also like to thank the State of Indiana for entrusting Mercer to perform this important study and hopes that the results are found to be of value.

Mercer did not audit any of the data sources but did compare overall totals with State provided reports. Mercer believes the findings in this report are based upon reasonable data. However, all conclusions and findings in this report are critically reliant upon the accuracy of data received from all sources named above. Mercer utilized its extensive proprietary databases and client experiences in performing the analysis foundational to this report. In our professional judgment, the most appropriate actuarial assumptions and methodologies were used by Mercer for this study.

All estimated savings, based upon the information available at a point in time, are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of volatility from the estimate.

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Study Methodology and Key Findings

Mercer studied the State of Indiana's medical plan experience since the implementation of the consumer-driven health plans (January 1, 2006 through September 30, 2009). During this period, the State introduced and successfully managed a significant transformation to consumer-health plans. On January 1, 2006, the State introduced its first consumer-driven health plan option. This plan, now named consumer-driven health plan 1 (CDHP1), meets the Federal requirements to be a qualifying high-deductible health plan and is eligible to have an associated Health Savings Account (HSA) for participants.

In 2007, a second consumer-driven health plan (CDHP2) was introduced. CDHP2 also meets the Federal requirements for a high deductible health plan and has an associated HSA account. The main differences between these two plans are the deductible and HSA funding are both higher in CDHP1 than CDHP2. The State has maintained other plan options. Most notably, the State offered traditional PPO plans which were consolidated from two plans to one plan (Traditional PPO II) beginning January 1, 2007. M-Plan (a large Indiana based HMO) terminated at the end of 2007, resulting in approximately 10,000 employees and dependents selecting new plan options in 2008. Wellborn HMO is a regional HMO with approximately 1,000 participants. No claim level experience data was available for M-Plan or Wellborn, and therefore, that experience data is excluded from this study.

Mercer's findings utilized detailed census, claims and account data provided by Anthem and Tower Bank. Mercer did not audit any of the data sources but did compare overall totals with State of Indiana provided reports. ***Mercer believes the findings in this report are based upon reasonable data. However, all conclusions and findings in this report are critically reliant upon the accuracy of data received from all sources named above. Mercer utilized its extensive proprietary databases, client experiences and professional judgment in performing the analysis. It must be noted that all estimated savings, based upon the information available at a point in time, are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of volatility from the estimate.***

Mercer received detailed claims and enrollment data from Anthem for the time period January 2006 through September 2009. For the same time period, Tower Bank provided HSA deposit, withdrawal and balance information. Mercer segmented the participants in the State's PPO and CDHPs into 170 cohorts reflecting distinct migration patterns over the four-year study period. The key statistics for each cohort were as follows:

- Count of employee households
- Employee age/gender factor
- Average contract size (family size)
- Average household health risk score
- Allowed medical and Rx PMPY claims pooled for medical claimants in excess of $250,000
- Allowed medical and Rx PMPY claims pooled for medical claimants in excess of $250,000 adjusted for differences in age/gender
- Average year-end HSA balance
- Average State HSA contribution
- Average employee HSA contribution
- Average HSA withdrawals
- Average period HSA gain/loss

CDHP1 and CDHP2 plans have, since their introduction, had lower cost per capita costs than the PPO. This, leads to the critical question: *How are the consumer-driven health plans reducing the cost of healthcare for The State and its employees?*
To answer this question, Mercer structured the analysis into five distinct explanatory categories. These categories are described below:

Plan Design

The consumer-driven health plans have relatively high member out-of-pocket costs. This is key to creating consumer engagement. To make these plans work, it is important for the plan sponsor to contribute money into an account for participants. This money can then be utilized by participants to cover a portion of the out-of-pocket costs. The value is two-fold: 1) the large out-of-pocket expenses are made financially more manageable and 2) participants are exposed to the full cost of healthcare services and forced to decide if the care is appropriate. After accounting for the HSA contribution from the State, the plan design differences between the three plans are relatively modest.

One concern has historically been that plan participants will defer or avoid important healthcare services. While this may have happened in a few instances, Mercer has found no evidence in this study that this happened in any material way during the four year study period. This conclusion was based upon the following: a) no reporting over the study period of any such issues of adverse results from deferred care (e.g., union grievance, press reports etc.) b) the migration patterns were virtually a one-way flow from PPO to CDHP2 to CDHP1. If participants were having adverse experiences this would not be the case c) the risk scores over the four year period remained stable (CDHP1) or increased slower (CDHP2) while the PPO risk scores grew the fastest. The new enrollees in CDHP1 and CDHP2 each year came largely from the worse PPO pool. This result was significant and showed that overall the CDHP likely contributed to the State's overall health status slight improvement during the study period. For a population such as state government this is noteworthy.

Demographics (Age, Gender and Family Size)

Mercer utilized age, gender and family size data to demographically adjust the populations enrolled in each plan. By doing this, the cost differences between the plans are adjusted for the key demographic profiles unique to each plan’s population. On average, both CDHPs have younger employees with larger families (more children), with CDHP1 having the youngest employee population and CDHP2 having the largest average family size. Generally speaking, a younger population will have lower costs than an older population, while a population with larger family sizes will have higher costs per employee. These differences are explored in subsequent sections.

Health Status (Beyond Demographic Factors)

It has been well established from prior studies that the initial enrollees in consumer plans tend to be, on average, healthier than their counterparts who remain in traditional plans (e.g., the PPO). In other words, two similarly situated employees with similar demographic profiles will have differing illness burdens. This category captures the cost differences between plans due to this health status difference (beyond the difference captured by the actuarial demographic factors). Mercer was able to utilize health risk scores independently provided by Anthem to compare and validate the results in this category.

Consumerism or Behavior Change

This has historically been the most difficult category to assess. Mercer conducted a cohort analysis to isolate the value of this category. Arraying all State of Indiana employees into one of 170 cohorts, Mercer was able to capture all of the migration patterns over the four year study period. These cohorts were clustered into groups with similar migration patterns and the cohorts that migrated into or out of consumer plans were studied in detail. First, Mercer calculated the average allowed charges (to remove the impact of plan design) before the year of a switch to a consumer plan. This cost was then compared with the cost in the subsequent year after the switch for the same employees. In this way the health status was also isolated since underlying health status of a cohort changes little from one year to the next for credible cohorts.

Unidentified Differences

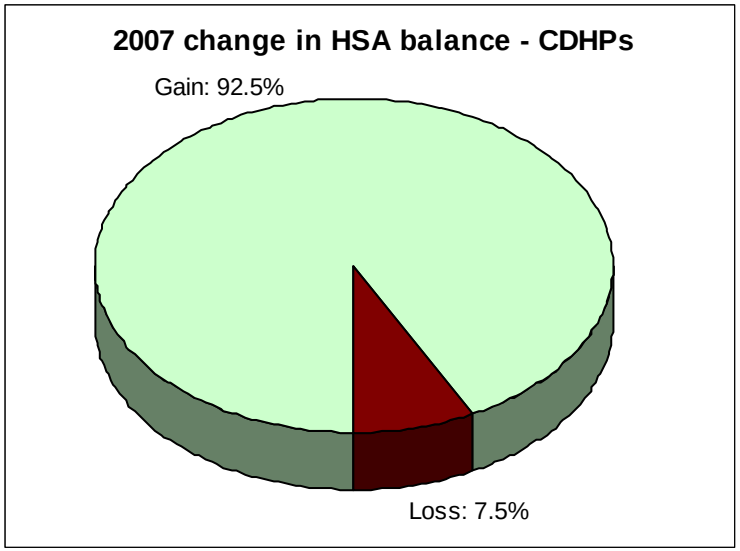
This category accounts for any remaining residual amounts not identified in the above four categories of cost variance between the PPO and the two CDHP plans. The Executive Summary, on page 4, shows that both consumer plans have saved money beyond the total of the four specifically defined categories above. This “unidentified difference” category could best be described as the accumulation of all residual amounts not specifically identified by the other four categories. In any population it is important to remember that actuarial factors and methodologies will produce some variance when applied to any specific population. Rather than allocate the residual amounts into one of the four categories, Mercer chose to leave them as a distinct category. It is fair to say that the four categories, particularly consumerism and health status, could be understated in their impact as evidenced by the residual value in this category. The larger unidentified difference in CDHP2 could be due to a number of factors such as the shorter amount of time that individuals spend in the CDHP2 prior to migrating to CDHP1.)

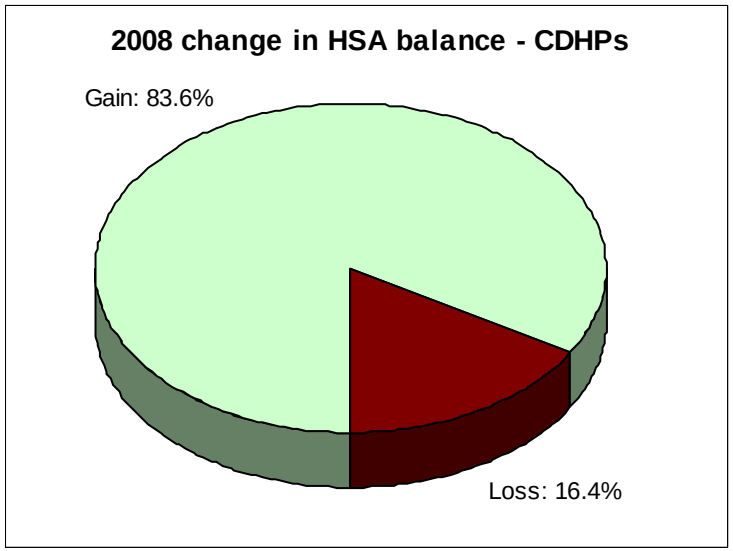
Account Funding

Since the implementation of CDHPs, the State has made a contribution to an enrolled employee's HSA. Beginning in 2007, the State began a strategy to fund an employee's HSA in the amount of 55% of their deductible. Over time a large majority of employees enrolled in the CDHPs have seen their HSA balances grow. As of September 30, 2009, **State employee HSA balances total $28.1 million**. The HSA balance represents a pool of funds to which both the State and employees have contributed to prefund future healthcare expenditures.

Each employee has a unique account position due to several factors including: length of enrollment in CDHPs, family status, personal contributions to the HSA and claims experience. However, the greater majority of employees enrolled in CDHPs in 2009 have significant HSA balances. The average HSA balance as of 9/30/2009 for employees enrolled in **CDHP1 is $2,072 and $1,196 for those enrolled in CDHP2**. Furthermore, there is a group of employees that are using the HSA as a savings vehicle. 20% of employees have HSA balances as of 9/30/2009 in excess of $3,500 in CDHP1 and $2,000 in CDHP2. However, not every employee has seen their HSA balance rise every year.

As shown below, a small portion of employees enrolled in CDHP1 and CDHP2 have seen a decrease in their account balance. As enrollment in the CDHPs continues to increase, Mercer expects a slight rise in the percentage of employees who experience a decrease in their account balance as a result of more incurred claims from less healthy employees moving into CDHP1 and CDHP2 in future years.

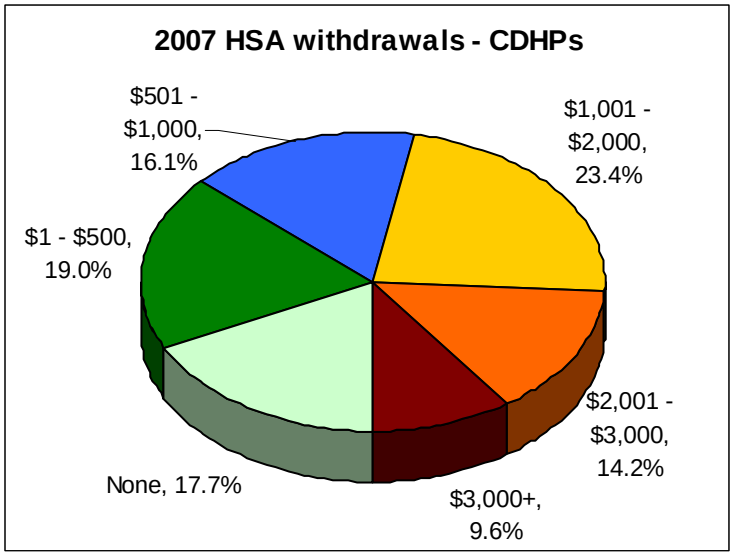


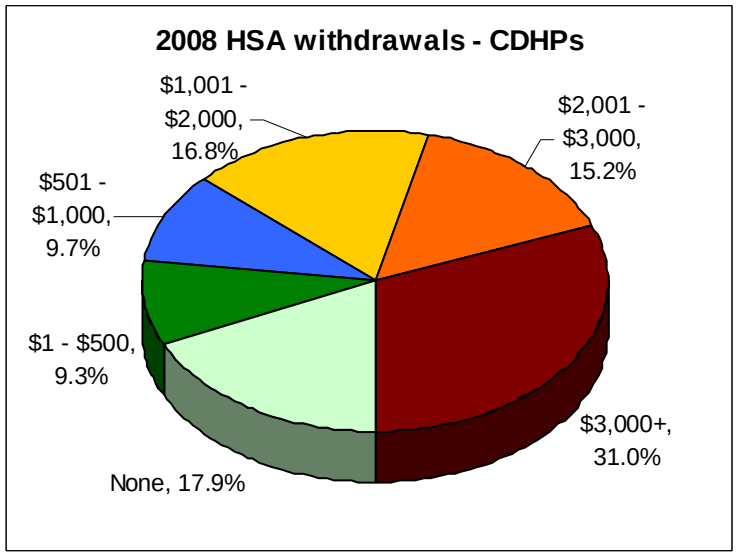


HSA Withdrawals

The State makes contributions to an employee-owned HSA each year. On average for every $2.00 that the State contributes, employees contribute, on average, $1.00. These HSA account balances are then used by employees and their dependents (at their discretion) to cover their out-of-pocket expenses. Two potential areas of concern for the State arise: 1) is the State providing more in contributions than is necessary? 2) Are employees paying out-of-pocket expenses with post-tax dollars and not fully taking advantage of their HSA?

As shown below, roughly 18% of employees in 2007 and 2008 did not make any withdrawals from their HSA. It is typical for 10% - 20% of an active population to not incur any claims during a given calendar year. Given this, and considering the remaining 82% accessed their HSA to cover out-of-pocket expenses, Mercer concludes that employees are accessing their HSA when appropriate, and the State is not over-funding the HSA.





Employee HSA Contributions

In 2008, 31% of employees withdrew at least $3,000 from their HSA. This is more than the State contributes to an employee's HSA regardless of plan and family tier. However, only 16.4% of employees in 2008 experienced a decrease in their HSA balance. This is because most employees also contribute to their HSA. The amount contributed by each employee varies greatly, but on average employees make 1/3 of the total HSA contribution each year, with the State contributing the other 2/3.

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Conclusions

Mercer believes that the State of Indiana has, to date, executed a very successful strategic initiative with the introduction of two consumer-driven health plans (CDHP1 and CDHP2) as medical plan choices for State employees. The savings to date have been impressive. The results hopefully demonstrate how healthcare costs can be controlled with the same type of consumer principals which drive all other economic activity in the US.

Perhaps even more impressive is the future potential of the initiative. As additional employees enroll in the consumer plans and become better consumers of healthcare expenses, the projected savings will grow and the State will be able to further "bend the healthcare cost curve". Not only will the State save money on healthcare expenses but employees will also save money on out-of-pocket costs and future premium contributions. Employees, as engaged and informed consumers, will improve the fundamental awareness and management of their own health and vitality.

For consumerism to realize its full potential, or in some cases to even be successful, employees must have access to transparent cost and quality information regarding healthcare providers and treatment options. A number of consumer tools are emerging and even more are in developmental stages. A high priority for the State will be to enhance existing tools and to acquire more consumer tools in the future to engage and support State employees and their dependents to make optimal healthcare choices from both a financial and care-driven perspective. Mercer believes that the positive results of this study can be amplified in future years with enhancements and additions to the consumer tools which have historically not been available to State employees and their dependents.

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Appendix – Plan Design Summary

	2009 Plan Design Summary					
	CDHP 1		CDHP 2		Traditional II PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
Single	$2,500 ($2,000 w/ tobacco incentive)		$1,700 ($1,200 w/ tobacco incentive)		$500 ($0 w/ tobacco incentive)	
Family	$5,000 ($4,500 w/ tobacco incentive)		$3,400 ($2,900 w/ tobacco incentive)		$500 ($0 w/ tobacco incentive)	
State HSA Contribution Amount						
Single	$1,375		$935		$0	
Family	$2,750		$1,870		$0	
Deductible Bridge (after HSA contribution)						
Single	$1,125 ($625 w/ tobacco incentive)		$765 ($265 w/ tobacco incentive)		$500 ($0 w/ tobacco incentive)	
Family	$2,250 ($1,750 w/ tobacco incentive)		$1,530 ($1,030 w/ tobacco incentive)		$500 ($0 w/ tobacco incentive)	
Out-of-pocket maximum [(1)]						
Single	$4,000		$2,400		$2,000	
Family	$8,000		$4,800		$4,000	
Office Visit	20%	40%	20%	40%	$20 copay	40%
Inpatient	20%	40%	20%	40%	$500 deductible	40%
Emergency Room	20%	40%	20%	40%	$75 copay	
Urgent Care	20%	40%	20%	40%	$35 copay	
Wellness and Prevention	0% (No deductible)	40% (No deductible)	0% (No deductible)	40% (No deductible)	$20 copay	40%
Prescription Drugs	**Retail (34 Days)**	**Mail Order (90 Days)**	**Retail (34 Days)**	**Mail Order (90 Days)**	**Retail (34 Days)**	**Mail Order (90 Days)**
Generic	10%	10%	10%	10%	$10 copay	10%
Formulary	20%	20%	20%	20%	$20 copay	20%
Brand (Non Formulary)	40%	40%	40%	40%	40%, min $40, max $100	40%, min $80, max $150
Specialty	40%	40%	40%	40%	40%, min $40, max $100	40%, min $80, max $150

(1) Coinsurance and deductible apply to out-of-pocket maximum

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