

# What Happens to Prescription-Drug Use After Consumer-Directed Health Plan Enrollment?

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Consumer-Directed Health Plans (CDHPs), which typically combine high-deductible benefit design with either a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA), have become increasingly popular among employers, as well as advocates of small businesses and uninsured consumers. Yet CDHPs are controversial, with some heralding their benefits — most notably, promoting responsible consumer purchasing of healthcare services — and others expressing concern about whether CDHP enrollees forgo essential medical care in order to save money.

At the present time, partly because Consumer-Directed Health Plans (CDHPs) are a relatively new innovation and partly because the debate over their merits are highly politicized, many opinions about CDHPs, both positive and negative, are based more on preconceived notions than on solid evidence. Most published research on the topic employs weak study designs, assesses small or non-representative samples, or relies on hypothetical mathematical models instead of actual experience.<sup>1-8</sup>

While currently available evidence is far from definitive, it is beginning to provide a preliminary picture of the effect that CDHPs are having on utilization and satisfaction with healthcare services. Enrollees who choose CDHPs tend to be somewhat healthier and higher-income than those choosing traditional insurance. They also generally experience lower healthcare costs and lower rates of cost increase than traditional plan enrollees.<sup>1</sup> A recently published study, using a relatively strong research design, linked mandatory CDHP enrollment with reductions in use of the hospital emergency room for non-severe conditions (for example, upper-respiratory-tract infections, otitis media, gastrointestinal symptoms).<sup>9</sup> Still, given the limitations of work to date, additional evidence about the effect of CDHPs on member healthcare utilization and cost in a variety of settings and benefits designs is needed.

In this report, we examine the experiences of two employers, both financial-services companies with members throughout the United States. Both employers implemented a CDHP as an option for their employees, beginning in January 2006. The two employers are profiled in **Table 1**. A substantial portion of each employer's members (36% for Employer A, 22% for Employer B) enrolled in a CDHP when it became available.

A particular focus of the study was to determine whether members who enrolled in a CDHP took advantage of the cost-savings opportunities available to them. These opportunities included substitution of generics for brand medications and use of Home Delivery.

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**Table 1 Benefit Designs Studied**

Employer	Traditional Benefit Design 2005 and 2006	CDHP Benefit Design 2006	N Enrolled in 2005 †	N Remaining in Traditional Plan in 2006 (Comparison)	N Switching (Traditional 2005, CDHC 2006)
<b>“A”</b>	<p>\$10/\$30 retail; \$20/\$60 mail for generic/brand</p> <p>*No deductible Q1 2005</p> <p>*Deductible beginning Q3 2005 \$50 indiv., \$100 family</p> <p>*Added 3rd tier (\$50 retail, \$100 mail) in January 2006</p>	<p>\$2,500 deductible individual</p> <p>\$5,000 deductible family</p>	19,508	12,420 (64%)	7,088 (36%)
<b>“B”</b>	<p>Generic retail: 10%, min. individual \$10 max. \$50</p> <p>Preferred brand retail: 20%, min. \$20 max. \$75</p> <p>Non-preferred brand retail: 35%, min. \$35 max. \$100</p> <p>Mail: 20/40/70</p>	<p>\$1,100 deductible individual</p> <p>\$2,200 deductible family</p>	14,998	11,644 (78%)	3,354 (22%)

CDHC deductible amount is a total amount, including both medical and pharmacy expense.

†Number with at least one month of eligibility

Study data were obtained through Express Scripts for the time period Jan. 1, 2005, through Sept. 30, 2006. For all members enrolled with each employer, the dataset included 1) information about eligibility for prescription-drug benefits and 2) all pharmacy claims.

*Profile of enrollees.* A profile of CDHP and traditional insurance enrollees was compiled to assess baseline differences between the groups at the time of enrollment in their respective plans. In addition to demographic (age, sex) differences, profiles included enrollees' Chronic Disease Score (CDS), a validated and widely accepted measure based on pharmacy-claims data that was used to assess disease burden.

*Trend analysis.* Key utilization measures, including average per-member count of prescription claims (total, brand and generic), payer's cost net of member copayment, generic-fill rate and Home Delivery use rate, were calculated for "pre" and "post" periods. Home Delivery use was calculated as a percentage of prescriptions for chronic medications.<sup>A</sup> The "pre" and "post" periods were, respectively, the first nine months of 2005 and 2006. Change scores were calculated as the post-period minus pre-period values; statistical significance of the change was assessed using the Student's T test. Members included in this analysis were continuously enrolled from January 2005 through September 2006.

*Patterns of chronic-medication use.* The sample for this analysis comprised members who: 1) had at least one claim for one of the top five chronic-medication classes during November or December of 2005 and 2) used only one drug within the therapy class<sup>B</sup> during that time. Members included in this analysis were continuously enrolled from January 2005 through September 2006. Because the number of Employer B members was insufficient to study individual therapy classes, this analysis was limited to Employer A.

Three different time periods were assessed. The first quarter of 2006 was assessed to get a picture of early trends in chronic medication use shortly following the switch to a CDHP. The period from January 2006 through September 2006 was assessed to determine whether early trends predicted overall patterns of use through the year. Finally, the time period of July 2006 through September 2006 was assessed to get a picture of the "steady state" of chronic medication use after six months of experience (during months seven through nine).

For each time period, non-persistence was measured as the percent of those who had no claim in the therapy class. Among those with at least one claim, generic and brand use were assessed, based on the final prescription claim during the time period. Analyses were performed separately for all users and for those whose final prescription claim in the therapy class during 2005 was for a brand medication.

*For all members enrolled with each employer, the dataset included*  
1) information about eligibility for prescription-drug benefits and  
2) all pharmacy claims.

<sup>A</sup> Classes examined for this assessment included: antihypertensives, antidepressants, antihyperlipid, antiulcer, beta blockers, calcium channel blockers, narcotic analgesics, NSAIDs, oral contraceptives, antidiabetics, diuretics, thyroid medications, and antiasthma drugs.

<sup>B</sup> Therapy class was assessed using Medispan's Generic Product Identifier (GPI). The first 2 digits of the GPI define the therapy class.

*Chronic Disease Score (CDS) matched sensitivity analyses.* Because the study groups significantly differed with respect to the baseline level of chronic disease, a series of sensitivity analyses assessed key outcome measures. The assessment used a dataset in which CDHP members were matched with traditional insurance members, based on their CDS. In matching CDHP enrollees to traditional plan enrollees, if exact matches were not possible the closest possible match was found. When approximate rather than exact matching was necessary, differences of between 1 and 5 CDS points between the matched cases (on a scale of 232 to more than 10,000) were typical; differences of >30 points were rare. No match could be found for five CDHP cases.

Consistent with previous research,<sup>1</sup> CDHP and traditional insurance enrollees differed significantly at baseline (**Table 2**). Employer A's CDHP, which had a higher deductible than that of Employer B, included a higher percentage of children and a lower percentage of older members than the traditional plan. For both employers, the level of chronic disease was lower (28% in Employer A, 18% in Employer B) for CDHP members, compared with traditional insurance enrollees.

**Table 2 Profile of Enrollees by Plan Type**

	EMPLOYER A		EMPLOYER B	
	CDHP (\$2,500/\$5,000)	Traditional	CDHP (\$1,100/\$2,200)	Traditional
<b>ALL ENROLLEES</b>				
Number of enrollees	7,088	12,420	3,016 <sup>4</sup>	11,644
Age mean (std) <sup>5</sup>	30 (18.0)**	35 (18.5)**	31 (17.4)**	29 (17.3)**
Percent age <17	33.3%**	22.9%**	27.6%	29.0%
Percent age 55+	7.9%**	17.3%**	8.0%	7.9%
Percent female	50.7%**	59.5%**	49.1%**	52.7%**
Chronic Disease Score mean (std) <sup>6</sup>	826 (851)**	1,153 (1,134)**	688 (728)**	836 (875)**
<b>CONTINUOUSLY ENROLLED</b>				
Number of enrollees	5,300	8,797	1,978	4,218
Age mean (std) <sup>7</sup>	31 (18.2)**	36 (18.6)**	31 (17.6)**	30 (17.3)**
Percent age <17	33.9%**	22.3%**	29.1%	29.2%
Percent age 55+	8.5%**	19.7%**	8.7%	8.7%
Percent female	50.9%**	60.3%**	48.8%**	53.2%**
Chronic Disease Score mean (std) <sup>8</sup>	836 (858)**	1,168 (1,145)**	701 (748)**	847 (870)**

\*\* p < .01

*Consistent with previous research, CDHP and traditional insurance enrollees differed significantly at baseline.*

<sup>4</sup> One small group (N=338) was removed from the sample, leaving 3,016 for final analysis.

<sup>5</sup> The difference of <2 years of age (30.7 versus 29.3) observed for Employer B does not appear to be substantively meaningful; its statistical significance is likely due to the large sample size.

<sup>6</sup> Limited to adults. N = 4,237 and 8,536 for CDHP and traditional enrollees, respectively, in Employer A. N = 1,784 and 4,318 for CDHP and traditional enrollees, respectively, in Plan B.

<sup>7</sup> The difference of 1 year of age observed for Employer B does not appear to be substantively meaningful; its statistical significance is likely due to the large sample size.

<sup>8</sup> Limited to adults. N = 3,527 and 6,863 for CDHP and traditional enrollees, respectively, in Employer A. N = 1,413 and 2,997 for CDHP and traditional enrollees, respectively, in Plan B.

**Table 3 Pre-to-Post Change in Utilization Measures by Plan Type**

	CDHP			COMPARISON		
	Jan-Sept 2005	Jan-Sept 2006	Change Amt (%)	Jan-Sept 2005	Jan-Sept 2006	Change Amt (%)
<b>EMPLOYER A</b>						
Number continuously enrolled <sup>9</sup>	5,300	5,300		8,797	8,797	
Total prescription claims**	7.47	7.14	-0.33 -4.4%	12.42	13.43	1.01 (8.2%)
Brand claims**	4.18	3.61	-0.57 -13.7%	6.78	6.76	-0.02 (-0.4%)
Generic claims**	3.28	3.53	0.25 7.5%	5.63	6.68	1.05 (18.6%)
Generic fill rate <sup>10</sup>	43.4%	48.6%	5.2 12.0%	45.1%	49.4%	4.3 (9.5%)
Home delivery use rate (chronic meds)*	49.6%	47.4%	-2.2 -4.4%	51.6%	52.4%	0.8 (1.6%)
Payor cost net of copayment**	298	113	-185 -62.1%	553	652	99 (18.0%)
<b>EMPLOYER B</b>						
Number continuously enrolled	1,978	1,978		4,218	4,218	
Total prescription claims**	6.15	6.10	-0.05 -0.9%	7.65	8.27	0.62 (8.1%)
Brand claims**	3.36	2.94	-0.42 -12.5%	4.09	4.10	0.01 (0.3%)
Generic claims*	2.79	3.15	0.36 13.0%	3.56	4.17	0.61 (17.0%)
Generic fill rate*	44.6%	51.1%	6.5 14.6%	45.9%	49.8%	3.9 (8.5%)
Home delivery use rate (chronic meds)*	47.2%	51.3%	4.1 8.7%	40.3%	42.2%	1.9 (4.7%)
Payor cost net of copayment**	244	185	-59 -23.9%	333	366	33 (9.9%)
<b>EMPLOYER A, Matched for Chronic Disease Score (adults only)<sup>11</sup></b>						
Total prescription claims**	9.56	9.21	-0.35 -3.7%	10.65	11.66	1.01 (9.5%)
Generic claims**	4.24	4.56	0.32 7.5%	4.77	5.82	1.05 (22.0%)
Payor cost net of copayment**	377	144	-233 -61.8%	457	530	73 (16.0%)
<b>EMPLOYER B, Matched for Chronic Disease Score (adults only)<sup>12</sup></b>						
Total prescription claims**	7.39	7.33	-0.06 -0.8%	7.60	8.44	0.84 (11.1%)
Generic claims	3.39	3.85	0.46 13.6%	3.50	4.27	0.77 (22.0%)
Payor cost net of copayment**	293	226	-67 -22.9%	316	377	61 (19.3%)

\* Change p < .05; \*\*Change p < .01

<sup>9</sup> From Jan. 1, 2005 through Sept. 30, 2006

<sup>10</sup> Generic-fill and Home Delivery rates are weighted by each member's number of prescription claims, holding total sample size constant. Thus, these figures are mathematically equivalent to results obtained by summing all generic, Home Delivery and total claims and calculating percentages. Calculations are limited to those with utilization in both the pre and post periods. Home Delivery calculations are limited to chronic medication classes: antihypertensives, antidepressants, antihyperlipids, antiulcers, beta blockers, calcium channel blockers, narcotic analgesics, NSAIDs, oral contraceptives, antidiabetics, diuretics, thyroid medications, and antiasthma drugs.

<sup>11</sup> N = 3,503 in each group. CDS = 839 each group (p = .984)

<sup>12</sup> N = 1,398 in each group. CDS = 689 in CDHC and 688 in traditional plan (p = .975).

## Utilization

*Drug cost.* Implementation of the CDHP produced considerable prescription-drug-cost savings for both employers. In both Employer A's and Employer B's traditional insurance plans, overall prescription-medication utilization in the first nine months of 2006 was 8% higher than in the first nine months of 2005. In contrast, utilization for the CDHPs declined by 4% for Employer A's plan and by 0.9% for Employer B's plan. In combination, utilization declines and copayment increases associated with the CDHPs led to net-cost reductions of 62% and 24% for Employers A and B, respectively.

*Generic utilization.* Enrollees in both CDHPs reduced their use of brand medications by about 13% to 14% following enrollment, which did not offset those reductions with increases in generic-medication use. This pattern was particularly striking for Employer A. Over the nine-month period, Employer A's per-enrollee brand claims declined by 0.57. At the same time, generic claims increased by 0.25, resulting in a net reduction of 0.32 claims total. Employer B's per-enrollee brand claims declined by 0.42, while generic claims increased by 0.36. Quarter-by-quarter investigation revealed that this pattern was due to a 19% upsurge in Plan B's generic utilization in the third quarter of the year (**Figures 1 and 2**), which was not observed in Plan A.

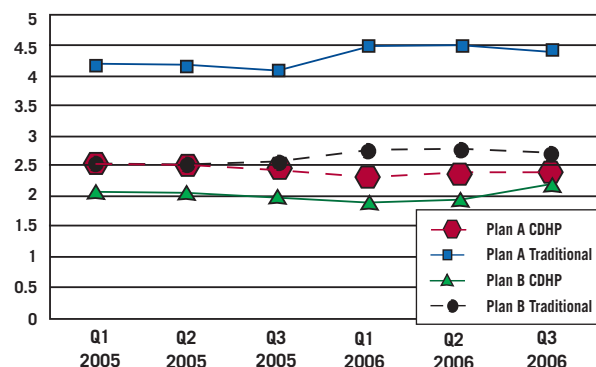
In contrast, brand utilization for enrollees in traditional plans generally remained unchanged from 2005 to 2006, while generic utilization increased, resulting in net-utilization increases.

*Home Delivery utilization.* CDHP enrollment was associated with mixed patterns in use of Home Delivery for chronic medications. Home Delivery use for Employer A declined by 4.4% for its CDHP and increased by 1.6% for traditional insurance. Employer B's Home Delivery use increased by 8.7% for its CDHP and by 4.7% for traditional insurance.

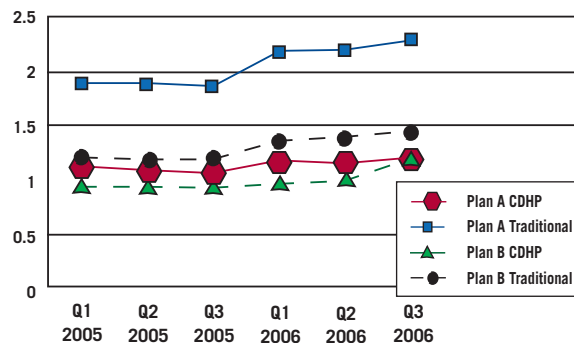
## Patterns of chronic-medication use: persistency and switching

Among Employer A's enrollees who used one of the top five chronic-medication classes in 2005, early trends in 2006 suggested markedly lower medication-persistency rates for the CDHP than for traditional insurance (**Table 4**). By the end of September 2006, these differences had mitigated considerably in the oral contraceptive and antilipid classes, mitigated somewhat in the ACE/ARB class, and persisted in the antidepressant and antiulcer classes. The utilization-rate differences between CDHP and traditional insurance enrollees were particularly marked in the antiulcer class, probably reflecting the availability of over-the-counter alternatives for this class.

**Figure 1**  
Claim Trends: CDHP vs. Traditional Insurance



**Figure 2**  
Generic Claim Trends: CDHP vs. Traditional Insurance



**Table 4 Behavior Patterns Among Users of Chronic Drug Therapy<sup>13</sup> With the Top Five Drug Classes Employer A (Deductible \$2,500 Individual/\$5,000 Family) — All Users**

	AS OF MARCH 2006				AS OF SEPTEMBER 2006		
	N	No Claim (%)	Of Those With a Claim: Percent Whose Final Script Was		No Claim (%)	Of Those With a Claim: Percent Whose Final Script Was	
			Generic (%)	Brand (%)		Generic (%)	Brand (%)
<b>Antidepressant</b>							
CDHP	350	23**	40	60	13**	46	54
Traditional	868	17**	42	58	7**	50	50
<b>ACE/ARB</b>							
CDHP	201	21**	50	50	7**	47	53
Traditional	715	13**	49	51	2**	48	52
<b>OCs</b>							
CDHP	280	17**	61	39	7	59	41
Traditional	630	11**	64	36	5	62	38
<b>Antilipid</b>							
CDHP	245	30**	9	91	9**	23**	77**
Traditional	617	18**	7	93	5**	33**	67**
<b>Antiulcer</b>							
CDHP	155	48**	16	84	31**	14	86
Traditional	484	28**	13	87	13**	17	83

**Table 4A Behavior Patterns Among Users of Chronic Drug Therapy<sup>13</sup> With the Top Five Drug Classes Employer A (Deductible \$2,500 Individual/\$5,000 Family) — Adult Users Matched for Chronic Disease**

	AS OF MARCH 2006				AS OF SEPTEMBER 2006		
	N	No Claim (%)	Of Those With a Claim: Percent Whose Final Script Was		No Claim (%)	Of Those With a Claim: Percent Whose Final Script Was	
			Generic (%)	Brand (%)		Generic (%)	Brand (%)
<b>Antidepressant</b>							
CDHP	342	24*	41	59	13	47	53
Traditional	298	17*	43	57	9	54	46
<b>ACE/ARB</b>							
CDHP	199	22*	49	51	7*	46	54
Traditional	247	13*	43	57	3*	42	58
<b>OCs</b>							
CDHP	265	18**	62	38	8**	60	40
Traditional	300	10**	66	34	2**	63	37
<b>Antilipid</b>							
CDHP	243	30**	9	91	9*	23**	77**
Traditional	230	17**	7	93	5*	34**	66**
<b>Antiulcer</b>							
CDHP	145	45	15	85	28	13	87
Traditional	140	36	17	83	21	17	83

\* p < .05    \*\* p < .01

<sup>13</sup> Brand utilizers during November 2005 through December 2005 who used only one drug during that time and were continuously enrolled from January 2005 through September 2006. Generic and brand assessments were based on the final claim in the specified time period. Tested using one-tailed Fishers Exact test.

Approximately equal proportions of Employer A's CDHP and traditional insurance enrollees were using generics as of the end of March 2006 and September 2006, with one striking exception. As of the end of September 2006, the generic-utilization percentage for antilipid medications was 10 percentage points higher in the traditional plan (33%) than in the CDHP (23%).

Similar patterns were observed in the analysis of brand-medication users (**Table 5**). As of the end of September 2006, persistency rates for CDHP and traditional insurance enrollees differed by only about 5 to 7 percentage points, with the exception of the antiulcer class. The rates at which patients switched to generics were similar for the two plans, once again with the exception of the antilipid class. In the traditional insurance plan, 30% of 2005's antilipid brand utilizers had switched to a generic by the end of September 2006. The switch rate in the CDHP was only 17%. Examination of behavior in the final quarter of the 2006 observation period (July 2006 through September 2006, **Table 6**) revealed the same patterns.

**Table 5 Behavior Patterns Among Brand Drug Users of Chronic Drug Therapy<sup>14</sup> With the Top Five Drug Classes Employer A (Deductible \$2,500 Individual/\$5,000 Family)**

	AS OF MARCH 2006				AS OF SEPTEMBER 2006		
	N	No Claim (%)	Of Those with a Claim:		No Claim (%)	Of Those with a Claim	
			Switched to generic (%)	Continued Brand (%)		Switched to generic (%)	Continued brand (%)
<b>Antidepressant</b>							
CDHP	214	25	2	98	13	18	82
Traditional	519	20	5	95	9	22	78
<b>ACE/ARB</b>							
CDHP	111	29**	1	99	9**	2	98
Traditional	367	14**	1	99	2**	3	97
<b>OCs</b>							
CDHP	119	22	4	96	9	7	93
Traditional	253	15	8	92	5	13	87
<b>Antilipid</b>							
CDHP	229	31**	2	98	10**	17**	83**
Traditional	580	18**	1	99	4**	30**	70**
<b>Antiulcer</b>							
CDHP	127	43**	10*	90*	25**	6	84
Traditional	402	23**	3*	97*	10**	6	84

\* p < .05; \*\* p < .01

<sup>14</sup> Brand utilizers during November 2005 through December 2005 who used only one drug during that time and were continuously enrolled from January 2005 through September 2006. Generic and brand assessments were based on the final claim in the specified time period. Tested using one-tailed Fishers Exact test.

**Table 6 Behavior Patterns in the Third Quarter of 2006<sup>15</sup> for Users of Chronic Drug Therapy<sup>17</sup> With the Top Five Drug Classes Employer A (Deductible \$2,500 Individual/\$5,000 Family)**

	ALL USERS				BRAND USERS			
	N	No Claim (%)	Of Those with a Claim:		N	No Claim (%)	Of Those with a Claim:	
			Last claim was generic (%)	Last claim was brand (%)			Switched to generic (%)	Continued brand (%)
<b>Antidepressant</b>								
CDHP	350	28*	49	51	214	29	21	79
Traditional	868	22*	52	48	519	24	25	75
<b>ACE/ARB</b>								
CDHP	201	20	48	52	111	23*	2	98
Traditional	715	15	48	52	367	14*	3	97
<b>OCs</b>								
CDHP	280	23	59*	41*	119	25	6**	94**
Traditional	630	22	67*	33*	253	30	16**	84**
<b>Antilipid</b>								
CDHP	245	27	25**	75**	229	26	20**	80**
Traditional	617	22	38**	62**	580	21	36**	64**
<b>Antiulcer</b>								
CDHP	155	52**	10	90	127	47**	3	97
Traditional	484	27**	15	85	402	23**	6	94

\* p < .05; \*\* p < .01

*Sensitivity analyses.* Using the matched dataset, the mean CDS score was 839 for both Employer A's CDHP and traditional member groups. For Employer B, mean CDS scores were 689 for CDHP and 688 for traditional members. Results using the matched and unmatched datasets were the same (Tables 3, 4 and 4A). The sole exception was that the continuation-rate differences for antiulcer drugs were no longer statistically significant.

<sup>15</sup> Based only on activity from July through September of 2006.

<sup>16</sup> Brand utilizers during November through December 2005 who used only one drug during that time and were continuously enrolled from January 2005 through September 2006. Assessment of switching versus continued use of brand was based on the final claim in the specified time period. Tested using one-tailed Fishers Exact test.

CDHPs produce considerable savings, both in total drug cost and net-payer cost. These savings are achieved by 1) payment of a greater proportion of cost by the enrollee and 2) reduction in brand use, which is only partially offset by increases in generic use.

The chronic-medication-persistency differences observed in the first quarter of the year had mitigated, but not disappeared altogether, by the third quarter. This finding suggests that members may have anticipated the change to CDHP and stockpiled medication prior to the end of 2005, making early (first-quarter) estimates of CDHP impact somewhat misleading.

CDHP enrollees do not appear to be taking advantage of all the savings opportunities available to them. CDHP enrollees did not consistently increase their use of Home Delivery for chronic medications. Finally, they curtailed medication use instead of consistently substituting generic for brand medications.

At the nine-month marker, persistency differences between CDHP and traditional insurance enrollees were often small, in the range of 5- to 7-percentage points. The only exception was the antiulcer medication class, in which numerous over-the-counter options are available. Thus, whether these persistency differences have any effect on health or on other medical utilization is unclear and should be a subject of future research.

Also unclear is why the rate of switching from brand to generic antilipid medications actually appeared to be higher for the traditional insurance than for CDHP enrollees in Employer A. These switches took place in approximately the third quarter of the year, shortly after Zocor (simvastatin) became available as a generic. In July of 2006, enrollees in both the CDHP and traditional plan taking the non-preferred brand Lipitor received letters explaining the opportunity to save by moving to a newly available generic simvastatin. For traditional plan enrollees, out-of-pocket savings of \$40 would result from a brand-to-generic switch. For CDHP members who had not yet reached the deductible, the out-of-pocket savings amount associated with a switch to simvastatin would vary, depending on the dose of Lipitor. For example, CDHP members taking Lipitor 10mg were shown savings of approximately \$6, while those taking Lipitor 20mg or 40mg were shown savings of approximately \$37, approximately equal to the savings experienced by those in the traditional plan. While the reasons underlying these switch patterns remain unexplained, the findings certainly do not suggest that CDHPs “automatically” produce more cost-effective behavior.

*CDHPs produce considerable savings, both in total drug cost and net payer cost. These savings are achieved by 1) payment of a greater proportion of cost by the enrollee and 2) reduction in brand use, which is only partially offset by increases in generic use.*

This suggestion is consistent with the findings of recent employer surveys. A 2006 Pharmaceutical Strategies Group employer survey found that the most typical reason for not meeting prescription-drug-utilization goals in CDHPs was “the common abandonment of traditional pharmacy management methods.”<sup>10</sup> More recently, a Watson Wyatt survey of 573 large companies found that the plans most successful at curbing high costs combine consumer-directed benefits with other approaches, such as education, healthcare information, early intervention and disease management.<sup>11</sup>

Generally, findings suggest a role for better education of CDHP enrollees. Generic drugs offer the greatest opportunity available to plan sponsors for lowering costs — as well as for making medications more affordable for consumers. The generic opportunity will only continue to increase as more brand medications go off patent, paving the way for more generics to come to market.

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