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More Preventive Care, and Fewer Emergency Room Visits and Prescription Drugs

Health Care Utilization in a Consumer-Driven Health Plan

by Amy R. Wilson, Eric P. Bargman, Derek Pederson, Annikka Wilson,
Nancy A. Garrett, David W. Plocher and Philip L. Ailiff Jr.

Although consumer-driven health plans (CDHPs) have grown dramatically, the question of whether CDHPs have reduced health care costs has not been answered definitively. This article presents what the authors believe to be the first study to analyze a large sample of claims data and to look in detail at different types of utilization among enrollees in a CDHP and those in a traditional comprehensive major medical (CMM) plan. After adjusting for the finding that CDHP enrollees are both younger and healthier than those in CMM plans, the authors found that CDHP enrollees show no consistent or significant utilization differences for measures over which consumers have little control (e.g., inpatient stays); lower utilization for measures over which consumers have greater control (e.g., emergency room visits); and higher utilization of preventive services.

BACKGROUND

While there are many varieties of consumer-driven health plans (CDHPs), until recently, most have been based on a high deductible and a financial account with a special tax status, where the account contribution limit is less than the deductible amount. The enrollee uses the account to pay for services until all funds in the account are spent. The enrollee then pays out of pocket for all expenses until the deductible is reached, at which point costs are covered by the plan. This type of health plan evolved in part from a need by employers and health plans to slow the rate of

growth of health care costs. The theory is that making health care costs more transparent to the enrollee will result in more active participation in managing health care needs.

Surveys of employers and health plans suggest that the number of employers offering CDHPs to their employees, and the number of lives covered by those plans, have increased dramatically in the last few years (Kaiser Family Foundation and Health Research and Educational Trust 2005; America's Health Insurance Plans 2006; Government Accountability Office 2006; Watson Wyatt Worldwide 2007). The question of whether CDHPs have had the desired ef-

fect of stabilizing or decreasing health care costs has not yet been answered definitively. Very little research has been published relating CDHPs to claims trends. Anecdotal evidence from employers and health plans suggests reduced total spending or a reduced spending trend, and several plans believe that CDHP enrollees' out-of-pocket spending grew more slowly than that for enrollees in comparison plans (Bertko 2004; Rosenthal, Hsuan et al. 2005; Aetna 2006; CIGNA Corporation 2006; UnitedHealth Group 2006; Watson Wyatt Worldwide 2007). One of the only peer-reviewed analyses exploring the relationship between CDHPs and expenditures and utilization used a prepost design to study cost and use by a cohort before and after the introduction of a CDHP at a large self-insured employer that had previously had only a health maintenance organization (HMO) and a preferred provider organization (PPO) (Parente, Feldman et al. 2004). Expenditures (adjusted for case mix, enrollee characteristics and plan design) increased each year over the three-year time period for all three plan types. Expenditures were lowest for CDHP enrollees initially; by the third year, however, expenditures for that group had outpaced those of the HMO, but were less than those for the PPO cohort. This study had the advantage of a cohort design, but did not employ utilization measures that are hypothesized to be affected by the CDHP design, e.g., preventive care and emergency room visits.

The literature describing changes in utilization associated with the introduction of CDHPs is also primarily anecdotal. Industry studies have found that consumers enrolled in CDHPs report having chosen a less extensive, less expensive treatment in the past 12 months, forgoing care for conditions they perceived as less serious, and receiving preventive services (Agrawal, Ehrbeck et al. 2005). Industry studies have also found little variation in overall utilization between individuals with CDHPs or high-deductible health plans (HDHPs) and those with comprehensive insurance (Fronstin and Collins 2005). Health plans have reported decreased utilization in CDHPs as compared to other plan types: decreased inpatient use, decreased utilization of acute health services and increased generic drug utilization (Bertko 2004; Rosenthal, Hsuan et al. 2005; Aetna 2006; UnitedHealth Group 2006).

Critics of CDHPs believe that the plan design will encourage consumers to forgo necessary care. This would be a difficult phenomenon to measure and all the existing evidence is anecdotal. Two online surveys of randomly selected, privately insured adults found that individuals with CDHPs and HDHPs were significantly more likely to report they had

avoided, skipped or delayed health care (including preventive care or medications) because of costs than were individuals with comprehensive insurance, even though overall utilization did not vary between the two types of plans (Fronstin and Collins 2005; Lee and Zapert 2005). Conversely, health plans report that CDHP enrollees exhibit either equal or higher rates of preventive care and care for chronic conditions than do enrollees in traditional plans (Aetna 2006; CIGNA Corporation 2006; UnitedHealth Group 2006; UnitedHealth Group 2007).

Another concern cited regarding CDHPs is that these plans will attract healthier and wealthier participants. Very little published research has addressed this issue, and the anecdotal evidence is conflicting. An analysis of demographic and claims data from a very early implementation of a CDHP found no significant demographic differences between the CDHP enrollees and those who stayed in the PPO or HMO plans offered by the same employer (Tollen, Ross et al. 2004). In a cohort study, Parente et al. found higher income and lower illness burdens initially among those choosing the CDHP, but these differences may not have persisted long after the introduction of the plan (Parente, Feldman et al. 2004). Using survey and payroll data for CDHP enrollees and a random sample of non-CDHP enrollees, another study found that employees who chose the CDHP were no healthier or younger than those choosing an HMO, but found that income was strongly and positively associated with the choice of the CDHP (Parente, Feldman et al. 2004). Although an Employee Benefit Research Institute (EBRI) survey found that the prevalence of a fair or poor self-reported health status was similar for those with and without an HDHP (Fronstin and Collins 2005), other studies find evidence of selection bias with respect to health status, age or income (Bertko 2004; Fowles, Kind et al. 2004; Lo Sasso, Rice et al. 2004; Tollen, Ross et al. 2004; Fronstin and Collins 2005; Government Accountability Office 2005; Government Accountability Office 2006).

Blue Cross and Blue Shield of Minnesota (BCBSMN) is a national health plan with approximately 67% of its commercial enrollees living in Minnesota. BCBSMN began offering CDHP products in 2003. Products include both health reimbursement accounts (HRAs), with part of the deductible funded by the employer; and health savings accounts (HSAs), which are portable if an employee leaves his or her employer. All the health plan's CDHPs offer first-dollar coverage for preventive services. Enrollment in these products has increased every year, and the number of employers offering them to their employees has also increased. Given the increasing availabil-

TABLE I**OUTPATIENT UTILIZATION MEASURE DEFINITIONS, CURRENT PROCEDURAL TERMINOLOGY (CPT)**

| Utilization Measure | CPT Codes |
|-----------------------|---|
| Emergency room visits | 99281 . . . 99285 |
| Preventive visits | Well baby: 99381-99383, 99391-99392, 99431-99435 Other preventive: 99383-99387, 99393-99397, 99401-99429 |
| X-ray/lab services | 80002-89399, R0070 . . . R0076 |

ity of and enrollment in these types of plans, stakeholders are very interested in assessing whether the CDHP model actually does affect utilization.

BCBSMN undertook a study of utilization as part of a quality improvement project. In this study, the authors analyzed medical and pharmaceutical claims data in three consecutive one-year periods to compare nine measures of utilization between CDHP enrollees and enrollees in a traditional, comprehensive major medical (CMM) plan. At BCBSMN, preventive services benefits vary significantly for enrollees in the CMM population, with some employers offering more comprehensive preventive coverage than others. The authors believe this is the first study to analyze a large sample of claims data and to look in detail at different types of utilization. Given the current dearth of analysis describing the impact of plan design, this study is an important early step in understanding that impact.

METHODS

In this analysis, the authors compared utilization of enrollees in a traditional plan to that of CDHP enrollees in three separate years: 2004, 2005 and 2006. In each year, the study population included all members enrolled in one of the health plan's CDHP products or in the traditional open access CMM plan, meeting the following inclusion criteria: Members were continuously enrolled in the study year, were 64 years of age or younger and had prescription drug benefit coverage through the health plan (thus enabling the analysis of utilization).

The analysis data set included both claims and enrollment data. Health plan enrollment data were used to satisfy the continuous enrollment criterion and to identify enrollees who had no claims in the analysis period. All members from the commercially insured population who were continuously enrolled in the

analysis year were included. The data were analyzed cross-sectionally. To control for differences in population morbidity, the adjusted clinical groups (ACGs) case-mix system was applied (Johns Hopkins Bloomberg School of Public Health 2005). The data included in this study consisted of incurred claims in each time period including a three-month run-out.

Before comparing utilization in two populations, it is important to understand whether morbidity varies between the groups. ACGs provide a claims-based measure of disease burden and can be used for risk adjustment. An individual is assigned one of 93 ACG categories for a given year based on the diagnosis codes associated with his or her claims for that year and on his or her age and gender. The categories represent the individual's disease burden and predict health care utilization. For each group, CMM and CDHP, total member months were adjusted to account for morbidity using BCBSMN-derived weights from each ACG category to provide an overall measure of disease burden in the population. The adjusted total for CDHP is then compared to that for CMM to obtain a morbidity index (MI) that describes the disease burden in the CDHP population relative to that in CMM. Confidence intervals (95%) around the MI were calculated as:

$$CI = MI \pm \frac{1.96 * MI}{\sqrt{n_{CDHP}}}$$

The analysis included nine measures of utilization, reported either as per 1,000 members per year, or as per member per year (PMPY). The measures described utilization of inpatient, outpatient, preventive and professional services, and of prescription drugs. Outpatient utilization measures are based on current procedural terminology (CPT) codes associated with claims data. Table I presents the mapping of codes to utilization measures. Emergency room visits and pre-

TABLE II**CHARACTERISTICS OF CONSUMER-DRIVEN HEALTH PLAN (CDHP) AND COMPREHENSIVE MAJOR MEDICAL (CMM) ENROLLEES, 2006**

| | CDHP n = 121,098 % (n) | CMM n = 612,954 % (n) | p-value* |
|--------|---|--|-----------------|
| Female | 49.41 (59,831) | 49.40 (302,824) | 0.9845 |
| Age | | | <0.0001 |
| < 1 | 0.09 (108) | 0.09 (524) | |
| 1-17 | 28.48 (34,494) | 25.12 (153,997) | |
| 18-44 | 37.77 (45,737) | 39.48 (242,001) | |
| 45-64 | 33.66 (40,759) | 35.31 (216,432) | |

*P-value associated with χ^2 test for independence.

ventive visits were calculated using logic that grouped claims by person and date to avoid overcounting those services. A very small number of emergency room visits start on one day, and conclude on the next day; thus this algorithm could potentially overcount this service. Given that the same logic is used for CDHP and CMM, however, there is no reason to believe that this issue will affect the comparison of utilization between the two groups. *Professional encounters* were defined as all professional claims except those associated with x-ray or lab services. The professional resource-based relative value scale (RBRVS), as defined by the Centers for Medicare and Medicaid Services, was derived from all professional claims based on the associated Healthcare Common Procedure Coding System (HCPCS).

Inpatient admissions and inpatient days were calculated using industry standard logic based on provider bill type, place of care, contracting specialty, diagnostic-related group, reason for care, emergency, type of service, service code, revenue code, CPT code, patient age at time of service and diagnostic classification. Prescription drug counts and days were based on unique prescription claims per member.

Individual CDHP utilization measures were risk adjusted to make them comparable to the observed CMM values. For each ACG category and utilization measure, the expected rate of utilization for CDHP equals the rate observed in CMM multiplied by the number of members in CDHP. To obtain risk-adjusted utilization, these values are then summed across ACG categories. Efficiency indices (EI) were calculated by dividing observed CDHP utilization by risk-adjusted CDHP utilization to estimate the extent

to which CDHP enrollees used more or fewer services than expected. Confidence intervals (95%) around the EI were calculated as:

$$CI = EI \pm \frac{1.96 * EI}{\sqrt{n_{CDHP}}}$$

An efficiency index less than 1 suggests that CDHP enrollees used fewer services than expected, while an index greater than 1 suggests that they used more. Claims and enrollment data were analyzed using SAS v. 9.1 (SAS Institute 2007).

RESULTS

In this section the authors present results for 2006. Results for 2004 and 2005 are included in the appendix and suggest that differences seen in 2006 between the CDHP and CMM utilization are representative of the entire analysis period.

Population Characteristics

Table II shows the characteristics of the continuously enrolled sample for 2006. The median age of the CMM sample, 34 years, was slightly (but significantly) higher than that of the CDHP sample, 33 years. The average age of adults (ages 18 to 64) in the two groups did not differ significantly ($p = 0.8344$), suggesting that the difference in ages relates to the percentage of enrollees between the ages of 1 and 17 years; enrollees in that age group represented a greater proportion of the total population in the CDHP sample than in the CMM sample.

In addition to being younger, the CDHP popula-

TABLE III**HEALTH SERVICES UTILIZATION BY SERVICE AND PLAN TYPE, 2006;
COMPREHENSIVE MAJOR MEDICAL (CMM), CONSUMER-DRIVEN HEALTH PLAN
(CDHP) AND PER MEMBER PER YEAR (PMPY)**

| Measure | Unadjusted | | | Risk Adjusted | |
|--|------------|-------|--------------|---------------|---------------------------|
| | CMM | CDHP | % Difference | CDHP | Efficiency Index (95% CI) |
| Emergency room visits/ 1,000 members per year | 141.2 | 114.6 | 19% | 129.1 | 0.888 (0.883, 0.893) |
| Preventive visits/ 1,000 members per year | 350.0 | 397.1 | -13% | 357.4 | 1.111 (1.105, 1.117) |
| Professional encounter/PMPY | 6.1 | 5.5 | 9% | 5.5 | 0.988 (0.982, 0.993) |
| Professional RBRVS/PMPY | 17.5 | 15.4 | 12% | 15.7 | 0.982 (0.976, 0.987) |
| X-ray/lab services/PMPY | 4.6 | 4.2 | 10% | 4.2 | 0.993 (0.988, 0.999) |
| Script days/PMPY | 255.1 | 194.2 | 24% | 231.0 | 0.841 (0.836, 0.845) |
| Script counts/PMPY | 8.4 | 6.8 | 19% | 7.7 | 0.890 (0.885, 0.895) |
| Inpatient admissions/ 1,000 members per year | 58.1 | 48.3 | 17% | 49.1 | 0.984 (0.979, 0.990) |
| Inpatient days/1,000 members per year | 217.5 | 169.3 | 22% | 177.1 | 0.956 (0.951, 0.962) |

tion appeared to be healthier than the CMM population. The morbidity index for the CDHP population of 0.863 (95% CI: 0.858 – 0.867) suggests that that population was 13.7% healthier than the CMM population as measured by ACG categories.

Utilization

A comparison of several key utilization indicators by plan type shows that for all but one measure (preventive services), CDHP enrollees used fewer health care services than did CMM enrollees (Table III). This result is not surprising given that CDHP enrollees appear to be healthier than CMM enrollees. CDHP enrollees used more preventive services. Table III shows differences in utilization by plan type. After adjusting the utilization for population morbidity using ACGs, the authors found that these conclusions did not change. For example, the unadjusted number of emergency room visits per 1,000 members in a year for CDHP enrollees was 114.6, lower than the unadjusted number for CMM enrollees. When risk adjusting the utilization for CDHP enrollees to make it directly comparable to that for the CMM enrollees, that value, 129.1, is still lower than the unadjusted value for CMM, 141.2. The efficiency index of 0.888 suggests that CDHP enrollees had 11.2% fewer emergency room visits than ex-

pected. The largest and most persistent deviations in utilization from the expected level occurred in services over which the consumer had a high degree of control, namely, preventive visits, prescription drug use and emergency room visits, but all utilization measures differed significantly from the reference population.

DISCUSSION

In this retrospective analysis of medical and pharmaceutical claims data, utilization for a continuously enrolled sample of participants in a traditional health insurance plan was compared to that for enrollees in a CDHP for three separate years. The CDHP sample had a greater proportion of children than did the CMM sample, lowering the average age. The CDHP population also appeared to be healthier than the CMM population, according to ACG categories. In all three time periods, unadjusted utilization was lower in the CDHP for every measure except preventive services, which was higher. After controlling for disease burden using ACGs, it was found that CDHP utilization was still significantly lower for the measures that might be considered to most reflect choice by the enrollee: emergency room visits, professional encounters, prescription drug use and, to a

lesser degree, x-ray and lab services. Preventive service utilization remained significantly higher for CDHP enrollees after risk adjustment. Measures describing utilization largely beyond the participant's control, namely, inpatient admissions and intensity of professional encounters, were neither consistently nor significantly lower for CDHP enrollees.

The findings in this analysis serve to both support and refute reservations commonly held about CDHPs regarding selection bias and their potential to cause enrollees to forgo necessary care. The younger age and apparent lower disease burden found in the CDHP sample lends support to the hypothesis that this type of plan design is more attractive to younger and healthier individuals. Conversely, the lack of significant differences in measures describing inpatient utilization, intensity of professional visits and, to a lesser degree, x-ray and lab services suggests that patients are not forgoing necessary care. Furthermore, the significant increase in preventive care seen in CDHP enrollees suggests that the plan design has not discouraged preventive visits, perhaps because of the first-dollar coverage for preventive services. Because this analysis did not include outcomes data, however, it cannot be known whether decreases in ER visits, professional visits or prescription drug usage resulted from decreasing unnecessary care, or forgoing necessary care.

Similarly, the analysis both agrees with and conflicts with findings in the literature about the impact of plan design on utilization and selection. The literature reports conflicting findings about whether persons who choose a CDHP differ demographically from those who do not. Analyses have found no demographic differences between CDHP and traditional plan enrollees (Tollen, Ross et al. 2004), higher income and lower illness burden after the initial offering of a CDHP that may not persist over time (Parente, Feldman et al. 2004), and higher income in CDHP enrollees (Parente, Feldman et al. 2004). While the authors did not have income data, the analysis does suggest that in all three years, CDHP enrollees were both younger and healthier. The analysis found a decrease in emergency room visits similar in magnitude to that found by an earlier study of emergency room use by enrollees in a full replacement HDHP as compared to a traditional plan (Wharam, Landon et al. 2007). The findings regarding the increased use of preventive services by CDHP enrollees lend credence to the self-reported use of preventive services found by surveys of enrollees in that type of plan (Agrawal, Ehrbeck et al. 2005) and to reports by health plans that CDHP enrollees received preventive services at rates equal to or higher than

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enrollees in traditional plans (Aetna 2006; CIGNA Corporation 2006; UnitedHealth Group 2006).

There are several key limitations to this study. While ACGs can control for morbidity, age and gender, there are several demographic variables that could not be included, such as income, education and ethnicity, which are hypothesized to affect both selection into a plan and utilization of health services. The study suggests that concerns about selection bias may be well founded. This analysis did not control for whether enrollees chose to join the CDHP or were forced to join because the employer offered a full replacement CDHP. This analysis also did not control for differences in benefit design among the CDHPs that may significantly affect consumer behavior. For example, HSAs offered by the health plan featured portable accounts that enrollees could take with them when they left their current employers. In addition to variability in benefit design across these CDHP types, within a plan type there were differences from employer to employer in how the plan was implemented. For example, employers fund accounts at different levels. All of these factors may well affect utilization and should be considered in interpreting these results and planning future analyses.

While these results do suggest a relationship between plan design and utilization, future studies should also focus on the aspects of utilization over which a consumer has some control, and assess whether he or she has the information needed to knowledgeably make decisions about that utilization. Research suggests that physician decisions determine 90% of expenditures (Eisenberg 2002). In addition, physicians report considering patients' out-of-pocket expenses regularly when faced with relatively simple decisions, such as prescribing a generic over a brand-name drug, but significantly less often when faced with more complex decisions, such as choosing a diagnostic test (Pham, Alexander et al. 2007). These findings suggest significant challenges to implementing a health plan that is truly consumer-driven. ◀

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APPENDIX

RESULTS FOR 2004 AND 2005

Because the numbers in Table I below describe continuously enrolled members, they do not reflect relative or absolute changes in enrollment across plans or years.

TABLE I

CHARACTERISTICS OF CONSUMER-DRIVEN HEALTH PLAN (CDHP) AND COMPREHENSIVE MAJOR MEDICAL (CMM) ENROLLEES, 2004 AND 2005

| | CDHP n = 35,339 | CMM n = 531,572 | |
|-------------|----------------------------------|----------------------------------|-----------------|
| 2004 | % (n) | % (n) | p-value* |
| Female | 48.87 (17,269) | 49.28 (261,943) | 0.1351 |
| Age | | | < 0.0001 |
| < 1 | 0.07 (26) | 0.08 (427) | |
| 1-17 | 29.71 (10,500) | 25.34 (134,699) | |
| 18-44 | 37.95 (13,411) | 40.28 (214,124) | |
| 45-64 | 32.26 (11,402) | 34.30 (182,322) | |
| | | | |
| 2005 | CDHP n = 75,163 | CMM n = 568,551 | p-value* |
| Female | 49.40 (37,127) | 49.37 (280,686) | 0.8907 |
| Age | | | < 0.0001 |
| < 1 | 0.07 (49) | 0.09 (505) | |
| 1-17 | 29.06 (21,840) | 25.13 (142,871) | |
| 18-44 | 37.66 (28,303) | 39.57 (224,953) | |
| 45-64 | 33.22 (24,971) | 35.22 (200,222) | |

*P-value associated with χ^2 test for independence.

In all three time periods, the median age of the CMM sample, 34 years, was slightly, but significantly, higher than that of the CDHP sample (32 years in 2004, and 33 years in 2005 and 2006).

In 2004 and 2005, CDHP enrollees were 14.2% and 13.7% healthier than CMM enrollees according to morbidity indices of 0.858 (95% CI: 0.849, 0.867) and 0.863 (95% CI: 0.857, 0.870), respectively.

Tables II and III suggest that unadjusted and risk-adjusted utilization measures followed patterns in 2004 and 2005 similar to those in 2006. One notable exception is inpatient utilization in 2005, where measures for CDHP enrollees significantly exceeded those for CMM enrollees.

APPENDIX**TABLE II**

**HEALTH SERVICES UTILIZATION BY SERVICE AND PLAN TYPE, 2004;
COMPREHENSIVE MAJOR MEDICAL (CMM), CONSUMER-DRIVEN HEALTH PLAN
(CDHP) AND PER MEMBER PER YEAR (PMPY)**

| Measure | Unadjusted | | | Risk Adjusted | |
|--|------------|-------|---------------|---------------|------------------------------|
| | CMM | CDHP | % Decrease | CDHP | Efficiency Index (95% CI) |
| Emergency room visits/ 1,000 members per year | 134.0 | 110.4 | 18 | 121.5 | 0.908 (0.899, 0.918) |
| Preventive visits/ 1,000 members per year | 327.9 | 362.4 | -10 | 329.2 | 1.101 (1.089, 1.112) |
| Professional encounter/PMPY | 5.7 | 5.0 | 12 | 5.1 | 0.974 (0.964, 0.984) |
| Professional RBRVS/PMPY | 15.5 | 13.3 | 14 | 13.7 | 0.971 (0.961, 0.981) |
| X-ray/lab services/PMPY | 4.3 | 3.7 | 15 | 3.8 | 0.958 (0.948, 0.968) |
| Script days/PMPY | 229.9 | 170.5 | 26 | 204.8 | 0.833 (0.824, 0.842) |
| Script counts/PMPY | 7.8 | 6.1 | 22 | 6.9 | 0.881 (0.872, 0.891) |
| Inpatient admissions/ 1,000 members per year | 58.3 | 48.4 | 17 | 48.6 | 0.995 (0.984, 1.005) |
| Inpatient days/ 1,000 members per year | 210.0 | 172.7 | 18 | 173.2 | 0.997 (0.987, 1.008) |

TABLE III

**HEALTH SERVICES UTILIZATION BY SERVICE AND PLAN TYPE, 2005;
COMPREHENSIVE MAJOR MEDICAL (CMM), CONSUMER-DRIVEN HEALTH PLAN
(CDHP) AND PER MEMBER PER YEAR (PMPY)**

| Measure | Unadjusted | | | Risk Adjusted | |
|---|------------|-------|---------------|---------------|------------------------------|
| | CMM | CDHP | % Decrease | CDHP | Efficiency Index (95% CI) |
| Emergency room visits / 1,000 members per year | 139.9 | 113.7 | 19 | 128.5 | 0.885 (0.879, 0.891) |
| Preventive visits/ 1,000 members per year | 339.8 | 385.4 | -13 | 344.6 | 1.119 (1.111, 1.127) |
| Professional encounter/PMPY | 5.9 | 5.3 | 10 | 5.4 | 0.990 (0.983, 0.998) |
| Professional RBRVS/PMPY | 16.3 | 14.5 | 11 | 14.5 | 0.995 (0.988, 1.002) |
| X-ray/lab services/PMPY | 4.5 | 4.0 | 11 | 4.0 | 0.991 (0.984, 0.998) |
| Script days/PMPY | 242.6 | 183.5 | 24 | 218.2 | 0.841 (0.835, 0.847) |
| Script counts/PMPY | 8.2 | 6.6 | 20 | 7.4 | 0.891 (0.884, 0.897) |
| Inpatient admissions/ 1,000 members per year | 57.1 | 49.6 | 13 | 47.6 | 1.042 (1.034, 1.049) |
| Inpatient days/1,000 members per year | 212.4 | 181.6 | 15 | 175.3 | 1.036 (1.028, 1.043) |

