

The Design and Implementation of National Health Reform: Lessons from Rhode Island's *HEALTHpact* Plan

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National Trends in Small Group Coverage

- ~2/3 of Americans under 65 insured in workplace
 - Large annual premium increases=>Coverage eroded
 - Shift costs to employees
 - Drop coverage
 - Firms dropping coverage from 1999 to 2009
 - <200 workers: 65% to 59%
 - <10 workers: 56% to 46%
 - >200 workers: steady at ~98/99%
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RI Trends in Small Group Coverage

- 94% of employers are small businesses (<50 workers), accounting for 35% of the state's workforce
 - The proportion of small employers offering coverage dropped from 70% to 53% between 1997 and 2008
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What Is HEALTH*pact*?

- ❑ State-sponsored health insurance product in RI small group market (firms w/<50 employees)
- ❑ Targeted at small businesses facing the options of offering high deductible health plans or foregoing coverage altogether
- ❑ Designed to help employees afford comprehensive coverage while linking benefit levels to risk reducing behavior
- ❑ Premiums capped at 10% of the average RI wage

Product Design Process

- Wellness Advisory Committee-Fall 2006
 - Small employers, employer groups, brokers, direct payers, unions
 - Insurers were present but not “voting” members
 - RFP to BCBS and United-Winter 2006
 - Rates and benefit components approved-May 2007
 - Effective-October 2007
 - Product offered by all plans, privately labeled and distributed through the brokers
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HEALTH*pact*

- Financial incentives for healthier choices and lower costs (“Advantage” vs. “Basic”)
 - Emphasis on personal responsibility
 - Advantage deductible/cost sharing lower than basic; where enrollees end up depends on their behavior
 - Premiums and coverage identical between “Advantage” and “Basic” plans
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HEALTH*pact*: Advantage v. Basic

	Advantage	Basic
Average Individual Monthly Premium	\$362 (United); \$372 (BCBS)	\$362 (United); \$372 (BCBS)
Deductible (individual/family)	\$750/\$1,500	\$5,000/\$10,000
Co-insurance	10% (United); None (BCBS)	20%
Primary care/ specialist copay	\$10/\$50	\$30/\$60
Rx copay	\$10/40/75	\$10/\$40/\$75 after \$250/\$500 deductible
Annual Out-of-Pocket Maximum	\$2,000/\$4,000	\$5,000/\$10,000
Life Time Benefit Maximum	Unlimited	\$1,000,000 per participant

HEALTH*pact*: Other Observations

- ❑ Insurers are required to provide small employers (<50 workers) the option of offering HEALTH*pact*
- ❑ Small employers may offer HEALTH*pact* alongside other plans
- ❑ Enrollment capped at 5,000 lives per insurer
- ❑ Participation has been very low
 - Only 268 employer groups and 528 subscribers
 - Only 921 plan members (81% in BCBS; 19% in United)
 - In “Basic”: No United enrollees; just 8.3% BCBS enrollees

Overview of Findings

- Poor Product Design
 - Lack of Subsidy
 - Poor Value
 - Inherent Complexity/Novelty
 - Failure to Secure Buy-In of Insurers and Brokers
 - Insufficient Resources Provided to Conduct Necessary Outreach and Oversight
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Poor Product Design: Lack of Subsidy

- Inclusion of a subsidy would have increased the plan's value, thereby facilitating take-up among firms not offering coverage
 - Rather than drawing additional employers into the market the focus has been on firms considering dropping coverage or replacing it with a high deductible plan
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Poor Product Design: Poor Value

- ❑ RI employers traditionally offer comparatively rich benefits; possibility of a “large” deductible therefore has proven to be a barrier to take-up
 - ❑ For a slightly higher premium employers can enroll employees in traditional high deductible plans without wellness requirements or risk of \$10,000 deductible
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Poor Product Design: Inherent Complexity

- ❑ Considered too complex and novel for insurers and brokers to explain to small business owners with insufficient expertise to make coverage decisions
 - ❑ Small employers typically lack human resources personnel; few have time or willingness to understand “paradigm” altering plans
 - ❑ Most small businesses would rather stick with what they know if they can afford it rather than adopt something perceived as unusual and different
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Limited Insurers and Broker Buy-In

- ❑ Insurers not included as voting members on WAC; feel committee had to little expertise to both meet price point and avoid adverse selection
 - ❑ Carriers devoted minimal resources to promoting the plan; one carrier actively discouraged brokers
 - ❑ Brokers did not want to risk alienating clients by promoting a plan they did not believe in, understand, or feel is too time consuming to explain and learn
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Lack of Resources for Outreach/Monitoring

- ❑ Few resources have been provided to fund program implementation; thus, little opportunity to stimulate “bottom up” demand from employers
 - ❑ State has to rely on insurers and brokers; two parties not necessarily interested in the program’s success
 - ❑ No money has been allocated for monitoring; thus, little opportunity to ensure broker and insurer compliance with plan requirements
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Lessons from Rhode Island's Experience

- Subsidies Are Critical to Stimulating Take-Up
 - Direct subsidies, tax credits, premium discounts
 - Those not offering coverage are unlikely to do so without them
 - Highlights the importance of up to six years of federal tax credits in the Patient Protection and Affordable Care Act (ACA)
 - But: Federal tax credits may not be large enough nor extend to sufficient numbers of small employers
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Lessons from Rhode Island's Experience

- Buy-In of Key Implementing Agents (e.g., Brokers and Insurers) Must Be Secured
 - Demonstrate benefits from participating exceed/equal the costs
 - Buy-in would be easier to achieve with a subsidy program
 - The ACA largely attempts to reduce the ranks of uninsured Americans through insurance market reforms
 - Health reform's success will depend, in part, on the ability of regulators, insurers, and other key implementing agents to collaborate productively
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Lessons from Rhode Island's Experience

- Allocate Sufficient Resources for Outreach & Oversight
 - Monitoring critical when implementation activities delegated
 - Aggressive outreach campaigns critical for take-up as well
 - Primary responsibility for implementing small group reform under the ACA rests with the states
 - Barring Republican defunding efforts, the federal government will provide initial support for state implementation efforts
 - Once up and running, states will need to identify ways to finance continued administration/other responsibilities
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Lessons from Rhode Island's Experience

- Wellness Incentives Should Be Kept Relatively Simple
 - The ACA increases discounts employers are allowed to offer workers who engage in certain behaviors/achieve certain goals
 - But: Limited expertise and HR personnel in small businesses
 - Small group market may not be the ideal venue for adopting complex strategies for achieving wellness
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