Evaluating the Implementation, Design, and Outcomes of the Rhode island HEAlTH*pact* Plans

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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%

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

Why Are Small Firms Especially Vulnerable?

- Can’t pool risk over a large population
- Have less power to negotiate favorable rates
- Face proportionately higher administrative costs

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

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

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:* Initial Enrollment

- Pick a Primary Care Doctor
  - Indicate on enrollment application a primary care physician (PCP) for each family member
- Complete a Health Risk Appraisal Form
  - Submit completed form(s) for each family member aged 18 years and over with enrollment application
- Sign a Pledge
  - Commit all enrollees aged 18 and over to meet all wellness participation requirements throughout the year, including participation in disease management, weight loss, and smoking cessation programs if applicable

HEALTH*pact:* Ongoing Participation

- Visit PCP
  - Have PCP complete a checklist, identifying appropriate wellness participation requirements for smoking cessation and weight management, within six months of enrollment
- Fill in Participation Commitment Form:
  - All enrollees age 18 and over must confirm participation in appropriate wellness programs as identified by their doctor within 8 months of enrollment
- Participate in Disease Management Programs:
  - If so identified by the insurer

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

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

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

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

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

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

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

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

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 responsbilities

Lessons from Rhode Island's Experience

- Wellness Incentives Should Be Kept Relatively Simple
  - The ACA increases discounts in premiums, co-payments, and deductibles employers are allowed to offer workers who engage in certain behaviors or 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