Evaluating the Implementation, Design, and Outcomes of the Rhode island HEALTHpact Plans

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- Robert Wood Johnson Foundation (Grant #64214)
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 HEALTHpact?

- 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
HEALTHpact

- 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
### HEALTHpact: Advantage v. Basic

<table>
<thead>
<tr>
<th></th>
<th>Advantage</th>
<th>Basic</th>
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<tbody>
<tr>
<td>Average Individual</td>
<td>$362 (United); $372 (BCBS)</td>
<td>$362 (United); $372 (BCBS)</td>
</tr>
<tr>
<td>Monthly Premium</td>
<td>$362 (United); $372 (BCBS)</td>
<td></td>
</tr>
<tr>
<td>Deductible (individual/family)</td>
<td>$750/$1,500</td>
<td>$5,000/$10,000</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>10% (United); None (BCBS)</td>
<td>20%</td>
</tr>
<tr>
<td>Primary care/ specialist copay</td>
<td>$10/$50</td>
<td>$30/$60</td>
</tr>
<tr>
<td>Rx copay</td>
<td>$10/40/75</td>
<td>$10/40/75 after $250/$500 deductible</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$2,000/$4,000</td>
<td>$5,000/$10,000</td>
</tr>
<tr>
<td>Life Time Benefit</td>
<td>Unlimited</td>
<td>$1,000,000 per participant</td>
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The table above compares the premiums, deductibles, co-insurance, copays, and maximum benefits for Advantage and Basic plans within the HEALTHpact network. The data includes both United and BCBS plans, with some plans offering different rates for individual and family plans. The annual out-of-pocket maximums vary significantly, with Advantage plans having lower limits compared to Basic plans.
HEALTHpact: 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
HEALTHpact: 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
HEALTHpact: Other Observations

- Insurers are required to provide small employers (<50 workers) the option of offering HEALTHpact

- Small employers may offer HEALTHpact 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
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
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
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 responsibilities
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