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Rhode Island's HEALTHpact Plan: Lessons for Small-Group Reform

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INTRODUCTION

Employer-based health insurance coverage has eroded substantially, especially among small businesses. Until now, reform of the small-group market has focused primarily on strategies such as modifying insurance market regulations (rate setting rules, guaranteed issue and renewal, etc.) and establishing purchasing pools. ⁱ This brief looks at an innovative alternative for state-level reform: Rhode Island's HEALTHpact—designed specifically to encourage take-up of health insurance coverage in the small-group market. Rhode Island's experience with this strategy offers several key lessons for future iterations of small-group reform, both in Rhode Island and other states.

PROBLEM: DECLINING SMALL-GROUP COVERAGE IN RHODE ISLAND

Employer-sponsored health insurance coverage has declined significantly in recent years, particularly in the small-group market, where coverage costs substantially more than in the large-group market. In Rhode Island, the percentage of small employers offering health insurance coverage decreased from 70% to 53% between 1997 and 2008. ^{ii,iii} This decline, exacerbated by a lack of insurer competition in the state, has had a significant impact on overall coverage rates in Rhode Island, since small businesses make up 94% of the state's employers. ^{iv}



SOLUTION: HEALTHpact

In an effort to encourage small employers to offer coverage, the Rhode Island general assembly passed legislation in 2006 mandating that any insurer participating in the state's small-group insurance market design a product meeting specifications determined by a Wellness Advisory Committee (to be convened by the Office of the Health Insurance Commissioner, or OHIC). The premium price for these plans—called "HEALTHpact"—was capped at 10% of the average annual wage in Rhode Island.

Two HEALTHpact plans were created, one offered by United Health Care of New England ("United") and the other by Blue Cross Blue Shield of Rhode Island ("Blue Cross"). Both plans establish incentives for healthy behaviors by offering two coverage levels—"advantage" and "basic" (Table 1)—for which premiums and covered services are identical but for which plan members are subject to substantially different deductibles (\$750/\$1500 individual/family and \$5,000/\$10,000 individual/family, respectively). All HEALTHpact enrollees start out at the lower-deductible "advantage" level, but continued advantage-level benefits are contingent upon the completion of certain wellness requirements: selecting a primary care physician; completing a health risk assessment; and pledging to participate in disease management, smoking cessation, and weight loss programs in the event that the enrollee has an applicable chronic

illness, smokes, or is overweight. Enrollees who fail to complete these tasks may remain with the HEALTH*pact* plan but are eligible only for “basic” coverage, with its higher deductibles.

Table 1. HEALTH*pact*: “Advantage” vs. “Basic”

	Advantage	Basic
Average Individual Monthly Premium¹	\$362 (United), \$372 (Blue Cross)	\$362 (United), \$372 (Blue Cross)
Deductible	\$750/\$1,500 (individual/family)	\$5,000/\$10,000 (individual/family)
Co-insurance	10% (United), None (Blue Cross)	20%
Primary Care Co-pay	\$10	\$30
Specialist Co-pay	\$50	\$60
Prescription Co-pay (Retail)	\$10/\$40/\$75	\$10/\$40/\$75 after deductible
Annual Out-of-Pocket Maximum	\$2,000/\$4,000	\$5,000/\$10,000
Lifetime Benefit Maximum	Unlimited	\$1,000,000 per participant

Sources: Blue Cross Blue Shield of Rhode Island ^v; Rhode Island Health Insurance Commissioner ^{vi}; United Healthcare ^{vii}

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Both United and Blue Cross are required by statute to provide small employers (those with 50 or fewer employees) the option of offering their workers the HEALTH*pact* plan, either as their only coverage option or alongside other plans. Small employers in Rhode Island generally purchase coverage through the state’s health insurance brokers, who are thus directly responsible for informing employers about the plan.

OUTCOME: LOW TAKE-UP

HEALTH*pact* enrollment began in October 2007. Insurers insisted that HEALTH*pact* enrollment be capped at 10,000 (5,000 for each carrier) due to concerns about biased selection (whereby more favorable clients would migrate toward HEALTH*pact* under the assumption that they could more easily maintain advantage-level benefits than could less favorable clients). However, take-up has been extremely low so far, with only 921 total enrollees as of January 2009, including 268 employer groups and 538 individual subscribers. ^{viii} This is despite premium rates being 15% to 20% lower for HEALTH*pact* plans than for other products with comparable “advantage”-level benefits.

WHAT WENT WRONG?

Enrollment data, archival documents, and a series of in-depth key stakeholder interviews reveal several explanations for the low take-up of HEALTH*pact*: poor product design, failure to secure insurer and broker buy-in, and failure to provide sufficient resources for program outreach and oversight.

Poor Product Design

*HEALTH*pact* is not subsidized.* Without a subsidy, which would have resulted in even lower premiums and/or more generous coverage, HEALTH*pact* has not stimulated take-up among employers who are not already offering coverage; instead, HEALTH*pact* has appealed to firms that were already providing coverage but who were considering dropping it or adopting a high-deductible plan in its place.

*With its burden of wellness incentives and the threat of a potentially significant deductible, HEALTH*pact* does not represent a good value for most employers.* While HEALTH*pact* is the cheapest product in Rhode Island’s small-group market, the state’s employers have traditionally offered comparatively rich benefits in order to recruit employees, so the possibility that workers might end up with a large “basic” deductible acts as a barrier to take-up. Even when compared to other, similar products, HEALTH*pact* is seen as a lower value due to its wellness requirements and the threat

of a \$10,000 deductible, both of which can be avoided by purchasing a comparable product for a premium that is just slightly higher.

HEALTHpact is considered too complex and novel, especially for the small-group market. Stakeholders described HEALTH*pact* as too complicated and too unlike other products for brokers and insurers to explain to small employers, few of whom have expertise in insurance coverage (or human resource personnel with such expertise) and most of whom would rather continue with a familiar product if they can afford it than adopt a plan with a novel structure.

Failure to Secure Buy-In of Insurers and Brokers

Neither insurers nor brokers feel that the design of HEALTH*pact* serves their interests, so they have not been invested in successfully implementing the program. This problem took root during HEALTH*pact*'s design phase when the Wellness Advisory Committee (WAC) was convened. Insurance carriers were invited to provide cost analysis and feedback to the WAC about what benefits and deductible levels could be obtained for a given premium price. However, the carriers were not voting members of the committee and didn't feel that the voting members had sufficient benefits design experience to meet the price point authorized in statute and to avoid adverse selection. This lack of buy-in on the part of insurers has influenced HEALTH*pact*'s implementation: stakeholders perceived, in general, that insurers did little to promote the plans, and brokers reported that communications from one carrier actively discouraged brokers from promoting take-up. It was also reported that brokers adopted a number of subtle ways to discourage participation because they did not believe in HEALTH*pact*, were uncertain about the implications of enrolling, did not fully understand it, and/or believed learning about and explaining it too time consuming.

Failure to Provide Sufficient Resources for OHIC to Conduct Outreach and Oversight

Interviewees reported that, while the design and development of HEALTH*pact* were well-funded, this was not the case for program implementation. This lack of funding limited the ability of OHIC to conduct the education and outreach necessary to promote greater take-up by stimulating "bottom-up" demand from employers. Instead, the state has had to rely almost entirely on insurers and brokers to promote HEALTH*pact*—two parties with little interest in ensuring the program's success, as seen above. Furthermore, since there was no money allocated to monitoring, there was little opportunity to ensure broker and insurer company compliance with HEALTH*pact*'s requirements. Thus, while insurers and brokers are required to offer HEALTH*pact*, for example, OHIC has few resources to make sure that this is done, let alone that the plans are being presented properly.

LESSONS FOR FUTURE SMALL-GROUP REFORM EFFORTS

Subsidies are critical to the stimulation of take-up.

Without subsidies of some kind, whether direct or given through tax credits or premium discounts, small employers who do not already offer coverage are not likely to enter the market and purchase coverage.

The buy-in of key implementing agents (e.g., insurers and brokers) must be secured.

Garnering buy-in from the insurance carriers requires convincing them that the tangible benefits from participating exceed or, at a minimum, equal the costs. Indeed, it is difficult to adopt premium discounts in the 15 to 20 percent range if insurers and brokers stand to lose financially from implementation. Conversely, it becomes easier to do so if a subsidy program is in place. Subsidies help generate support among insurers by offering the potential to draw additional customers into the market and thereby expand insurers' base of subscribers. Garnering the support of insurers is likely, in turn, to influence brokers, who are significant actors in the small-group market, since more than half of small firms purchase coverage through a broker or agent.^{ix}

Sufficient resources must be allocated for government outreach and oversight.

Funding for outreach and education is important in stimulating demand at both the insurer/broker level and the employer/worker level, particularly with respect to innovative products such as HEALTH*pact*. The need to fund government oversight is especially significant as well, particularly in cases where key implementation activities have

been delegated to non-governmental actors. This is especially true if subsidies have not been put into place to financially incentivize successful implementation, as recommended above.

Wellness incentives should be kept relatively simple.

Given the limited benefits expertise of most small business owners, few of whom have human resources personnel to manage health insurance coverage decisions, the small-group market may not be an ideal venue for adopting comparatively complex strategies for achieving wellness.

CONCLUSION

The creation of a health insurance product such as HEALTH*pact*, designed specifically for small businesses, is a unique strategy for small-group reform at the state level. Lessons learned should therefore inform similar state-level efforts down the road. These lessons point to issues that should be addressed in any effort to reform the small-group market, particularly with respect to the role of subsidies, insurer and broker buy-in, wellness incentives and government outreach and oversight, which must be adequately funded to ensure successful implementation. Widespread adoption can only take place once the other challenges identified here are also overcome.

NOTES

- ⁱ Napel, S.T., A. Bulchis, M. Trinity, E., Martinez-Vidal, C. McGlynn, and I. Friedenzohn. 2009, January. *State of the States, Charting a Course: Preparing for the Future, Learning from the Past*. Washington, D.C.: AcademyHealth.
- ⁱⁱ Kaiser Family Foundation. 2009. *www.statehealthfacts.org*. Washington, D.C.: Kaiser Family Foundation. [accessed November 2, 2009]. Available at: <http://www.statehealthfacts.org>.
- ⁱⁱⁱ Office of the Health Insurance Commissioner. 2007, September 10. *An analysis of Rhode Island's Uninsured: Trends, Demographics, and Regional and National Comparisons*. Providence, RI: Office of the Health Insurance Commissioner. [accessed November 2, 2009]. Available at: http://www.ohic.ri.gov/documents/Press/PressReleases/2007uninsuredreport/2_070910%20Final%20Uninsured%20Report.pdf.
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- ^v Blue Cross Blue Shield of Rhode Island. 2009. *Blue CHiP for Healthy Options*. [accessed November 3, 2009]. Available at: <https://www.bcsri.com/BCBSRIWeb/plansandservices/GroupPlans/BlueCHiPforHealthyOptions/index.jsp>.
- ^{vi} Koller, C. 2008, October. *No Money but Some Public Authority*. Presentation before the Annual Conference of the National Academy for State Health Policy.
- ^{vii} United Healthcare. 2009. *Pledge*. [accessed November 3, 2009]. Available at: http://www.uhc.com/group_plans_search/state_specific_products/unitedhealthcare_pledge_plan/relatedinformation/28b863094c104210VgnVCM2000003010b10a.htm.
- ^{viii} Office of the Health Insurance Commissioner, State of Rhode Island
- ^{ix} Marquis, M.S., and S.H. Long. 2000. "Who Helps Employers Design Their Health Insurance Benefits?" *Health Affairs* 19(1): 133-138.

ABOUT SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that supports rigorous research on health reform issues, specifically as they relate to the state implementation of the Affordable Care Act (ACA). The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

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