HSR Health Services Research

DOI: 10.1111/j.1475-6773.2010.01198.x
USING STATE-LEVEL EVIDENCE TO INFORM NATIONAL POLICY: RESEARCH FROM THE STATE HEALTH ACCESS REFORM EVALUATION (SHARE) PROGRAM

Small Group Health Insurance Reform in Rhode Island: Promises and Pitfalls of the HEALTH*pact* Plan

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Objective. This study analyzes what design elements inhibited enrollment in HEALTH*pact*.
Study Setting. HEALTH*pact* is a high deductible plan with a premium capped at 10 percent of the average Rhode Island wage. Deductibles are reduced if enrollees meet wellness criteria.
Study Design. Qualitative case study.
Data Collection. Archival documents and 23 interviews.
Principal Findings. Inclusion of a subsidy would have led to lower premiums and more generous coverage. Although priced lower than other plans, HEALTH*pact* still did not offer good value for most firms. Wellness incentives also were too complex.
Conclusions. Subsidies for purchase of insurance coverage are critical to national reform of the small group market. Designers also will need to carefully balance program complexity with innovation in encouraging wellness and product appeal.

Key Words. Employer-based insurance, small group market, health reform, state innovation, wellness

Employer-based health insurance coverage has eroded substantially, particularly in the small group market. This has been especially acute in Rhode Island (RI) where 94 percent of employers are firms with <50 employees who together employ 35 percent of RI workers (Office of the Governor 2005). Although the offer rate among large RI employers (>50 workers) has remained steady at 98 percent, it declined from 70 to 53 percent among smaller employers between 1997 and 2008 (Office of the Health Insurance Commissioner [OHIC] 2007; Kaiser Family Foundation 2009). Offer rates have been especially low in the fastest growing segments of the economy—low wage sectors such as retail and services (Maxwell et al. 2006). Overall, the average commercial premium more than doubled between 1997 and 2008, to

U.S.$13,363 for family coverage (OHIC 2007; Kaiser Family Foundation 2009). This study evaluates RI's primary policy innovation used to bolster coverage among small employees—the HEALTH*pact* plan.

The 2006 legislation authorizing HEALTH*pact* capped the price of the premium at 10 percent of the average annual RI wage. It also authorized the OHIC to convene a Wellness Advisory Committee, which included 16 representatives of small employers, local chambers of commerce, insurance brokers, and direct pay consumers. RI's two major insurers—United Healthcare of New England and Blue Cross Blue Shield of RI—were present as nonvoting members. The WAC was charged with developing and enforcing guidelines for insurers, which, in turn were required to develop products satisfying those guidelines.

HEALTH*pact* became open for enrollment in October 2007. It creates incentives for healthy behaviors by offering two coverage levels, "advantage" and "basic" (Table 1). The premiums and covered services are the same. However, "basic" plan members are subject to a substantially higher deductible of U.S.$5,000 for an individual and U.S.$10,000 for a family as compared with U.S.$750 and U.S.$1,500, respectively, in "advantage." Each HEALTH*pact* enrollee begins in "advantage," with continuing enrollment contingent upon selecting a primary care physician, completing a health risk appraisal, and pledging to participate in disease management, smoking cessation, and weight loss programs if applicable (Figure 1). Those who do not meet these criteria may remain in HEALTH*pact* but are eligible only for "basic."

As of October 2008, average monthly individual premiums for HEALTH*pact* were U.S.$362 and U.S.$372 for United and Blue Cross, respectively (Koller 2008). These rates are 15–20 percent lower than the premiums charged for products with comparable "advantage"-level benefits. Insurers are required to provide employers with 50 or fewer workers the option of offering HEALTH*pact*. Furthermore, if an employer chooses, HEALTH*pact* may be offered alongside other plans. At the insistence of insurers, enrollment was capped at 10,000—5,000 for each carrier. Take up has

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Table 1: HEALTH*pact*: Advantage Versus Basic

	Advantage	*Basic*
Average individual monthly premium*	U.S.$362 (United), U.S.$372 (Blue Cross)	U.S.$362 (United), U.S.$372 (Blue Cross)
Deductible	U.S.$750/U.S.$1,500 (individual/family)	U.S.$5,000/U.S.$10,000 (individual/family)
Co-insurance	10% (United), none (Blue Cross)	20%
Primary care co-pay	U.S.$10	U.S.$30
Specialist co-pay	U.S.$50	U.S.$60
Prescription co-pay (retail)	U.S.$10/U.S.$40/U.S.$75	U.S.$10/U.S.$40/U.S.$75 after U.S.$250/U.S.$500 deductible
Annual out-of-pocket maximum	U.S.$2,000/U.S.$4,000	U.S.$5,000/U.S.$10,000
Lifetime benefit maximum	Unlimited	U.S.$1,000,000 per participant

Sources: Blue Cross Blue Shield of Rhode Island (2009); Koller (2008); United Healthcare (2009).
*October 2008.

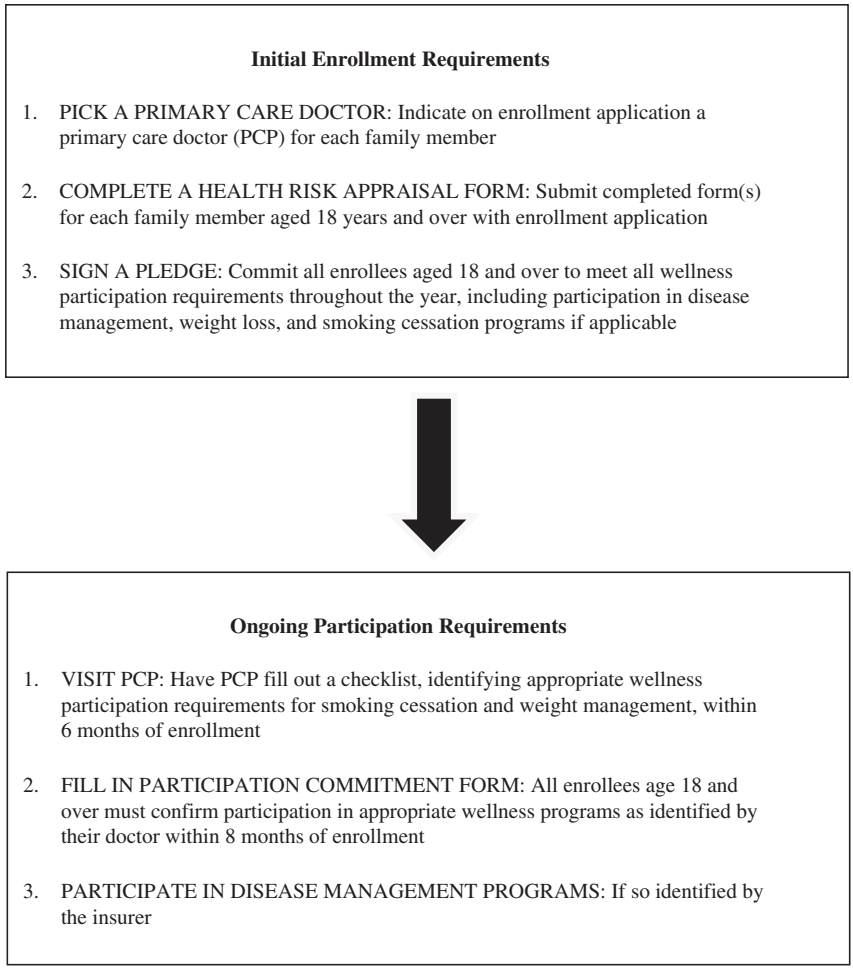
been low (Table 2). Most enrollment (81.0 percent) has taken place in Blue Cross; relatively little (19.0 percent) in United. No United and just 8.3 percent of Blue Cross enrollees are in "basic." This study identifies what design elements inhibited enrollment in HEALTH*pact*.

METHODS

The design of HEALTH*pact* was studied using enrollment data, archival documents, and in-depth open-ended interviews. Data on enrollment were obtained from OHIC. Archival resources derived from material generated by key stakeholders. Interview data were derived from semi-structured interviews with persons knowledgeable about HEALTH*pact* and the small group market. All subjects were asked about HEALTH*pact*, other state-mandated plan designs, and the role of government in this area more generally.

Twenty-three interviews, lasting approximately 60 minutes each, were conducted from November 2008 to May 2009 with 25 individuals. Subjects included 7 state officials, 4 insurance representatives, 7 brokers, 5 small employers, and 2 direct pay customers. All interviews were recorded and transcribed. Transcripts were coded to identify recurring themes and patterns in responses (Miles and Huberman 1994).

Figure 1: Initial and Ongoing Requirements for Advantage-Level Benefits[1]



[1]Adapted from material provided to small business groups by the Office of the Health Insurance Commissioner, Rhode Island.

FINDINGS

There was general agreement that HEALTH*pact*'s design impeded program success. Lack of a subsidy, poor value, and inherent complexity/novelty were all factors believed to contribute to lack of enrollment (Table 3).

Table 2: HEALTH*pact* Participation and Enrollment, January 2009

	United Healthcare	*Blue Cross*	*Total*
Employer groups	49	219	268
Subscribers	121	417	538
Total members	175	746	921
Advantage	175 (100%)	684 (91.7%)	859 (93.3%)
Basic	0 (0%)	62 (9.1%)	62 (7.2%)

Source: Office of the Health Insurance Commissioner, State of Rhode Island.

No Subsidy

Because of prevailing fiscal concerns there was no subsidy associated with HEALTH*pact*. However, most stakeholders felt that a subsidy would have

Table 3: Major Themes Arising from Key Informant Interviews with Illustrative Quotes

Theme 1: Lack of Subsidy

"The value for a subsidy is . . . about getting a foothold in the market for a product that's not palatable to a state that's used to a very rich benefit" (State Official).

"This product as it's designed now . . . really ends up being for businesses that have health insurance, that are already at this lower price point, meaning that's all that they can afford, and they're looking at the option of either increasing their deductibles to U.S.$2,000/U.S.$2,500 . . . or taking the wellness incentives and living with a lower deductible . . . Low wage businesses that have given up . . . you could conceivably bring back in if you had a subsidy—we lost those people" (State Official).

Theme 2: Poor Value

"The customers that we are explaining this plan to are saying, "okay, for a little bit more each month I have 100% coverage after my deductible, I have a lesser drug co-payment. I have a lesser ER. I have a lesser specialist." "What is the benefit?" (Insurance Broker).

"When you really weigh apples and apples of this plan compared to the other plans that carriers offer, I don't think the rate differential is enough to really entice people" (Insurance Broker).

Theme 3: Too Complex and Novel

"The problem with HEALTH*pact* is you've got to understand it . . . 'What am I doing? It's cheaper? Why? What am I losing?' And if I don't really get involved and understand all those things, I'm going to be a little uncomfortable with the change, and most people don't like to change anything" (Employer).

"The people that are unhealthy don't buy it . . . They don't want that burden. It's the healthy people that don't care. 'I'm healthy. I don't have to do any of that crap . . . Nothing to report, nothing to do. Don't smoke. Don't drink. Don't have high blood pressure. Don't have diabetes. [The] healthier groups are more responsive to it" (Insurance Broker).

"There's been a lot of anecdotal discussion about how you don't do everything exactly right, the penalty to you as the subscriber is really significant. So, there are lots of stories about how people don't want to participate because they were afraid" (State Official).

resulted in lower premiums and/or more generous coverage, thereby facilitating take-up. The original legislation authorizing HEALTH*pact* included a reinsurance-based subsidy paid for, in part, through U.S.$5–U.S.$7 million in annual interest payments generated by U.S.$100 million in securitized tobacco settlement payments (Department of Human Services 2007). Though included in the final legislation, the subsidy was left unfunded, since the tobacco money was directed to closing the state's budget deficit instead.

Stakeholders felt that the absence of a subsidy subsequently altered the focus of HEALTH*pact*. Rather than spurring additional take-up, the plan instead targeted firms that were already providing coverage but considering dropping it or adopting a high deductible plan (HDP). Therefore, insurers may have perceived that HEALTH*pact* would siphon existing customers, rather than generating new business. In contrast, a subsidy could have generated new volume and therefore piqued the interest of carriers to promote and sell HEALTH*pact*.

Poor Value

It was generally agreed that HEALTH*pact* was successfully positioned as the cheapest product in the small group market. Yet most respondents reported that HEALTH*pact* still did not represent good value. RI employers traditionally offer comprehensive coverage. Therefore, many small businesses feel that they must offer comparatively rich benefits to recruit employees. As such, the possibility of their employees incurring a large "basic" deductible and coinsurance inhibited take-up. Furthermore, employers tend to change coverage incrementally, which reduced the likelihood of transitioning from a comparatively rich benefit to an HDP.

Virtually all interviewees believed that HEALTH*pact* was not as attractive as other HDPs. For a slightly higher premium, employers could enroll employees in traditional HDPs with benefit levels similar to HEALTH*pact* "advantage" but without the burden of reporting a health assessment, participating in disease management, or the risk of facing a U.S.$10,000 deductible. The ability to offer a comparable plan, however, varies across the state's two carriers. United has considerably more plans competing in the same product space, making HEALTH*pact* seem less attractive by comparison, which may explain why more HEALTH*pact* subscribers were enrolled with Blue Cross than United. Clearly, given the perceived burdensomeness of HEALTH*pact*'s requirements, it should not be surprising that employers

tended to opt for less onerous products, all else being equal, absent even greater discounts provided by a subsidy.

Too Complex and Novel

Although some small employees supported the authorizing legislation, understood the product, and offered it to their employees, stakeholders generally felt that HEALTH*pact* was too complex and too unlike other products for brokers and insurers to explain to the majority of small business owners with insufficient expertise to make coverage decisions. They also felt that it was too complex for most small business owners to explain to their employees, particularly the requirements necessary for maintaining "advantage" coverage. Small employers typically lack human resource personnel. Consequently, few have the time or willingness to understand, let alone adopt and implement, "paradigm-altering" plans such as HEALTH*pact*. Most businesses would rather stick with what they know if they can afford it.

Incorporating wellness into health benefit plan design received general support. Still, most stakeholders believed that the particular incentives incorporated into HEALTH*pact* were poorly conceived. Employers were worried about not being able to assist workers in complying with the plan's requirements and about who would see the information collected. Brokers further raised the specter of HIPAA, which precluded them from reviewing completed health assessment forms and preventing subscribers being assigned "basic" because their forms were filled out incorrectly.

It was theorized that HEALTH*pact*'s incentives would be more likely to appeal to healthier employees since such individuals would not view a high deductible as a risk for them nor need to engage in the wellness behaviors required. Furthermore, it was felt that the difference in deductibles between "advantage" and "basic" was too stark to attract those who would benefit the most from wellness. The reality, though, is that only 7.2 percent of HEALTH*pact* enrollees were in "basic" due to failure to meet plan requirements. Two major explanations were proposed. First, enrollees can simply select another option if HEALTH*pact* is offered alongside another plan. Second, both regulators and carriers/brokers initially sought to prevent transfers to "basic." During the plan's first year state officials encouraged insurers to more aggressively communicate plan requirements given that some noncompliance stemmed from enrollees simply not knowing what to do. Brokers too sought to prevent transfers to maintain goodwill with clients.

Some stakeholders suggested reducing the gap between the two benefit levels or adopting alternative, less penalizing approaches; for example, requiring employees to contribute 10 to 15 percent more to their premiums if they do not follow the rules. Still others suggested that the carrot would work much better than the stick; for example, instituting a deductible credit rather than penalty, say, by reducing a U.S.$2,000 deductible to U.S.$500 if appropriate wellness behaviors become engaged. Others suggested a refund on premiums paid; for example, a check equal to 10 percent of their annual premium if, at the end of the year, enrollees comply with certain behaviors.

DISCUSSION

Results highlight the challenges of expanding coverage without subsidies or other premium support. Thus, it is critical that the Patient Protection and Affordable Care Act (PPACA. P.L. 111–148) includes up to 6 years of tax credits for small, low-wage businesses beginning retroactively January 2010. The full credit, covering 35 percent of employer's premium contribution is available to companies who pay at least half of their employee's premiums and have 10 or fewer full-time equivalent (FTE) employees and average wages of U.S.$25,000 annually. This will increase to 50.0 percent by 2014, after which companies may qualify for 2 additional years. Tax credits phase out for employers with between 10 and 25 FTEs and average wages between U.S.$25,000 and U.S.$50,000. Beginning in 2014 subsidies also will be made available to individuals and families earning between 133 and 400 percent of the federal poverty level purchasing coverage through state-sponsored insurance exchanges. Lack of enrollment in HEALTH*pact* illustrates just how important subsidies such as these can be for increasing take-up.

Previous experience indicates that as with the PPACA subsidies need to be large to spur take-up among small employers (Long and Marquis 2001; Silow-Carroll, Waldman, and Meyer 2001). It also suggests that as with the PPACA subsidies need to be directed toward firms with low-wage workforces to better "maximize the 'bang for the subsidy buck'" (Neuschler and Curtis 2003). Perhaps the potential of a subsidy to drive enrollment is best reflected in *Healthy New York*, which requires all HMOs to offer a state-mandated benefits package to uninsured individuals, sole proprietors, and small business employers who had gone at least 12 months without coverage, subsidized through a state-sponsored reinsurance mechanism. More than 150,000 individuals were enrolled during November 2008; more than half a million people since

2001 (Navigant Consulting 2009). Small business employees constitute one-third of *Healthy New York* enrollees (33 percent); individuals a little more than half (52 percent); sole proprietors 15 percent. Growth has been driven largely by premium discounts of approximately 40.0 percent (Swartz 2005), far higher than the HEALTH*pact*'s 15–20 percent but in the range provided by the PPACA for small businesses.

The PPACA includes grants, technical assistance, and other resources to facilitate the implementation and evaluation of workplace wellness. Beginning in 2014 the PPACA also increases the level of discounts employers are allowed to offer workers who engage in certain behaviors or achieve specific goals from 20.0 to 30.0 percent of premiums, co-payments, or deductibles, although alternative standards must be made available to those who cannot reasonably be expected to meet the standards laid out. Companies may also petition the government to offer discounts as high as 50.0 percent. Together these provisions may stimulate additional interest in wellness by small employers, particularly since evidence supports the efficacy of such programs for motivating behavioral changes, reducing medical costs, and increasing productivity (Volpp et al. 2008; Baiker, Cutler, and Song 2010).

Further evidence is needed regarding the types of incentives that work best, both for achieving desired outcomes and for encouraging the use of such programs in the first place. Relatively few small businesses implement workplace wellness programs, let alone connect insurance plan design to lifestyle behaviors and outcomes (Kaiser Family Foundation/HRET 2009; McPeck, Ryan, and Chapman 2009). The absence of benefits specialists makes it difficult for small firms to navigate the complex web of federal and state laws governing this area (Mello and Rosenthal 2008). Being small also increases the opportunity costs of offering these programs. Since there is only so much time and expertise available, small employers may be reluctant to adopt such programs or must rely on outside experts if they do.

In general, results imply that there is a careful balance between being innovative in encouraging wellness and developing insurance products designed to appeal to the small group market. Keeping similarly priced plans in mind during the plan development process could make a difference in promoting take-up. Because small employers were willing to trade a small increase in costs to avoid a large increase in perceived burden, lack of enrollment in HEALTH*pact*, especially in the case of United, derived, in part, from the availability of closely priced high deductible alternatives without wellness incentives. This highlights the need for states to evaluate the relative attractiveness of new offerings when seeking to promulgate novel plan designs

intended to compete with already established products. Simplification of HEALTH*pact*'s wellness incentives could increase employer acceptance as well, in addition, perhaps, to relying more on carrots (premiums discounts, deductible credits) than sticks (higher copayments and deductibles). No matter the approach, however, most small employers would still need to rely, in part, on input from brokers, insurers, and the state when learning about and choosing a plan (Garnick, Swartz, and Skwara 1998; Marquis and Long 2000; Silow-Carroll, Waldman, and Meyer 2001; Kingsdale 2009; Napel et al. 2009). Changes to the state's insurance code, allowing for discounts of up to 10 percent if workers commit to healthy lifestyle behaviors, enabled Blue Cross Blue Shield of Michigan (2009) to market *Healthy Blue Living*, a split benefit plan design similar to HEALTH*pact*, that now serves more than 100,000 members and 800 large and small employers. It is likely that active insurer involvement accounts for a large part of the plan's relative success.

The need to limit program complexity is a particularly important lesson for national health reform more generally. Indeed, this imperative, along with reductions in price, is one of the major reasons why, beginning in 2014, the PPACA will establish state-administered health insurance exchanges to facilitate the purchase of coverage by individuals and small businesses with up to 100 employees. If the level of effort required to purchase coverage through the exchanges nonetheless remains too great, however, small employers may elect not to offer coverage and instead have their workers shop for coverage on their own. Thus, the degree of complexity will serve, in part, to determine whether small employers eschew coverage and, in the case of larger firms, opt to pay a per employee penalty that rises from U.S.$824 to U.S.$1,400 among firms with 51–100 workers (Gravelle 2010).

CONCLUSION

Up until passage of the PPACA federal intervention in the small group market had been limited, consisting primarily of HIPAA reforms affecting preexisting condition exclusions, issue, and renewal. Thus, it had been left to state governments to take the lead in reforming the small group market. HEALTH*pact* represents a unique strategy to tackling small group health insurance reform at the state level, which has generally been dominated by rate-setting restrictions, guaranteed issue and renewal, and small group purchasing cooperatives (Napel et al. 2009). Identifying impediments to HEALTH*pact*'s success, therefore, should inform implementation of small

group reform more generally—that is, lessons learned regarding the role of subsidies, complexity, and incentives for wellness in a revised market.

ACKNOWLEDGMENTS

Joint Acknowledgment/Disclosure Statement: Funding for this study was provided by the Robert Wood Johnson Foundation (grant #64214). The authors would like to acknowledge Hailee Dunn for excellent administrative support, Melissa Clark for reviewing the interview protocol, and Katherine Swartz for providing expertise and advice. There are no conflicts of interest and disclosures to report.

Disclosures: None.

Disclaimers: None.

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