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Small-Group Health Insurance Reform in the States: Lessons from Rhode Island's HEALTHpact Plan

– *Edward Alan Miller, Ph.D., M.P.A.,* Amal Trivedi, M.D.,^ Sylvia Kuo, Ph.D.,^ Katherine Swartz, Ph.D.,† Vincent Mor, Ph.D.^*

**Department of Gerontology and Gerontology Institute, John W. McCormack Graduate School of Policy Studies, University of Massachusetts Boston*

^Department of Community Health, Brown University

†Department of Health Policy and Management, Harvard School of Public Health

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EXECUTIVE SUMMARY

This study analyzes why HEALTH*pact* (HP), a category of health plan made available to small Rhode Island (RI) employers since October 2007, has failed to meet expectations—for example, enrolling less than 10 percent of its 10,000 member enrollment cap as of January 2009.

HEALTH*pact* provides high-deductible health insurance with premiums capped at 10% of the average RI wage. To create these plans, the state convened a stakeholder panel to develop guidelines for insurers, who, in turn, were required to develop products satisfying those guidelines. The result is two levels of HEALTH*pact* benefits—"advantage" and "basic." The premiums for both levels are the same, but "basic" plan members are subject to substantially higher cost-sharing. All enrollees begin with "advantage" level benefits; however, to maintain these benefit levels, enrollees must engage in pre-specified wellness behaviors in the way of disease management, smoking cessation, and weight-loss programs, as applicable.

For this study, twenty-three semi-structured interviews were conducted with persons who had experience with HEALTH*pact* and the small-group health insurance market of Rhode Island. Interviewees were chosen through a combination of purposive and snowball sampling. Transcripts were coded to identify recurring themes and patterns in responses. Enrollment data and archival documents were examined as well.

Interview subjects identified several factors that contributed to low HEALTH*pact* enrollment. First, although HEALTH*pact* was priced somewhat lower than other plans for small businesses, it did not offer a good value for most firms. Additionally, the wellness incentives incorporated into HEALTH*pact* were poorly designed, being too novel and complex to appeal to the small-group market. Further, since few funds were allocated for government outreach and oversight, there was little opportunity to stimulate "bottom up" demand from employers and to ensure faithful implementation on the part of insurers and brokers. Finally, seeing the success of HEALTH*pact* as working against their interests, insurers adopted strategies that restrained enrollment, and brokers generally chose not to recommend the product, believing it did not suit their clients' needs.

The findings of this study indicate that future iterations of small-group reform should consider: (1) instituting a subsidy or other premium support program; (2) prioritizing broker and insurance company buy-in; (3) providing the resources necessary for effective government oversight and outreach; and (4) carefully designing wellness incentives, (although doing so may still not be sufficient to promote take-up given the impediments posed by the other challenges enumerated).

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INTRODUCTION

Employer-based health insurance coverage in the U.S. has eroded substantially in recent years, particularly in the small-group market. Small businesses and their employees have been hit hard because small-group purchasers are especially vulnerable to rising health insurance costs: First, small groups do not offer the advantage of pooling risk over a large population. Second, they have less purchasing power to negotiate favorable rates with health insurers. Finally, small firms experience proportionately higher costs in setting up and administering a health insurance plan than do larger firms (Abraham, DeLeire, and Royalty 2009). These market imperfections have led some state governments to take an active role in the small-group market, where they have, for example, adopted rate-setting restrictions, established guaranteed issue, initiated premium assistance programs, and created state-sponsored insurance pools (Napel, et al. 2009; National Conference of State Legislatures 2009).

Between 1999 and 2009, premiums paid by small- to medium-sized employers (3 to 199 workers) increased by 123%; at the same time, the proportion offering coverage declined from 65% to 59% (Kaiser Family Foundation/Health Research and Educational Trust 2009). Among very small firms (3 to 9 employees), just 46% now offer coverage, compared to 56% ten years earlier. Furthermore, it has been estimated that more than half of workers in firms with 50 or fewer employees were uninsured or underinsured in 2007 as compared to just over one-quarter in larger firms (Doty et al. 2009). Clearly, there is a need to develop further innovative solutions to making affordable coverage available to small employers. This study evaluates one such innovation—Rhode Island's *HEALTHpact* plan.

RHODE ISLAND'S *HEALTHpact* PLAN

Erosion in small-group coverage has been especially acute in Rhode Island, where 94.0% of employers are firms with 50 or fewer employees, employing 35.0% of the state's workforce (Office of the Governor 2005). Overall, the average commercial premium in the state more than doubled between 1997 and 2008, to \$4,930 and \$13,363, respectively, for single and family coverage (Kaiser Family Foundation 2009b; Office of the Health Insurance Commissioner 2007). Although the offer rate among large Rhode Island employers (>50 workers) has

remained steady at 98%, it declined from 70% to 53% among smaller employers between 1997 and 2008. Largely driven by deterioration in employer-based coverage, the percentage of uninsured Rhode Islanders has increased, doubling from 6.9% in 2000 to 12.8% in 2008.

Loss of health coverage in Rhode Island may have been exacerbated by a lack of insurer competition (Allen and Laliberte 2006; Department of Human Services 2007). Prior to 2009, only two health insurance carriers—United Healthcare of New England and Blue Cross Blue Shield of Rhode Island—served the Rhode Island market. However, Tufts Health Plan reentered the market in 2009 after a ten year absence.

In response to high annual premium increases, combined with declining coverage offers and growing numbers of uninsured, the state authorized *HEALTHpact*, a unique type of wellness benefit plan made available to firms with 50 or fewer employees. The goal in establishing *HEALTHpact* was to design an affordable alternative for small businesses that were not offering coverage or that were considering dropping coverage.

HEALTHpact grew out of the agenda of Rhode Island Governor Donald L. Carcieri, who wanted to increase the affordability of health insurance to small businesses and who wanted to do this, in part, through the development of insurance plans that incorporate incentives for wellness and prevention. Developed with the aid of a Health Resources and Services Administration (HRSA) planning grant (Department of Human Services 2007), legislation authorizing *HEALTHpact* was passed by the Rhode Island General Assembly during the summer of 2006. This legislation capped the price of the premium at 10.0% of the average annual Rhode Island wage. It also laid out several "affordability principles" that emphasized the use of primary care prevention and wellness; the lowest-cost, most effective provider settings; evidence-based medicine; and chronic disease management. The legislation authorized the Office of the Health Insurance Commissioner (OHIC) to convene an advisory panel to develop guidelines for insurers, who, in turn, were required to develop products satisfying those guidelines. The OHIC was also granted the authority to approve, disapprove, or modify the rates, administrative practices, and other plan features proposed by the carriers. The purpose in

vesting this unique authority with the OHIC was to grant the small-group market the same negotiating leverage available to large employers.

During the fall of 2006, the OHIC convened the advisory panel mandated in statute. This panel, called the Wellness Advisory Committee (WAC), included 16 members representative of small employers, local chambers of commerce, insurance brokers, and direct-pay consumers. Rhode Island's two major insurers were also present for the WAC's deliberations but did not have voting privileges.

Committee meetings were facilitated by the OHIC and a Boston-based consulting firm. Consistent with the legislation, the goal of the WAC was to develop general requirements for a plan design with a maximum yearly cost of 10% of the average annual Rhode Island wage and with appropriate incentives for wellness. Resulting recommendations were included in a request for proposal (RFP) issued to insurers. Specific rates and benefit components, which were negotiated with each carrier, were approved by the Insurance Commissioner.

HEALTHpact was designed, negotiated, and open for enrollment by October 2007. At United, the *HEALTHpact* option is known as the Pledge Plan; at Blue Cross, Blue-CHIP for Healthy Options. Upon entering the market in 2009, Tufts Health Plan was also required to develop a plan for *HEALTHpact*, but its product has yet to be marketed.

HEALTHpact creates incentives for healthy behaviors by offering two products with different levels of coverage: "advantage" and "basic" (Table 1). The premiums for "advantage" and "basic" are the same, as are covered services. However, "basic" plan members are subject to a deductible of \$5,000 for an individual and \$10,000 for a family, while "advantage"-level beneficiaries face deductibles of only \$750 for an individual and \$1,500 for a family. Each enrollee in *HEALTHpact* begins at the "advantage" level, with enrollment being contingent upon three wellness tasks: (1) selecting a primary care physician, (2) completing a health risk appraisal, and (3) pledging to participate in disease management, smoking cessation, and/or weight loss programs if the enrollee has a chronic disease, uses tobacco, and/or is overweight (Figure 1). Subsequently, enrollees who do not visit their doctor or affirm participation in appropriate wellness and disease management programs may remain in *HEALTHpact*, but they are eligible only for "basic"-level benefits. Thus, *HEALTHpact* trades more ge-

nerous coverage for adopting pre-specified behaviors believed to promote wellness.

As of October 2008, average monthly individual premiums for *HEALTHpact* were \$362 and \$372 for United and Blue Cross, respectively (Koller 2008). These rates are 15% to 20% lower than the premiums charged for other products with comparable "advantage"-level benefits. Rhode Island applies modified community rating to the small-group market. Consequently, actual premiums paid by employers depend on the age, gender, family size, and health status distribution of each group, though the highest rates charged can be no more than four times the lowest.

As a condition of doing business, insurers are required to provide small employers with 50 or fewer workers the option of offering *HEALTHpact*. Furthermore, if an employer chooses, *HEALTHpact*, which is distributed through the state's health insurance brokers, may be offered alongside other plans. At the insistence of insurers, overall enrollment in *HEALTHpact* was capped at 10,000—5,000 for United and 5,000 for Blue Cross. So far, however, take-up has been extremely low, with only 268 employer groups and 538 subscribers participating, for a total of 921 enrollees as of January 2009 (Table 2). Most enrollment (81.0%) has taken place in the Blue Cross plan, with relatively little (19.0%) occurring in the United option. Moreover, there are no United enrollees participating in "basic" coverage, and just 8.3% of Blue Cross enrollees are at the "basic" level.

Given such limited take-up in *HEALTHpact*, the principal objective of this report is to explain why enrollment in *HEALTHpact* has failed to meet expectations, with the aim of drawing on this experience to formulate lessons for future intervention in the small-group market, both in Rhode Island and in other states. A qualitative, case-study methodology drawing on multiple data sources was used to create a cohesive picture documenting what factors in *HEALTHpact*'s development and administration inhibited greater enrollment in the plan.

METHODS

This case study analyzed the design and implementation of *HEALTHpact* using enrollment data, archival documents, and in-depth open-ended interviews with key stakeholders.

Data on *HEALTHpact* enrollment were provided by OHIC. Archival resources were derived from material generated by OHIC, as well as by the Governor's Office, the General Assembly, United, Blue Cross, the WAC, and

various brokers. These documents included press releases, policy statements, benefits descriptions, statutory provisions, and regulatory directives.

Semi-structured interviews were undertaken with people chosen through a combination of purposive and snowball sampling (Patton 2002). With purposive sampling, prospective respondents are chosen for specific purposes and for specific representation. Snowball sampling first identifies respondents who meet the criteria for inclusion and then asks them to recommend others they know who also meet the criteria; these in turn recommend others, and so on. Thus, using a combined purposive-snowball approach, selection of respondents was initially based on our own knowledge regarding the individuals who could best inform our study. Later, however, we based more of our choices on information provided by our respondents in terms of those additional individuals who might prove appropriate for inclusion.

In general, we sought to conduct interviews with individuals with known or demonstrable experience with *HEALTHpact* and the small-group health insurance market of Rhode Island. Five open-ended interview protocols were developed—one each for employers, health insurance brokers, insurance company representatives, state officials, and WAC participants. This ensured that all subjects were asked the same questions and given the opportunity to comment on the same areas while, at the same time, the interviews were oriented toward each subject's respective strength as an informant. All subjects were asked about the passage, design, and implementation of *HEALTHpact*; other state-mandated plan designs; and the role of government in the small-group health insurance market more generally.

Twenty-three interviews, lasting approximately one hour each, were conducted from November 2008 to May 2009 with 25 individuals. Subjects included 7 state officials, 4 insurance company representatives, 7 insurance brokers, 5 small employers, and 2 direct-pay customers. All of the small employer interviewees and direct-pay subscribers, as well as two of the brokers, also served on the WAC. All interviews were recorded and transcribed. Transcripts were subsequently coded to identify recurring themes and patterns in responses (Miles and Huberman 1994). This was an emergent process to the extent that we formulated new categories and revised old ones as we read through the transcripts. Once a full set of codes were developed, we went back and recoded all transcripts using the common set of themes that we developed. Quotes illustrative of each theme were excerpted.

FINDINGS

The interviews highlighted three major explanations underlying the prevailing lack of enrollment in *HEALTHpact*: (1) *HEALTHpact* was poorly designed; (2) neither insurers nor brokers viewed *HEALTHpact* as consistent with their interests; and (3) OHIC lacked the resources necessary to effectively conduct program education and oversight.

HEALTHpact Was Poorly Designed

There was general agreement that aspects of *HEALTHpact's* design posed impediments to program success. Lack of a subsidy, poor value, and the complexity and novelty of the plan structure were all factors believed to contribute to lack of enrollment in the plan.

No Subsidy

A number of respondents stated that inclusion of a subsidy would have increased the value of *HEALTHpact*. The widely held view among interviewees was that a subsidy would have resulted in lower premiums and/or more generous coverage, thereby facilitating take-up. As one knowledgeable observer said: "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."

The original legislation authorizing *HEALTHpact* did include a reinsurance-based subsidy program. The subsidy would have been paid for, in part, through \$5 to \$7 million in annual interest payments generated by a trust fund consisting of \$100 million in securitized tobacco settlement payments (Department of Human Services 2007). It was estimated that this trust fund, together with annual fees on surplus health plan administration and profits, would have resulted in additional discounts of 10% for up to 23,000 low-wage Rhode Islanders. However, while the subsidy program was authorized by the final legislation, it was left unfunded, with the tobacco settlement money being directed toward closing the state's budget deficit instead.

The absence of a subsidy has subsequently defined the focus of *HEALTHpact*. One state official noted, "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 \$2,000/\$2,500 ...or taking the wellness incentives and living with a lower deducti-

ble...Low wage businesses that have given up...you could conceivably bring back in if you had a subsidy—we lost those people.” Thus, rather than promoting additional take-up, *HEALTHpact* ended up being targeted toward firms that were already providing coverage but considering dropping it or adopting a high-deductible plan (though even among these firms, *HEALTHpact*'s reach may be limited without a subsidy, particularly for low-wage workers who may still not be able to afford their share of the premium). Indeed, it may only be through the potential new volume generated by a subsidy that the interest of carriers may be sufficiently piqued to promote and sell a state-mandated health insurance product such as *HEALTHpact*. Otherwise, the perception among insurers is that the program is siphoning enrollees from their existing customer base and not generating new business.

Poor Value

There was general agreement among those interviewed that *HEALTHpact* was successful in positioning itself as the cheapest product in the small-group market, as was intended. Consequently, some firms offered *HEALTHpact* simply because it represented the lowest price point in the market, not because it also was designed to promote employee wellness. “Some of the employers look at it for the price only,” explained one broker. “They haven't really looked at it as, ‘Wow, this is a great plan to keep my subscribers healthy.’”

Despite its price tag, key stakeholders generally believed that *HEALTHpact* did not represent a good value for most firms and that this is why most small businesses never offered their employees the option to enroll. Like other New England states, the small-group market in RI has a long tradition of offering comprehensive coverage, so small businesses often feel that they must offer plans with comparatively rich benefits in order to remain competitive in the market for employees. As such, the possibility that workers might end up with inflated “basic” deductible and co-insurance levels proved to be a barrier to take-up. Even the “advantage”-level co-pay and co-insurance requirements were seen as a deterrent, as they exceeded those available in other comparable plans. One broker commented, “The customers that we are explaining...[*HEALTHpact*] to are saying, ‘Okay, for a little bit more each month [on a different plan], 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?’”

One knowledgeable observer explained that “because

[the legislation] dictated a price [10% of the average RI wage]...[it] really forced a benefit design that is leaner than what the market wants.” This may be particularly true, since few small employers are actually at the point of choosing between dropping coverage and offering a high-deductible plan: “Most, given these two choices, take a third choice, which is to pay more for richer products,” noted one respondent. Furthermore, to the extent that employers change coverage, they tend to do so incrementally. To expect them to move from a comparatively rich benefit to a high-deductible product such as *HEALTHpact* is unlikely.

Even when compared to other, similar products, *HEALTHpact* lacks appeal. Virtually all respondents believed that *HEALTHpact* is less attractive than other high deductible plans. “When you really weigh apples and apples,” observed one stakeholder, “...of this plan compared to the other plans that carriers offer, I don't think the rate differential is enough to really entice people.” For example, for a slightly higher premium, employers could enroll employees in traditional high-deductible plans with deductibles and benefit levels similar to *HEALTHpact* “advantage” but without the burden of reporting a health assessment, participating in disease management programs, or facing the risk of a \$10,000 deductible. This scenario is reflected in the comments of one broker, who explained that “sometimes [there will be a] \$100 difference in the family rate for the *HEALTHpact* plan versus a \$1,000 deductible plan....Groups looking at it say, ‘You know what? I know exactly what my deductible is going to be. I don't have to do all that additional paperwork’...[They are] willing to pay a little extra not to have to do the work.”

The ability to offer a comparable plan differs for the state's two insurance carriers. United offers substantially more plans with high deductibles than does Blue Cross. As a consequence, United has considerably more plans competing in the same product space, making *HEALTHpact* seem less attractive by comparison. That *HEALTHpact* represented a better price point for Blue Cross than for United may explain, in part, why more *HEALTHpact* subscribers were enrolled with Blue Cross.

Some stakeholders felt that *HEALTHpact* could have been made even more affordable, independent of prevailing cost-sharing requirements, had the Wellness Advisory Committee been allowed to exclude one or more of the health insurance mandates required by the State. “If there was any criticism about...[*HEALTHpact*'s authorizing] legislation...it would have been the...different mandates that are required by the State of Rhode Isl-

and,” one Committee member explained. “The legislation did not allow us to say, ‘Alright, you know what? Maybe...we’re going to exempt [infertility treatments] from this program...Don’t constrain us like that.’ Thus, to reach the price point mandated, the Committee did not have the ability to exclude or choose among mandated benefits such as infertility treatments, maternity care, chiropractic services, and mental health care. It is unclear, however, whether the ability to work with the mandates would have made much of a difference in plan costs. One knowledgeable observer reported that health insurance mandates in Rhode Island account for about 9% of the average premium, with mental health and fertility services constituting the bulk of those costs. Another reported that insurers were not bringing any lower-cost products to market free of mandated benefits as authorized by other legislation. “The insurers will tell you,” this observer explained, “...‘We can’t sell a product that doesn’t have all those benefits in it, because people don’t buy it.’” In a benefits-rich state like Rhode Island, a lot of benefits that people think are basic health coverage services are actually mandates. Excluding them, though potentially beneficial for the bottom line, may further impede take-up. “If this is about getting people in the game,” one respondent pointed out, “you wouldn’t want to walk in there and say, ‘We’ve left out whole categories of coverage there in the marketplace’...It had to be as similar as possible to other benefit plans in terms of the types and breadth of coverage available.”

Too Complex and Novel

Stakeholders generally felt that HEALTH*pact* was too complex and too unlike other insurance products for brokers and insurers to explain to small business owners with insufficient expertise to make health insurance coverage decisions. The stakeholders also felt that it was too complex for small business owners to explain to their employees, especially with respect to the requirements necessary for maintaining “advantage” versus “basic” coverage. Small employers typically lack human resource personnel. Consequently, few have the time or wherewithal to understand, let alone adopt and implement “paradigm-altering” health plans such as HEALTH*pact*. “The problem with HEALTH*pact*,” explained one employer “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.” This is particularly true since, according to one respondent, employer-based purchasing tends to bias decisions toward the “lowest common denominator.” Employers

who are less willing to accept the tradeoffs in HEALTH*pact* may select plans that result in the least amount of hassle and pushback from employees as possible. In contrast, some workers might independently be willing to accept the tradeoffs involved in HEALTH*pact*. The consequence is inertia, where most businesses would rather stick with what they know if they can afford it rather than adopt something perceived as unusual or different.

Incorporating wellness into health benefit plan design received general support from the key stakeholders interviewed. The goal, according to one WAC member, is to “let people see that they’re putting skin in the game—that their health behaviors matter when it comes to cost and that they have a role and a responsibility in that number.” Most stakeholders, however, believed that the particular incentives incorporated into HEALTH*pact* were poorly conceived. The initial health assessment questionnaire proved too long and daunting, incorporating questions that seemed intrusive to employees and their employers. Employers were worried about not being able to assist workers in keeping up with the plan’s requirements. Employees were worried about who would see the information collected, describing, for example, “profound suspicion in providing their personal health information to an insurer that is underwriting them.” They also were worried that they might not be able to find a primary care provider, and even if they did, that they might be unable to obtain an appointment in the timeframe necessary to avoid being penalized: “Is that my fault that my doctor can’t fit me in within 8 months? Why should I get penalized for not being able to meet that criteria?” On top of this, brokers raised the specter of the Health Insurance Portability and Accountability Act (HIPAA), which precluded them from reviewing completed health assessment forms, thereby making it difficult to ensure that subscribers did not end up in “basic” because their forms were filled out incorrectly.

Given these concerns, stakeholders were skeptical that the wellness behaviors incentivized by HEALTH*pact* would reduce health care costs or improve health outcomes. They believed that it was not only “too much work for people” to fill out the necessary forms, but that it was a challenge making sure that workers were aware of the need to fulfill those requirements in the first place. Stakeholders also theorized that HEALTH*pact*’s incentives would be more likely to appeal to healthier employees who would not view a high deductible as a significant risk or be required to engage in smoking cessation, weight loss, and disease management. Explained one broker: “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." Several stakeholders also believed that the difference in deductibles between "advantage" and "basic" was too stark to attract those who would benefit the most from wellness. "There's been a lot of anecdotal discussion," explained one state official, "about how [if] you don't do everything exactly right, the penalty to you as the subscriber is really significant...there are lots of stories about how people don't want to participate because they were afraid."

Despite prevailing fears, only 7.2% of HEALTH*pact*'s 921 enrollees were in "basic" due to failure to meet the plan's wellness requirements. Two major explanations for the low transfer rate from "advantage" to "basic" were proposed by the people we interviewed. First, enrollees can simply select another option if HEALTH*pact* is offered alongside another plan. In the experience of one broker: "If you get that card, and you have a \$10,000 deductible, you're going to get off that plan, and you're going to go back to a fully-insured plan. Clients have said, 'Well, we'll do this for a year, and then we'll see what happens. We can always go back to the other thing'....There's no longevity in the plan. There is for healthy people, but if the goal is to change behavior, I don't think it's happening." Second, both regulators and carriers/brokers sought to prevent transfers from "advantage" to "basic," at least initially. This was particularly true during the first year when, in light of growing awareness that some non-compliance stemmed from enrollees simply not knowing what they had to do, insurers were encouraged by state officials to more aggressively communicate plan requirements. Indeed, both United and Blue Cross reported making extra efforts at renewal time to ensure that the correct forms had been filled out. One insurance company representative explained that, prior to transfer to the "basic" plan, "We make three or four phone calls...We call the broker. We call the group, the employer. We even have a letter that we'll send out certified mail: 'This is your last chance.'" Brokers, too, sought to prevent large numbers of transfers. This was driven by the need to maintain reasonable levels of goodwill with their clients, something which might be difficult to achieve should high proportions of their employees end up in "basic."

In light of perceived challenges such as these, some stakeholders suggested reducing the gap between the two benefit levels or adopting an alternative, less penalizing approach to promoting wellness; for example, em-

ployees could be required to contribute 10% to 15% more to their premiums if they do not follow the rules. Still others suggested that the carrot would work better than the stick in promoting compliance. Rather than "getting hit with this other plan if you don't do certain things," enrollees could receive a deductible credit for completing the wellness tasks. For example, reducing a \$2,000 deductible to \$500 might more effectively motivate wellness behaviors. "That's much more of an incentive for me," explained one stakeholder, "because it's money in my pocket, as opposed to, 'I'm really going to get the crap whacked out of me if one of us goes in the hospital.'" The deductible credit approach is also more nimble, allowing the accrual of credits during the course of the year, rather than waiting until the end of the enrollment period to determine whether requirements were met and the enrollee will be transferred to "basic" or not. Instead of offering reductions in plan deductibles, others suggested a refund on premiums paid. This approach is perhaps best illustrated by the wellness benefit plan Blue Cross was required to develop and implement for its direct-pay subscribers, a provision that did not apply to United since it does not service Rhode Island's individual market. If an individual is enrolled in a high-deductible plan at Blue Cross, he or she may elect to enroll in Blue Cross' wellness rewards program. Rather than providing substantially richer benefits to members who are compliant with the plan's requirements, participants receive a check equal to 10% of their annual premium at the end of the year if they comply with wellness behaviors.

Limited Insurer and Broker Enthusiasm

Insurers and brokers did not view the success of HEALTH*pact* as consonant with their interests. This is both with respect to product development, where insurers chafed at limitations imposed by OHIC and the original legislation, as well as during implementation, where both insurers and brokers took steps to deter enrollment.

Product Design Phase

The purpose in convening the WAC, rather than defining HEALTH*pact* in statute or regulation, was to ensure that whatever product emerged would be something "that would actually sell in the small-group market and that businesses would actually buy." A number of stakeholders felt this process represented an improvement over other state-mandated benefit design efforts which, because they tend to be more prescriptive, provide plan designers with few, if any, opportunities to cater to the particular needs of the marketplace in question. Indeed,

most members believed that the “committee came together” and “worked well”; the openness of the Committee’s deliberation and the inclusion of multiple stakeholder groups were typically highlighted. There was disagreement, however, regarding the quality of the product that emerged. Some were quite pleased with the results, noting that the “[Committee members] were really excited about what they had... that they had something genuinely unique that got at some of the underlying issues.” Others were disappointed, reporting, for example, that “people didn’t like the [benefit] but it became a situation of ‘we’re at the point [where] we have to turn it over and here’s what we have.’”

Most committee members reported receiving “cost analyses and feedback from the health insurance carriers,” obtaining “their input to say where they thought [it] was going to be a real stickler, or where this could be something that they could work with...to get a sense of what...could get through.” This included using industry actuaries to provide feedback about what benefits and deductible levels could be obtained for a given premium price. But while insurers appreciated being included in the product design phase, they complained that they had limited influence since they were not “voting members” of the committee. Of particular concern was how a committee without much experience in benefit design could develop a plan that met the price point set out by the legislature. “As a company,” recalled one industry representative, “we were concerned about the process, concerned about a committee that frankly had limited knowledge of designing benefit plans, putting together a product...that...from the benefit side may not necessarily...plop down and meet 10 percent of the average annual wage.” “If you’re going to put the rate in the statute,” said another, “then let us design the benefit plan. Just give us the ability to do what we do as a company and a business...give us a little bit more flexibility in doing that.” While the insurers were confident that providing them with greater flexibility would be more likely to result in a plan that met the price point authorized in statute, they doubted that having a premium capped at 10% of the average wage would be sustainable over the long term absent future benefit design changes. Since wage growth has traditionally lagged far behind the growth in medical costs, insurers speculated the proposed premium caps would not be easily maintainable. The authority of the OHIC to set rates made carriers especially uncomfortable because, “it creates the opportunity that the Commissioner could just say, ‘Hey, the rates are the rates, like it or not.’”

Interviewees who were not connected to insurers inter-

preted committee activities differently. The feeling was that, despite whatever useful information and analysis the carriers provided, they were brought in “kicking and screaming” and “never really embraced the process.” Indeed, it was felt that the two carriers “didn’t bring as much to the table as they could have” to get to the price point mandated by the General Assembly or to attract as much enrollment as possible.

A key component of the HEALTH*pact* legislation was that there would be a reduction in cost in exchange for commitments to health and wellness. During its deliberations, the WAC considered how best to engage employees in this respect. Reported one observer: “It’s not like [the Committee members] sat down and came up with all the ideas, but they definitely pushed the OHIC to engage the consumer in a direct sort of way...to design the incentives for the employee rather than the employer, because it was employee behavior that you’re trying to get at.” However, the WAC, making estimates based on insurance carriers’ assumptions about the impact of the wellness incentives on costs, was not able to design a product that offered a significantly greater discount. “If there was some way we could squeeze out a 30 to 40 percent discount [from the insurers],” reported one observer,” then the trade-off [between HEALTH*pact* and other plans] ends up being different, but there’s no way we could do it and be able to withstand [their] scrutiny.” “They didn’t bring anything to the pricing,” explained another. “What happened was you had to continually move the deductible higher and higher and higher, and the co-pays higher and higher to get to the price point when, in fact, if they could have put more faith in the disease management programs, you wouldn’t have had to have had the deductibles there [i.e., set so high].” Thus, rather than meeting the State’s mandated price point by granting greater pricing credit to the plan’s wellness and disease management requirements, the insurers insisted on higher deductible and cost-sharing than members of the WAC would have preferred.

Several factors underlay insurance company reluctance to discount rates further based on wellness. It was widely recognized, according to Committee members, that prevailing research demonstrates that disease management, obesity prevention, and tobacco cessation are cost-effective. Nonetheless, carriers resisted because they doubted that they would ultimately benefit financially from investing in those programs. “The cost of the wellness program is borne in year one,” explained one observer. “The benefits...are down the road. The carriers don’t keep members forever, and so the value of investing in an individual member’s wellness program just

isn't there." It was suggested that the only way to overcome this "fundamental flaw in the market" is to require all insurers to cover wellness, so that each carrier would be just as likely to benefit from other carriers' investments in this area. Barring that, "encouraging the carriers to design benefit plans that achieve the [wellness] principles laid out in HEALTH*pact* in a way that they felt would have more market traction and would be more administratively simple for them" was offered as an option.

In addition to raising the price of HEALTH*pact* by granting minimal pricing credit to wellness, steps taken to ameliorate insurer concerns about adverse selection served to limit enrollment. Carriers were worried about the selection of people leaving their current products and enrolling in HEALTH*pact*—a particular concern should HEALTH*pact* be offered alongside other plans. The fear was that more favorable risks would migrate toward HEALTH*pact*, with its lower costs and wellness requirements, and less favorable risks would move toward higher-cost alternatives with richer benefits packages. At first insurers were reluctant to offer HEALTH*pact* bundled with any other option. This was unacceptable to the Committee, in part because they felt that "employers would be more open to experimenting with [HEALTH*pact*] if they didn't have to swap it out and put all their eggs in one basket." Despite WAC recommendations, however, insurers continued to express reluctance to offer HEALTH*pact* together with a richer plan. The Committee finally agreed to allay carriers' concerns by capping enrollment in HEALTH*pact* at 5,000 lives per insurer. However, some felt that insurer concerns on this point were overblown, as subsequent enrollment numbers would, in part, demonstrate.

Ultimately, United agreed to allow HEALTH*pact* pairings with any other plan within its small-group portfolio. This was not the case with Blue Cross, however, which restricted the types of plans with which HEALTH*pact* could be paired to other high-deductible plans with actuarially similar benefit levels. This posed a disincentive to participating for some employers, as reflected in the experience of some of the stakeholders interviewed. "Because Blue Cross decided to bundle [HEALTH*pact*] with [a very high, \$1,000 deductible plan] that we do not participate in, we were not able to implement it," reported one employer. "We have an aging workforce here...we tend to migrate to plans that are fairly rich in benefits...To disrupt that at this point by radically switching to a different plan design would not be well received by our employees." Another employer explained, "I [wanted] to be able to offer...my rich plan that

I had alongside HEALTH*pact*, but the first thing they said was, 'Oh, no. You can allow other plans with HEALTH*pact*, but not the one you're on at [your company]. That one is not a compatible one. You have to have either this one or this one.' And so they were dictating which ones could marry up with the HEALTH*pact*...It wasn't in the spirit of what we had [agreed upon], but you know, when you're in business, you learn you have to be very, very specific sometimes."

Implementation Phase

Because insurers were not interested in promoting HEALTH*pact*, they adopted strategies to inhibit enrollment. Explained one respondent: "We've got this product out there with higher regulatory authority than anything else in the marketplace...[if I were a carrier] the last thing I want is a product with high regulatory authority to be successful. The incentives aren't aligned." "It's like Political Science 101," added another. "It's really difficult to move bureaucracies or even interested parties if they're not in favor of the direction. If they're being pushed, they're going to be less enthusiastic than if they're walking alongside." This is particularly true in light of insurance company discontent over devoting more time and resources to administering HEALTH*pact* than other products: Both carriers reported advertising the program and participating in seminars explaining HEALTH*pact* to brokers and employers. In addition, Blue Cross reported that they had devoted substantial resources to "getting the product up and running," and United reported how "cumbersome" it was to administer. For example, enrollee information is typically tracked by different departments for different purposes, but HEALTH*pact* requires that insurers pull this information together for quarterly reports submitted to OHIC. Furthermore, as discussed earlier, both insurers reported devoting extra effort to minimize the number of enrollees transferred from "advantage" to "basic."

There was a general sense among those interviewed that the insurance carriers devoted insufficient resources to the implementation of HEALTH*pact*. Some perceived "a complete lack of marketing" on the part of the insurers. Others believed that although some community outreach took place, it was not at the level that was needed or expected. Still others believed that at least one carrier's communications actively discouraged brokers from promoting the plan. Several of the brokers interviewed reported that one carrier told them that no feedback would be provided about which enrollees did or did not end up in "basic" through failure to meet the plan's wellness requirements. Moreover, the carrier warned that it

would place someone in “basic” for not filling out their health assessment forms correctly (for example, if all of their “i’s” weren’t dotted and “t’s” weren’t crossed). “When [the carrier] rolled out this plan,” recalled one broker, “you could tell they weren’t supportive of it...[They told us that if] the paperwork didn’t go in exactly like it was supposed to be, a subscriber could end up on the high-deductible plan...I remember sitting around the table [with the other brokers] and [the carrier] is rolling this thing out...The brokers said, ‘we’re not selling this. There’s no way I’m putting myself in the middle of my client and you guys. We’re not doing it.’” Another broker reported, “The carrier is not giving the broker the information of when someone is not meeting the criteria and if someone gets bumped up to that deductible...There is no checks and balances from the carrier to the client, ‘Oh yes, we received it. Oh no, we didn’t receive it.’” Perceiving a heightened risk of enrollees ending up in “basic” and lacking the information necessary to intervene proved to be a substantial disincentive for brokers to offer HEALTH*pact*. The fact that the carrier ultimately limited the number of enrollees being transferred to “basic” suggests that they may have overstated their claims in order to discourage broker efforts on the product’s behalf.

Insurance brokers essentially serve as the human resources personnel for small companies that cannot afford to hire their own personnel. They typically have long-standing relationships with their clients and consequently are reluctant to recommend products that do not suit their clients’ needs. Instead, they sift through the various options available and recommend those deemed most appropriate. Thus, although state law requires that brokers show HEALTH*pact* and other products to their clients, this does not necessarily happen in practice. “The good broker,” explained one observer, “doesn’t want to sit there and go through 15 different product options, when they know damn well that...here’s a guy that’s had a zero deductible plan for the last ten years. He’s not about to go to a \$5,000 deductible.” Furthermore, there are many subtle ways brokers could discourage participation in HEALTH*pact* even if they do present the plan as an option. For example, a broker might simply say, “The state requires me to put that on there, but these are the ones you should really consider.” Or, the broker might “compare the benefits side-by-side but...state, ‘Oh, by the way, there are additional requirements that you have to meet.’” Alternatively, he or she might emphasize the novelty of the product: “This is kind of new. The health plans aren’t really all that sold on it, so I don’t know how they’re going to administer it. You might want to kind of wait around to sort of see

what it looks like in a year, because the benefits might change.”

The brokers felt that, ultimately, it was their reputation on the line where HEALTH*pact* was concerned. One stakeholder observed, “If [a broker goes] to an employer and says, ‘I want you to sign on to this thing,’ they feel like they’re on the hook, and I think that there were a lot of questions about HEALTH*pact*, whether it was going to be around for more than a couple of years, whether the rate was going to spike in year or two. They were concerned about [their own] liability moving forward, like ‘If I get people to sign onto these pledges, can I go through the [wellness] forms [to ensure accuracy]?’” If a broker does not believe HEALTH*pact* is a good product, is uncertain about the implications of enrolling, does not fully understand it, and/or believes that learning about and explaining it are too time-consuming, the broker is simply not going to sell it.

Lack of Resources for Program Outreach and Monitoring

The General Assembly and HRSA helped fund the development of HEALTH*pact*, including hiring a benefits consultant and running the plan development process (e.g., the Wellness Advisory Committee). However, few additional resources were provided to fund program implementation, an especially significant disadvantage for HEALTH*pact* given OHIC’s other responsibilities and limited staffing (the office has only two FTEs in addition to the Commissioner—a lawyer and administrative assistant). First, the lack of implementation funding limited the ability of OHIC to conduct education and outreach. Consequently, there was little opportunity to stimulate “bottom up” demand from employers and promote enrollment. Furthermore, since there was no money allocated to monitoring and oversight, there was little opportunity to ensure broker and insurance company compliance with HEALTH*pact*’s requirements. “Yes, that was fundamental,” observed one WAC member. “[The] insurance companies didn’t really like...[promoting HEALTH*pact*], wouldn’t spend any money on it. And the state didn’t have any money to spend on it.” Another member added, “You can’t fix something if you have no resources with which to fix it.”

Interview subjects generally agreed that education and outreach were key to promoting greater take-up, both among employers and their employees. Although some believed the plan was well-publicized, most felt that additional efforts were needed, citing the lack of communication and marketing effort on the part of insurers but

especially the lack of resources provided to OHIC for this purpose. “You can’t create a brand new program different than anything that’s ever existed before with no money to educate the people who need it most,” argued one employer. “Why is there low enrollment? How could there *not* be low enrollment? It’s almost like you doom it to failure...It’s [like teaching] kids to learn penmanship, only you can’t have any paper, and you can’t have any pencils.” This is not to say that no outreach took place. Indeed, OHIC and the insurers took the “show on the road,” introducing HEALTH*pact* to small employers through a series of seminars conducted around the state. With the aid of a consultant, OHIC also developed brochure material, a website (www.healthpactplan.com), and brand standards for the insurers to apply to their own websites and collateral material. Since this brief flurry of activity at start-up, however, the government has relied almost entirely on insurers and brokers to get the word out about HEALTH*pact*, and, as indicated above, these are two parties who are not necessarily interested in seeing HEALTH*pact* succeed.

State officials pointed out that they were successful in producing a product for businesses that had not been there before, but they, too, emphasized the importance of investing more in system change to ensure proper implementation. They explained, “...we’re now asking pieces to work in a different way,” but “...we’re not making sure that they’re doing it.” It was observed that “if [OHIC had the] resources for somebody to sit there and hold the carriers’ feet to the fire and spend more money on marketing, that could probably happen...But [OHIC] doesn’t have the resources to do that...[There is a significant] lack of regulatory resources.” Additional resources would also help OHIC ensure that HEALTH*pact* is always being offered as a product option; that decisions made about “basic” versus “advantage” coverage were not arbitrary but fair and equitable; that necessary information flowed between OHIC, the carriers, brokers, and employers; and that the product was continually updated to account for lessons learned and changes in the marketplace. It is important, one observer concluded, for the public to know that “people are watching [the carriers],” that “this is not...being done on a wing and a prayer.”

DISCUSSION

With the adoption of HEALTH*pact*, the State of Rhode Island sought to use the authority vested in the Health Insurance Commissioner’s Office to create for small businesses the negotiating leverage that large employers possess. The State also sought to incorporate wellness

principles into the plan through a two-tiered benefits structure contingent upon enrollee adherence to pre-specified behaviors. The primary purpose of this study was to identify factors that impeded enrollment in HEALTH*pact*, with the aim of generating lessons for small-group health insurance reform both in Rhode Island and in other states. Our results highlight the difficulties of expanding small-group coverage without allocating additional resources for subsidies or other premium support. The results also highlight the importance of enlisting the support of the health insurance and broker communities and ensuring effective government outreach and oversight. Additionally, while our findings reveal broad support for incorporating wellness incentives into health insurance plan design, they suggest that such incentives need to be designed carefully and, even so, they may not be sufficient to promote take-up given impediments posed by other challenges.

Instituting a Subsidy Program or Other Premium Support

Affordability is among the most frequently identified reasons that small businesses do not offer coverage to their employees (Fronstin and Helman 2003). Furthermore, most firms not offering coverage report that they would be more likely to do so if the government provided financial assistance. The nation’s smallest firms pay 18.0% more, on average, for the same health insurance benefits as the largest firms (Gabel, et al. 2006). Moreover, while workers within the smallest firms contribute substantially more toward the cost of those premiums (Gabel and Pickreign 2004), workers in firms that do not offer coverage tend to have substantially lower incomes than workers in firms that do offer coverage (Fronstin and Helman 2003). The lack of enrollment in HEALTH*pact* illustrates just how difficult it is under these conditions to increase take-up in the small-group market without subsidizing coverage, particularly among firms with disproportionately high numbers of low-wage workers.

Previous experience indicates that subsidies need to be large in order to spur significant numbers of small employers who had not been offering coverage to begin doing so (Hadley and Reschovsky 2002; Long and Marquis 2001; Silow-Carroll, Waldman and Meyer 2001). Additionally, since a large proportion of uninsured individuals are connected to small firms with low-wage workforces, it has been suggested that public subsidies be directed toward these firms, in particular, to better “maximize the ‘bang for the subsidy buck’” (Neuschler and Curtis 2003). It appears that this was the original

intent of Rhode Island's HEALTH*pact* legislation, which, as initially conceived, did include a subsidy program targeted at low-wage firms. Silow-Carroll, Waldman, and Meyer (2001) argue that financial support for subsidy programs such as this should be viewed "as an investment that will pay off in a lower burden of uncompensated care in the community and reduced use of other public programs, as well as better health outcomes and a more productive workforce." However, the outcome of the HEALTH*pact* legislation's subsidy provision illustrates how hard it is to sustain a commitment to these types of goals when overriding budgetary concerns prevail.

Several states do currently provide direct subsidies, tax credits, or premium discounts in the small-group market (Kaiser Family Foundation 2009b; Napel, et al. 2009). Perhaps the potential of a subsidy to drive enrollment is best seen in the experience of *Healthy New York* (Navigant Consulting 2009), the "success story" most frequently identified by those interviewed for the present project. Established in 2001, *Healthy New York* requires all HMOs in the state to offer a state-mandated benefits package, though other insurers may also elect to participate (Swartz 2001; 2005). The program includes a state-subsidized reinsurance mechanism whereby the State reimburses health plans for 90% of members' claims between \$5,000 and \$75,000. It is available to small employers with fewer than 50 employees—approximately one-third of whom earn less than \$33,000 annually—provided that they have not offered health insurance during the previous 12 months. It is also available to low-income self-employed and uninsured workers. More than 150,000 individuals were enrolled in *Healthy New York* during November 2008, and more than half a million have participated since 2001. It is likely that enrollment has been driven largely by premium discounts of approximately 40.0% compared to the average HMO premium available in the small-group market (Swartz 2005)—discounts far higher than the 15% to 20% available under HEALTH*pact* Rhode Island.

Prioritizing Insurance Company Buy-In

This study highlights the importance of enlisting the support of the health insurer and broker communities, without which small-group reforms based on the existing private health insurance system are unlikely to be successful. The State of Rhode Island did try to engage both brokers and insurers by, for example, including brokers on the Wellness Advisory Committee and relying in part on analyses generated by United and Blue Cross when evaluating the feasibility of various product

options. In addition, aspects of HEALTH*pact*'s design were shaped by insurer concerns. This includes granting greater pricing credit to beneficiary cost-sharing and deductibles than to wellness and permitting Blue Cross to restrict the types of plans with which HEALTH*pact* could be paired. However, these concessions did not prove to be sufficient to overcome insurance company beliefs that they would not benefit from HEALTH*pact* and that the carriers—rather than a "lay" committee like the WAC—should be in charge of the plan design process. As a result, insurers inhibited enrollment by engaging in limited marketing of HEALTH*pact* and by discouraging brokers from selling the product.

In order for plans such as HEALTH*pact* to succeed, it is critical that sufficient enthusiasm be generated on the part of key implementing agents, a lesson consistent with other states' experiences in this area (Deprez, et al. 2009; Long and Marquis 2001; Napel, et al. 2009; Silow-Carroll, Waldman, and Meyer 2001). Garnering such support from carriers, however, requires convincing them that the tangible benefits from participating exceed—or at least equal—the costs. This is perhaps the primary reason why subsidy programs are so important.

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, insofar as such programs increase plan attractiveness to small employers. While subsidies may serve to direct potential clients away from other products—a particular concern for insurers—they may also serve to keep some employers from dropping coverage or, more importantly, entice new employers into the market, thereby enabling carriers to maintain or expand upon their existing base of subscribers. Concerns about crowd-out could further be addressed by making employer eligibility for subsidies contingent upon not having offered coverage during the previous 12 months. Experience suggests that doing so could be particularly effective in ensuring—to the satisfaction of carriers—that state-mandated benefit plans such as HEALTH*pact* serve employers who might not have otherwise purchased coverage (Silow-Carroll, Waldman, and Meyer 2001; Swartz 2005). A prime example of a successful provision like this can be seen in *Healthy New York*, which, despite imposing a state-mandated plan design, has garnered HMO support (or at least avoided active opposition) by including a generous reinsurance-based subsidy with a 12-month look-back period (Swartz 2006).

Allowing greater autonomy for insurance carriers is

another strategy that would likely increase insurer cooperation. Rather than imposing a specific plan design, states could require carriers to develop their own designs so long as they met certain, general requirements laid out in statute or regulation (i.e., a health insurance plan with wellness incentives that cost no more than 10% of the average RI wage). States could also encourage insurers to implement certain plan design elements without necessarily requiring that they be put into place. Some states have utilized the latter approach to encourage carriers to incorporate wellness incentives in plan offerings for small businesses. As part of comprehensive health reform, for example, Vermont now permits insurers to develop products for the small-group market that offer premium discounts of up to 15% for subscribers engaging in healthy lifestyles (Besio and Chen 2009). Additionally, Vermont permits the development of split-benefit plans with lifestyle differentials in cost-sharing for the same premium amount.

As a point of contrast to the limited autonomy granted to insurers under HEALTH*pact*, we can consider the case of Michigan's *Healthy Blue Living*, a split-benefit plan that has been marketed by Michigan's Blue Care Network, an HMO affiliated with Blue Cross Blue Shield of Michigan. This plan was enabled by an amendment to the state's insurance code which permitted health plans to offer reduced cost-sharing and premium rebates of up to 10% if workers commit to healthy lifestyles behaviors (The Commonwealth Fund 2007). As with HEALTH*pact*, all subscribers initially receive "enhanced" rather than "standard" benefits, including substantially lower deductibles and copayments. To qualify for continued access to "enhanced" coverage, however, enrollees and their spouses must choose a primary care physician (PCP); complete and submit a health risk appraisal form (assessing alcohol use, blood pressure, blood sugar, cholesterol, smoking, and weight); and, if they score below 80 points on the appraisal, comply with a recommended treatment plan (Woll 2008). Consistent with the aforementioned regulatory changes, employers receive 10.0% off the cost of premiums for workers enrolled in "enhanced." *Healthy Blue Living* became effective October 2006 and now serves more than 100,000 members and 800 employers, both small and large (Blue Cross Blue Shield of Michigan 2009). It appears, therefore, that *Healthy Blue* has performed substantially better than HEALTH*pact* despite marked similarities between the two plans. Though it is beyond the scope of the current study to explain prevailing differences in enrollment, it is likely that having an insurer initiate, develop, and implement such a plan voluntarily has made a substantial difference in this regard.

Prioritizing Insurance Broker Buy-In

Besides insurers, the other key implementing agents in the HEALTH*pact* story are the brokers. To date, there has been little research regarding the role of brokers in the small-group market. This is despite the fact that more than half of small firms purchase health insurance coverage through a broker or an agent (Marquis and Long 2000), and 90% or more of small business referrals in some insurance markets derive from brokers (Conwell 2002). Consistent with other investigations, the present study highlights the extent to which policymakers ignore brokers at their peril (Conwell 2002; Hall 2000; Long and Marquis 2001). Brokers serve in an intermediary role between health insurers and small businesses. Consequently, there are a number of strategies insurers can adopt to influence brokers and thereby undermine reform. These include adjusting the size and structure of brokers' commissions and discouraging the recruitment of high risk clients (Hall 2000). Although neither insurance carrier appeared to adopt strategies such as these in the case of HEALTH*pact*, at least one is reported to have actively discouraged broker efforts on the product's behalf by reserving the right to transfer enrollees from "advantage" to "basic" without notification.

Perhaps the more important issue regarding the broker role is how they interpret health plan requirements to clients. Garnick, Swartz, and Skwara (1998) observe that "public perceptions of the affordability of individual health insurance options are affected by the limited information that they receive from agents and brokers." This is especially true of the small-group market, where brokers serve, essentially, as the health benefits personnel for businesses that are too small to hire their own. In this respect, brokers provide a valuable service, helping small businesses navigate the complex task of choosing a health insurance plan—a task that includes not only comparing and contrasting different rate quotes and benefits structures but also helping to facilitate and maintain enrollment in the plans that are ultimately chosen. Clearly, there are a variety of ways brokers could steer employers away from products that they don't like. Thus, although state law requires brokers to inform all prospective clients about HEALTH*pact*, few seem to have done so enthusiastically, while others have actively discouraged enrollment. This is a dynamic that has played out elsewhere. One noteworthy example has been health insurance purchasing cooperative efforts in some states that floundered, in part, because brokers marketed against them (Long and Marquis 2001). Our

results provide further evidence that small-group market reform cannot succeed without sufficient buy-in from health insurance brokers who serve as the primary conduit through which small businesses purchase coverage.

Resourcing Government Outreach and Oversight

It is critical that future iterations of small-group reform provide adequate resources for implementation. While the development phase of HEALTH*pact* was well-funded, little additional funding was directed toward supporting subsequent OHIC efforts on the program's behalf. In the face of OHIC's already limited resources (in terms of both funding and staff), the additional task of ensuring faithful implementation of HEALTH*pact* proved beyond OHIC's capacities.

Providing sufficient resources for government oversight is especially important in cases where key implementation activities have been delegated to non-governmental actors who do not necessarily view a program favorably and who may, in the absence of monitoring, undermine its success. Our results strongly suggest that where small-group reform relies heavily on brokers and insurers, sufficient oversight should be put into place to ensure compliance with state marketing, enrollment, and other requirements. This is particularly important in situations such as HEALTH*pact* where financial incentives for steering broker and insurer behavior are absent.

Sufficient resources need to be devoted not only to government oversight but also to government outreach and education. This includes efforts aimed at informing not just employers but also brokers, insurers, local chambers of commerce, and other potentially influential actors, about the advantages and requirements of participating in small-group initiatives. Grassroots efforts aimed at workers and their families could spur employer interest in participating as well. While OHIC conducted some outreach when HEALTH*pact* was first implemented, it was not ongoing, nor was it sufficient to adequately publicize the program, particularly in light of limited broker and insurer outreach efforts. The HEALTH*pact* experience contrasts markedly with other states' reform efforts where observers attribute program success, in part, to education and outreach efforts conducted on the part of the government, frequently in collaboration with other interested parties. In Vermont, for example, evaluators largely ascribe the reduction in the percentage of uninsured people after comprehensive health reform to "an aggressive outreach campaign" that "has spread knowledge about both new and existing

programs" and "facilitated enrollment in these programs" (Deprez, et al. 2009). In Massachusetts, the state collaborates with "dozens of other organizations" to promote comprehensive health reform and also "conducts an ongoing campaign that includes a public information office, hundreds of educational meetings, and broad-based advertising" (Kingsdale 2009). In New York, ten percent of funds earmarked for *Healthy New York* is directed toward advertising aimed at increasing the program's visibility, including a toll-free telephone line and aggressive radio-, television- and Web-based marketing (State Coverage Initiatives 2009). These success stories highlight the importance of state involvement in promoting health reforms. It is highly unlikely that innovative health reform efforts such as HEALTH*pact* will succeed unless actively promoted by the state.

Incentivizing Wellness

Consistent with growing interest in wellness initiatives nationally, key stakeholders in Rhode Island reported widespread support for incorporating wellness incentives into health insurance plan design. Increasing national interest is reflected in a 2006 *Wall Street Journal*/Harris Interactive survey, which found that 53% of Americans believe that it is fair to ask people with unhealthy lifestyles to pay higher insurance premiums, copayments, and deductibles than those with healthy lifestyles (Bright 2006). It is also reflected in a 2007 National Business Group/Watson Wyatt survey of 587 large firms (>1,000 workers), 28.0% of whom reported offering premium differentials for participation in health management programs, up from 16.0% just a year earlier (Watson Wyatt and National Business Group on Health 2007). Employers adopt wellness programs based on the belief that healthier employee lifestyles will reduce absenteeism, improve worker productivity and control rising health care costs. Thus, in addition to creating supportive environments by, for example, providing healthier food choices and exercise classes at the workplace, employers have established financial incentives for filling out health risk appraisal forms, participating in fitness regimes, engaging in smoking cessation and weight loss programs, and improving blood pressure, glucose and cholesterol levels (Business Roundtable 2007; Okie 2007). These incentives may be promulgated both within the confines of employers' health plan offerings (through lower premiums, copayments, and deductibles) and outside the plan (through rewards such as gift cards, bonus payments, and service discounts).

The use of insurance-based wellness incentives was stimulated at the national level in December 2006, when

the U.S. Departments of Labor, Treasury and Health and Human Services clarified HIPAA rules governing this area. These rules permit employers and insurers to offer discounts of up to 20% on premiums, co-payments, or deductibles to workers who have taken steps to improve wellness (Mello and Rosenthal 2008). They also permit discounts for those who achieve specific health goals (e.g., quitting smoking, attaining a healthier weight), although alternative standards must be made available to those who cannot reasonably be expected to meet the standards that have been laid out. A provision in the 2009 Senate health reform bill would increase the level of discounts permitted under HIPAA to 30.0% while companies could petition the Department of Health and Human Services to offer larger discounts, perhaps as high as 50.0% (Kranish 2009). In addition to HIPAA, a number of other federal and state laws govern the legality of such plans, including ERISA and the Americans with Disabilities Act (ADA). There are also privacy protections governing the administration of these plans. Federal rules, for example, require that an organization separate from the employer collect and store personal health data collected through a health risk appraisal (Okie 2007).

Although employers of various types are increasingly turning to wellness programs, relatively few small businesses do so. This is reflected in the results of one nationally representative survey, which found that small employers (3 to 199 workers) are considerably less likely to offer health risk assessments to employees than are large employers (200+ workers)—14.0% v. 55.0%, respectively. Moreover, small employers are also less likely to offer financial incentives for participating in health risk assessments, when available (7.0% v. 34.0%) (Kaiser Family Foundation/Health Research and Educational Trust 2009). There are a variety of factors that explain the lack of small employer investment in wellness. The absence of health benefits specialists or other dedicated personnel makes it difficult to navigate the complex web of federal and state laws governing this area. Being small also increases the opportunity costs of offering these programs. Since there is only so much time and expertise to go around, small employers may be reluctant to adopt such programs themselves or must rely on outside experts to develop and administer them if they do (McPeck, Ryan and Chapman 2009). These factors served, in part, to undermine the success of *HEALTHpact*.

The prevailing challenges to incorporating wellness initiatives in the small-group market indicate that there is a careful balance between using innovation to encourage

wellness, on the one hand, and designing products that appeal to the small-group market, on the other. Thus, although stakeholders generally favored incorporating wellness incentives into health insurance plan design, few expressed more than tepid support for the particular incentives featured in *HEALTHpact*. (This should not be surprising in light of comparative resistance on the part of small employers to incorporating wellness initiatives more generally, both in realm of health benefits and in the workplace itself.) The perceived complexity of the two-tiered benefits structure, the need to complete a health risk appraisal and possibly engage in pre-specified wellness behaviors, and substantial differences in cost-sharing between “advantage” and “basic” coverage proved to be especially significant barriers to take-up.

It would seem that simplification of *HEALTHpact's* wellness incentives would be a first step toward increasing employer acceptance of the plans. In addition, relying more on carrots (premiums discounts, deductible credits) for compliance than on sticks (substantially higher copayments and deductibles) for non-compliance would likely be helpful. No matter the approach, however, most small employers would still need to rely on broker and insurer input to understand and implement these requirements, so the buy-in of these other groups must be secured. Additionally, the state has a critical role to play in outreach and oversight, and this role must be adequately funded. Furthermore, no matter how desirable it may be to pursue wellness, it is unlikely any health plan targeted at increasing take-up among small businesses will be successful unless it results in substantially lower costs for most firms, and achieving such cost reductions is difficult to achieve without also including a generous subsidy program. In light of these broader observations, it is clear that designing effective wellness incentives is only a necessary condition for success; widespread adoption will likely only take place once the other challenges identified are also addressed.

CONCLUSION

Disproportionately high premium increases, together with millions of uninsured Americans connected to small firms, have placed small businesses at the center of health reform (Abelson 2009; Anonymous 2009; Obama 2009). This is reflected in provisions in the House and Senate reform bills that would provide small employers with tax credits of up to 50 percent of premiums and that would expedite access to savings available through participation in newly established health insurance exchanges (Doty, et al. 2009). However, despite this recent

flurry of activity, federal intervention has been limited to date, consisting primarily of HIPAA reforms affecting pre-existing condition exclusions, issue and renewal. In the meantime, it has been left to state governments to take the lead in reforming the small-group market (Napel, et al. 2009; National Conference of State Legislatures 2009).

HEALTHpact represents a unique strategy to tackling small-group health insurance reform at the state-level, which has generally been dominated by other approaches, including regulatory changes (such as mandatory community rating, guaranteed issue, and guaranteed

renewal) and the establishment of small-group purchasing cooperatives. Identifying prevailing impediments to *HEALTHpact*'s success, therefore, should inform future iterations of small-group reform in both Rhode Island and other states—that is, lessons learned regarding the role of subsidies, insurer and broker buy-in, government outreach and oversight, and wellness.

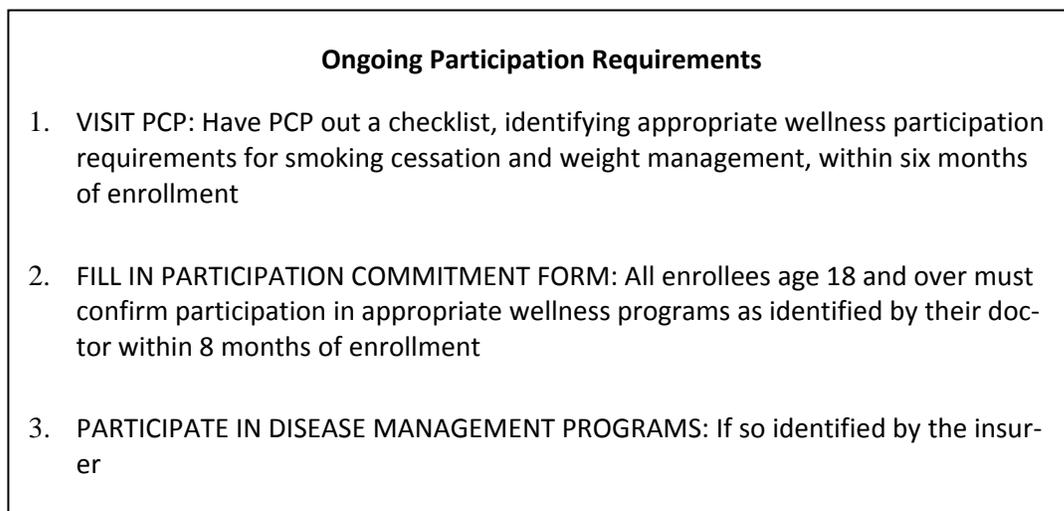
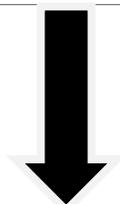
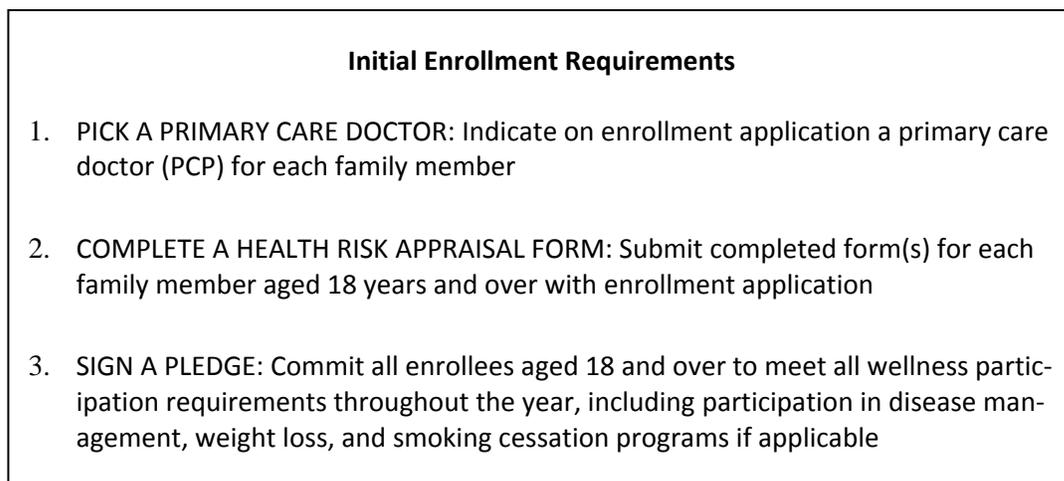
TABLE 1. HEALTH*pact*: ADVANTAGE VS. BASIC

	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 \$250/\$500 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 (2009); Koller (2008); United Healthcare (2009)

¹October 2008

FIGURE 1. INITIAL AND ONGOING REQUIREMENTS FOR ADVANTAGE-LEVEL BENEFITS¹



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

TABLE 2: HEALTH*pact* PARTICIPATION & ENROLLMENT, JANUARY 2009

	United Healthcare	Blue Cross	Total
Employer Groups	49	219	268
Subscribers	121	417	538
<u>Total Members</u>	175	746	921
Advantage	175 (100%)	684 (91.7%)	859 (93.3%)
Basic	0 (0%)	62 (9.1%)	62 (7.2%)

Sources: Office of the Health Insurance Commissioner, State of Rhode Island

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ABOUT THE AUTHORS AND ACKNOWLEDGMENTS

Edward Alan Miller is an associate professor in the Department of Gerontology and a fellow at the Gerontology Institute at the John W. McCormack Graduate School of Policy Studies at the University of Massachusetts Boston. Amal Trivedi and Sylvia Kuo are assistant professors in the Department of Community Health at Brown University. Katherine Swartz is a professor in the Department of Health Policy and Management at Harvard School of Public Health. Vincent Mor is a professor and chair in the Department of Community Health at Brown University.

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ABOUT THE SHARE INITIATIVE

SHARE is a national program of the Robert Wood Johnson Foundation and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

To accomplish these goals, SHARE has funded 16 projects covering 29 states.

CONTACTING SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. 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.

State Health Access Data Assistance Center
2221 University Avenue SE, Suite 345
Minneapolis, MN 55414
Phone (612) 624-4802