Final

To: Interested Parties

From: OHIC

Date: December 14, 2006

RE: Wellness Health Benefit Plan: 20 Questions

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

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1. **What is the wellness health benefit plan?**
   Under legislation passed this spring, carriers in the small group and direct pay markets are required to offer a "wellness health benefit plan" to employers with 50 or fewer employees and to individual (Blue Cross Direct Pay) subscribers. The average premium for the plan cannot exceed 10% of average wages in Rhode Island, or $314 for single coverage (for 2007). An advisory committee has released the requirements document for this plan to the insurers for their responses.

2. **What is the requirements document?**
   The General Assembly set the price requirement and broad criteria for the wellness health benefit plan. In addition they asked for the creation of an advisory committee to give the insurers more detailed criteria toward designing an affordable product. The requirements document released today is the result of the committees efforts in this regard.

3. **What does the proposed product look like?**
   The proposed wellness health benefit plan offers comprehensive coverage at a lower total cost than what is available now. It does this by asking patients and providers to be partners in the efforts to keep costs low. Specifically, there are financial incentives for enrollees who participate in wellness programs and who use a first tier provider network.

4. **How does the wellness component work?**
   If enrollees choose to participate in the plan's wellness programs, they will pay less in the form of lower deductibles and co-pays, etc. There are five key wellness components in the plan:

   - Selection of a primary care physician;
   - Completion of a health risk appraisal;
   - Pledge to either remain at a healthy weight or participate in weight management programs if morbidly obese;
   - Pledge to either remain smoke free or participate in smoking cessation programs; and
   - Pledge to participate in disease and case management programs if applicable.

   In the first year, enrollees will be asked to promise to participate. In the second year, they will be asked to prove participation.

5. **Why have a "tiered provider network"?**
   The Requirements Document asks the health plans to set standards for quality and efficiency. Costs for a given service can vary widely. For example, a colonoscopy at provider X can cost 1/3 of the price for the same service at provider Y. As we struggle with rising costs of health insurance, the Committee believes this approach offers incentives to enrollees to use providers that get the best outcomes in the most efficient manner.

6. **How does the cost sharing compare with current product offerings?**
   In comparison to the cost sharing reflected in comparable products currently available in the small group and direct pay markets at similar premium rates, the proposed plan includes lower cost sharing.

7. **What makes the proposed wellness health benefit plan special?**
   It is different than current small group market offerings in RI, which primarily rely on cost sharing and benefit reductions to lower the premium. The committee created incentives for primary care and prevention, while incenting more efficient purchasing of quality medical services.

8. **Is the proposed wellness benefit plan design unique?**
   It is in Rhode Island. Nationally, large businesses are already working with insurers to tier provider networks and implement wellness programs.

9. **How do the proposed benefits compare with benefits of a comparably priced plan that is already in the small group market?**

	UnitedHealthcare	**WellCare Advisory Committee**	**Blue Cross Blue Shield**
Comparable Plans	RI I	Wellness Health Benefit Plan	HealthMate 80/60
Estimated Individual Premium	$315	$314❖	$341
In Network Deductible	$1,000	$500*	$2,000
Hostpitalization co-insurance	0%, after deductible	0% after deductible	20% after deductible
Other Co-insurance (patient responsibility)	0%	0%**	20%
Office Visit Copay (primary/specialist)	$20/$20	$15/30***	$15/25
Urgent Care co-pay	$50	$50	$25
Emergency Room co-pay	$100	$100	$100
Prescription co-pays	$10/30/50	$5/40/75	$7/30/50

❖Target premium established by the Legislature.
* for subscribers engaged in the five wellness programs
** 0% for most benefits; 10% or 20% for select benefits
*** for tier 1 providers

This table uses estimates and benefit summaries that are for comparison purposes only; actual rates vary based on group demographics.

10. **Why do this?**
    Employers and Direct Payers need a lower premium option that won't break the bank with cost-shifts and cost-sharing. We wanted small employers and individuals to have a voice in the design of health insurance the same way large employers do. We wanted to make sure their priorities were reflected in the plan design.

11. **Who designed the plan?**
    The insurers will design the fine details of the plan within the criteria laid out by the WellCare Advisory Committee (WCAC), a representative group of small employers, Direct Pay subscribers, employer organizations, brokers, consumer advocates and public unions. The Committee met regularly for the last three months.. They saw the flaws in the current direction of health benefits design – higher cost sharing for enrollees. They understood that patient and provider behavior – even though well intentioned and rational - was driving the cost increase. It was their idea to develop the key components – that ask for enrollees to be more engaged in keeping their health costs low.

12. **Were there any health care providers or insurers on the committee?**
    The General Assembly specified that the advisory committee be comprised of representatives of employers, health insurance brokers, local chambers of commerce, and consumers who pay directly for individual health insurance coverage. Insurers were present at all public meetings. Health care providers were consulted as needed by the committee.

13. **Who can buy it?**
    Employers with 50 or fewer employees and Direct Pay subscribers (through Blue Cross only).

14. **When will it be available for purchase?**
    May 1, 2007.

15. **What will it be called? SelectCare? WellCare? Wellness health benefit plan?**
    Wellness health benefit plan, SelectCare and WellCare all refer to the same thing – an innovative, lower cost health insurance option for small employers and Direct Payers. SelectCare was the name as referenced in early legislation. WellCare was the name used by the WellCare Advisory Committee. Wellness health benefit plan is the name used in the legislation that passed in 2006. The name for plan will be determined in the coming weeks.

16. **What is the state's role in this? Is this like Medicaid?**
    This is nothing like Medicaid. The wellness health benefit plan is a commercial choice. The state's role has been to design a process that gives small employers and individuals the clout that large employers do. As a condition of doing business with the state, insurers are required to offer the plan as set forth by the WellCare Advisory Committee and the General Assembly.

17. **Is the product publicly subsidized?**
    No.

18. **When do the insurers have to respond?**
    January 2, 2007.

19. **Are the insurers on board with this?**
    They are on board with the goal of affordable coverage for small businesses and Direct Payers, and are active participants in the process towards that goal. They also understand the WCAC's central concern that higher deductibles defeat the affordability goal. The insurers are working to respond to the requirements set forth by the WCAC. We look forward to their responses in January.

20. **Will this product provide a solution for the growing population of uninsured individuals and families?**
    Employer based insurance is eroding in the face of the only two alternatives available: increasing premium costs for employers and/or increasing deductibles and co-pays for employees. This plan offers a third way for employers and employees who want more comprehensive coverage at a lower premium. It is a good step towards slowing the rate of new uninsureds. Long term, we think this option will only become more attractive as the premiums for the traditional "no responsibility", "broad-choice" health coverage increases.