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**Health Care**
**Employer-built 'wellness' plans**

 By Marion Davis,  
 PBN Managing Editor

How much does your company spend on health insurance, and what does it get in return? How would you like to pay \$309 per employee per month for a plan with only a \$750 deductible, free annual checkups and immunizations, and 90-percent coverage for hospitalizations?

If that sounds like an employer's dream, it's because employers, for the most part, were the ones who put it together, with guidance from Health Insurance Commissioner Christopher F. Koller's office and plenty of feedback from insurers.

So when a reporter asked Donald R. Nokes, president of NetCenergy LLC and one of the plans' architects, whether he planned to offer this coverage next year, he answered promptly:

"Oh, absolutely!"

The new "wellness" health plans unveiled by Koller last week, which are expected to be available to groups of up to 50 by Oct. 1, are not quite like anything small businesses have been able to get in Rhode Island before, and no one knows exactly what to expect.



PBN PHOTO BY STEPHANIE EWENS  
 GOV. DONALD L. CARCIERI, joining in announcing the new insurance plans, says the 'wellness' plans will give smaller firms 'the leverage of big businesses.'

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“It’s kind of hard to tell; it’s too early,” said Debora M. Spano, spokeswoman for UnitedHealthcare of New England. “But from a purely cost point of view, it should be more attractive” than other options, she added, and the coverage is comprehensive.

“It’s not a plan that’s stripped down,” she said.

But the coverage comes with strings, and that’s where the uncertainty lies. To get the low deductible, low fees and low cost-sharing, the people covered by these plans will have to meet five requirements:

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- \* They must pick a primary-care doctor.
- \* They must complete a health risk assessment.
- \* They must avoid smoking, and if needed, sign up for a smoking cessation program.
- \* They must watch their weight, and join a weight-loss program if needed.
- \* If they have a chronic illness or other high-cost health problem, they must participate in the relevant disease or care management programs.

If they don’t comply – and for family plans, every person covered by the plan must comply, for the family to get the “advantage” package – they are bumped down to a “basic” package that requires substantially more out-of-pocket costs, with a \$5,000 deductible (\$10,000 for families).

In the first year, workers just need to pledge to comply, Spano noted, so “advantage” enrollment may be higher. Yet concerns about privacy and other issues are expected to keep some workers away.

“We just know from experience,” said Matthew Stark, principal policy associate under Koller, noting that one employer had offered a full week’s paid vacation to workers who took health risk assessments – and 25 percent still wouldn’t do it.

Lacking any solid basis for predicting workers’ behavior, insurers assumed that 80 percent of plan enrollees would qualify for the “advantage” package, Stark said.

Given the richness of the benefits, insurers need some “basic” enrollees to keep their costs low, and

concerned that those people would simply choose other plans if they could, insurers sought to offer the “wellness” plans available only as the single option, Koller said.

The stated reason, he said, was that as one of several choices, the plans would lead to adverse selection – the same issue frequently raised with “consumer-driven” plans, though that hasn’t been proven to actually happen. Koller insisted on having the plans be offered as both a single option or one of several, aiming to maximize enrollment.

As a compromise, he allowed the health plans to cap enrollment in the first year to as few as 5,000 lives for each company. The small-group pool includes about 116,000 lives, but that’s OK, he said: “I don’t think this plan will be for everybody.”

Who will it be for? Not for the population that first got state leaders talking about creating lower-cost plans: employers who are dropping or have dropped coverage. In passing a law that required Koller to work to create the “wellness” plans, the General Assembly ordered that the target average premium be no more than 10 percent of the average annual statewide wage – which worked out to \$314 this year. But Stark said that’s probably not low enough to bring employers back into the fold – just to keep those on the edge from falling off.

Part of the problem is that both United’s \$309 premium and Blue Cross’ \$322 are just average premiums, not what actual employers will pay. To maximize the viability of these plans in the market, Koller said, they were built to follow all the existing small-group rules, and those include the modified community rating system.

Under that system, there’s an average rate for the pool, and then it’s adjusted for each employer to reflect the age, gender, family composition and health status of the actual members of that group (health status may only lead to a 10-percent adjustment).

Altogether, the highest premium for a group can be up to four times the lowest premium for a similar group. With the “wellness” plans, that means the actual premiums could be lower than \$300 for some employers, while others will pay hundreds more. Koller said he expects the savings to be about 18 percent compared with other available plans. (The average small-group plan cost \$427 per person in 2006, Stark said.)

But the value of these plans isn’t just that the premiums are low, Koller and Stark stressed, but that they’re designed to address the major factors driving up health costs – that people don’t watch their health enough, that they don’t get preventive care, that they don’t do enough to manage conditions such as diabetes and asthma and end up in the hospital.

(On that point, insurers strongly agree. Spano said United believes disease management “is the most effective way of improving the quality of somebody’s health and reducing costs.”)

Also significant, said NetCenergy’s Nokes, is that employers were directly involved in creating the plans, so they reflect business owners’ concerns and priorities. “It was really empowering ... to have

a seat at the table and help design this health plan,” he said.

And because employers were so active in shaping the plans, they’re already promoting them within the business community. At an event last Tuesday, they kept coming up to Stark offering their ideas on how to get other employers to share their enthusiasm.

Philip M. Papoojian, president and chief operating officer of Metachem Resins Corp., in West Warwick, and a vocal advocate for small-group health insurance reforms, said he expects to offer the plans to his 23 workers next year, as one of multiple options.

“I think it’s a very attractive plan, and I think the employees will be very receptive to it,” he said, adding that the affordable premiums are a big plus. Metachem now pays, on average, \$575 to \$600 for individuals and about \$1,500 for families, he said, and last year’s premium hike alone – 22.6 percent – cost the company \$43,000.

“I was basically forced into this discussion,” he said, because health care “is the fastest-increasing cost on our profit and loss statement. Nothing is even close.”

*For more information about the new “wellness” plans, go to [www.dbr.ri.gov](http://www.dbr.ri.gov), and follow the link to the Office of the Health Insurance Commissioner.*

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