



The Role of Producers and Other Third Party Assistors in New York's Individual and SHOP Exchanges

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Role of Producers and other Third Party Assistors in New York's Individual and SHOP Exchange

Executive Summary

The Affordable Care Act (ACA) of 2010 and exchange regulations published in March of 2012 allow each state-based exchange a fair amount of latitude in whether and how to use agents and brokers to assist qualified individuals, employers and employees enrolling in qualified health plans (QHPs). In this paper, we describe in detail the current roles of commercial third party assistors: agents and brokers (collectively referenced throughout as producers); chambers of commerce and business associations; general agencies (GAs); and private exchanges as they relate to the small group (50 employees or less) market in New York today. Our findings confirm that producers and these other commercial third party assistors do not generally operate in the individual market, and as such, we primarily address their roles in, and the needs of, small employers and the Small Business Health Options Program (SHOP) exchange.

It is hoped that understanding how these individuals and entities presently interact with both buyers and sellers will assist New York's exchange planners in developing a program for producers and the other third party assistors to support the sales and marketing objectives of the exchange. We then consider various models for incorporating and compensating producers and the other intermediaries in the exchanges.

Key findings, considerations and potential models include:

- Producers and other intermediaries dominate the small group distribution channel today and are responsible for 88% of the small group enrollment of the nine carriers who collectively enroll more than 80% of the market across the state.

- The individual market is both exceedingly small (less than 33,000 subscribers in 2009) and enrollees are generally not assisted by producers or other third parties.
- The health insurance market in New York has strong regional variations, and at a minimum, must be looked at from both a downstate and upstate basis.
- Chambers of commerce and business associations have significant influence within virtually every business community across the state and have long played a key role in health care distribution, particularly for micro-employers (those with less than 10 employees). This role, however, is changing for some organizations. While some chambers have succeeded in developing innovative programs, others are re-thinking their role in connecting small businesses with health care. Some chambers are more closely aligned with a producer model and others might align more closely with the roles of navigator.
- General agencies (GAs) have influence in the heavily populated downstate market but are not involved with carriers in upstate New York. Some suggest that carrier support for GAs may be waning in the face of pressure to reduce commission costs. Where utilized, GAs understand the producer community inside and out and may be well-suited to play a similar facilitation role in the exchange. Similarly, there are at least two private exchanges in New York that offer experience, technology and exchange market intelligence that will be of interest to exchange planners. Both GAs and the private exchanges may have value to the exchange for outsourcing key processes for the SHOP exchange
- Our research informed the development of four models for paying producers and managing the exchange's relationship with them:
 1. Carriers pay exchange-appointed producers, same rates in and out of the exchange.
 2. Exchange pays producers directly, same rates (on average) as carriers pay outside the exchange.

3. Exchange pays producers directly, at a “discounted” rate from commercial carriers.
4. Exchange appoints producers as navigators and supports them with grants.

However New York decides to proceed, it will benefit from a talented and enthusiastic community of producers, chambers, associations, general agencies and private exchange staffers who did not hesitate to offer their insights, recommendations and concerns when interviewed for this research. We thank them all for their forthright opinions and invaluable assistance.

Introduction

As envisioned by the Affordable Care Act (ACA) of 2010, state-based health benefit exchanges are intended to create a competitive marketplace where individuals and small businesses will be able to purchase affordable private health insurance. Once fully in place, exchanges are expected to provide access to health insurance for 24 million Americans nationally and up to 1.1 million New Yorkers¹.

New York's Individual and Small Business Health Options Program or SHOP exchanges will serve as a "one stop" marketplace where both individuals and small employers can get information on available plan choices, eligibility guidelines, tax credits and subsidies, and general enrollment needs. As prescribed by the ACA, the exchange will simplify the shopping and enrollment processes for all, including those individuals who might qualify for Medicaid or other public health plan options. To help with this streamlined access, the ACA requires the exchange to develop a navigator program to provide personalized assistance for both individuals and small businesses. The navigator role includes an outreach and educational component, as well as enrollment guidance. As such, to many, navigators are perceived as the practical equivalent of the field sales staff for the exchange.

In March 2012, the U.S. Department of Health and Human Services (HHS) issued final rules on the navigator program as part of its exchange regulations. The regulations stipulate that the exchange must identify a community and consumer-focused nonprofit group for receipt of a navigator grant. In addition, the exchange must also include an entity from one other category of allowable entities. Licensed agents and producers, chambers of commerce, and trade, industry and professional associations are included as allowable entities.

The purpose of this paper is to describe the way producers and chambers currently assist buyers in New York's small group marketplace today and to present various models for deploying them in the exchange. The models consider both traditional producer roles

whereby services are compensated through carrier commissions, as well as a producer-as-navigator role that is financially rewarded through grants as required under the ACA. The research also reviews the roles played by related intermediaries such as General Agents (GAs) and private exchanges.

A Note on this Study's Focus

Prior to this paper, a separate study was completed reviewing the navigator role, as well as how Consumer Assistance Programs (CAPs) could work together to help individuals and small businesses make good coverage choices, simplify enrollment and troubleshoot coverage issues if and when they arise. “Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York,” authored by the Empire Justice Center and Community Service Society under a grant by the NYS Health Foundation, was published in September of 2011. This work focuses on public health insurance programs, New York’s Facilitated Enrollers (FEs) and a multitude of consumer assistance and social service agencies. Additionally, an issue brief on the merits of a New York City-based navigator program was developed in April by the NYC Human Resources Administration Office of Citywide Health Insurance Access.ⁱⁱ Wakely’s work on the role of producers and other third party assistors avoids duplicating the research already conducted and instead concentrates on the producer community in New York State and the other elements of the commercial insurance distribution channel devoted to the employer market (chambers, various business associations, private exchanges, et al).

Navigator Program

On March 12, 2012, HHS published a final rule on Affordable Health Insurance Exchanges.ⁱⁱⁱ This rule gives states the flexibility to determine what roles producers and agents will play in their respective state exchanges, while providing some minimum standards for how an agent or producer could assist an applicant. The exchange can determine whether producers and agents assist small employers and consumers with enrollment in qualified health plans, as well as whether producers and agents might assist individuals with applications for advance payment of premium tax credits and cost-sharing reductions. HHS recognizes states' role in licensing and overseeing producers and agents and allows states to determine which standards would apply to agents and producers acting in the exchange. HHS also recognized the important role producers and agents play in the healthcare market by determining that they will be among a list of stakeholders with which exchanges must consult on a periodic basis.

Finally, while producers and agents can serve as navigators, the final rule prohibits Navigators from receiving “any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individual or employees in a QHP *or a non-QHP* [italics added].” Thus, while some producers expressed the opinion that they should have the option to act as a navigator for plans sold within the exchange, while continuing to sell commissioned plans outside the exchange for carriers offering plans both inside and outside of the exchange, the final rule does not appear to permit this option.

Section I

New York's Producer Community

There are currently about 164,800 licensed “accident and health” brokers and agents in New York State with licensing requirements prescribed under sections 2103 (a); 2104(b)(1)(A); and/or 2104 (b)(1)(B) of the Insurance Law.^{iv} Licensed entities include individuals, corporations, partnerships and limited liability companies. While many other states now issue a “producers” license which does not differentiate between brokers and agents, New York continues to examine and license both parties and largely does so because New York Insurance Law reference brokers and producers differently (e.g., NY licenses read “Producer is licensed as an insurance broker” or “Producer is licensed as an insurance agent”). From a licensing perspective, there is one primary difference between the two positions: an agent must be appointed by a sponsoring insurance company to obtain a license while a broker does not. In addition, an agent can provide only services included in the insurance contract and cannot charge the employer a separate fee^v (i.e., all agent compensation is paid by the sponsoring insurer). A broker can charge the buyer a fee (in addition to the commission) provided there is a service agreement in place specifying what the fee is for; that this fee is reasonable and that a like fee for like services is charged to all. From a practical perspective, the work of the two is very similar, but the argument is generally made that an agent represents the best interests of the sponsoring insurer(s) while a broker represents the best interests of his client.^{vi} For this purposes of this paper, the term producer is used to include both agents and brokers except where specifically stated otherwise.

To accept a commission, an individual must be licensed, which in New York entails taking a pre-licensing course, passing an exam, submitting a detailed application (which includes questions intended to identify candidates with questionable financial or criminal background issues), payment of an \$80 fee, and fulfilling fifteen credits of Continuing

Education during each two year licensing period.^{vii} Errors and Omissions insurance, while not required as part of licensing, is generally required by carriers and the appointment process will ask the applicant to provide the face page of his E&O insurance as part of the application.

A producer can request an appointment from any health insurance carrier licensed to sell in New York State. While there are more than 60 companies licensed to sell health insurance in New York, the majority of individual and small group enrollment is concentrated among twelve or so carriers^{viii}. Based on the producer interviews conducted for this research, most producers represent fewer than a dozen carriers each, with three to six carriers capturing most of their enrolled book of business. As most producers function in only one or two regions of NYS, rather than across the state, and each regional market within the state is largely served by 2-4 carriers, producers need not represent all of the major carriers in the state in order to represent the major ones of interest to any local employer. Moreover, a producer needs to understand the benefit offerings, provider networks, enrollment process, billing procedures, underwriting guidelines and many of the policies and procedures for each of the carriers s/he represents, so it is more practical to focus on the prevalent carriers in each region.

Across New York State, producers dominate distribution of coverage in the small employer market, defined as those employers with fifty or fewer employees. As part of the research for this paper, nine carriers^{ix} were surveyed by NY's Department of Financial Services and asked to provide the percentage of their small group enrollment sold through a producer (or other intermediary). These carriers sold 73% to 99% of their small-group book through producers, and averaged 88% on a weighted enrollment basis across the state (see Exhibit A). The carriers selected for the survey represented 80% of the downstate and upstate small group enrollments based on 2009 data. Carriers more closely associated with the downstate market did consistently reflect higher percentages of brokered business.

Producers have virtually no presence in the individual market (also called the direct pay or non-group market). Only three of the eight carriers surveyed reported any individual sales by producers and two of the three responded that producers sold 15% or less of their total individual enrollment (even these results might be overstated as the survey was intended to capture only true “direct pay” business and it appears that a few carriers included Healthy New York sales to individuals in their submission). The individual market is *de minimus* in New York. In 2009, the private pay individual market numbered 32,714 (or 1% of the total enrollment in all Article 44 HMOs for both public and private coverage)^x Therefore, we focus this descriptive study of commercial insurance distribution channels exclusively on the small group market.

| Exhibit A | | | | | | | | | |
|--------------------------------------------------------------------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------------|
| Percent of Small Group Market Sold Through Producer or Other Intermediary | | | | | | | | | |
| Company 1 | Company 2 | Company 3 | Company 4 | Company 5 | Company 6 | Company 7 | Company 8 | Company 9 | Weighted Average |
| 77% | 76% | 83% | 78% | 73% | 91% | 96% | 95% | 99% | 88% |
| <i>(Downstate NY market generally represented higher producer penetration)</i> | | | | | | | | | |

Regional Variations

To best capture a representative view of the producer community in New York State, we first looked at carrier enrollment by geography for the small group market to determine if regional differences were likely to emerge. As expected, the health care market in New York, where multiple carriers have created a competitive landscape, tends to reflect regional sub-markets. There are seven regions across the state, of which two are generally considered to comprise downstate New York (NYC, Long Island and Mid-Hudson regions), and the remaining five regions (Albany, Buffalo, Rochester, Syracuse, and Utica/Watertown) comprise upstate New York. If there is disagreement on the dividing line between upstate and downstate, the most common position would limit downstate to the NYC region only, including the boroughs and Long Island. For the purposes of this paper, the downstate designation will include NYC, Long Island and Mid-Hudson, unless stated otherwise.

In downstate New York, the dominant carriers are Oxford, Empire, Health Net (whose NY membership was acquired by United through its Oxford subsidiary in late 2009) and MVP as shown in Exhibit B. In the Syracuse, Utica/Watertown and Rochester markets, Excellus dominates with 84%, 67% and 58% of the small group markets respectively. Capital District Physician Health Plan (CDPHP) and HealthNow NY share more than half of the Albany small group market, while Independent Health and HealthNow NY equally share 86% of the Buffalo market. These market positions are based on 2009 enrollment data submitted to NY DFS. In late October 2011, Empire Blue Cross and Blue Shield announced that it was withdrawing a significant number of popular products in its small group portfolio, beginning with renewal dates in early 2012, and that it was sharply trimming producer commissions to a flat fee of \$5 per contract (employee), per month. While it is too early to predict which carriers will enroll much of this business, it is reasonably likely that meaningful market share shifts will occur as a result.

Interviews with producers familiar with all regions of New York were conducted during November 2011 through February 2012. More than twenty five interviews with producers were completed, of which more than half were held with producers working in downstate NY. (70% of the state's population resides in these seventeen downstate counties^{xi}.) For each of the upstate regions, at least two interviews were conducted with a producer knowledgeable on the region and the carriers that market their products locally. Producers were also selected based on a preference for those who specialized in small employers, especially those who worked with groups of less than twenty five employees, a likely target market for the SHOP exchange given the availability of tax credits. An interview guide for all discussions was developed to lead participants through a series of questions but producers were encouraged to re-direct the conversation when warranted. On average, most interviews ran between 60 and 90 minutes and not all producers were asked all of the same questions. Several interviews resulted in second and third sessions in order to more fully flesh out relevant information. To encourage candor, all participants^{xii} were assured that their input and comments would not be identifiable in this report.

Exhibit B^{xiii}

**3 Largest Small Group Carriers by Region, Based on Calendar Year 2009 Claims Paid
(% of Small Group Market by Region* - Includes Affiliates)**

Total Number of Insureds: 1,631,806 (at 2Q 2009)

ALBANY

| | |
|-----------------|-------|
| CDPHP | 31.9% |
| HealthNow NY | 26.7% |
| MVP | 16.6% |

BUFFALO

| | |
|-----------------|-------|
| HealthNow NY | 45.8% |
| Indep Health | 40.4% |
| Excellus | 6.9% |

**MID-
HUDSON**

| | |
|--------------|-------|
| MVP | 29.0% |
| Oxford (UHC) | 27.1% |
| Empire | 12.7% |

NYC

| | |
|-----------------------------------|-------|
| Oxford (UHC) | 41.5% |
| Empire | 26.2% |
| Health Net | 12.7% |
| (Membership bought by Oxford/UHC) | |

ROCHESTER

| | |
|------------------------------|-------|
| Excellus | 57.7% |
| MVP Preferred | 33.1% |
| Assurance (Bought by MVP) | 6.1% |

SYRACUSE

| | |
|-----------|-------|
| Excellus | 83.7% |
| United HC | 6.6% |
| MVP | 3.5% |

UTICA/WATERTOWN

| | |
|--------------|-------|
| Excellus | 66.7% |
| GHI (Emblem) | 11.4% |
| MVP | 10.3% |

ALL REGIONS TOTAL

| | |
|-----------------------------------------------------|-------|
| Oxford (UHC) | 30.6% |
| Empire | 19.9% |
| Health Net | 9.0% |
| (Membership subsequently acquired by Oxford/UHC) | |

*** COUNTIES IN EACH REGION LISTED:**

- Albany:** Albany, Rensselaer, Washington, Warren, Essex, Clinton, Saratoga, Schenectady, Schoharie, Montgomery and Fulton.
- Buffalo:** Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.
- Mid-Hudson:** Putnam, Dutchess, Columbia, Greene, Ulster, Orange, Sullivan and Delaware.
- NYC :** Suffolk, Nassau, Kings, Queens, Richmond, New York, Bronx, Rockland and Westchester.
- Rochester:** Monroe, Livingston, Ontario, Wayne, Yates and Seneca.
- Syracuse:** Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga and Tompkins.
- Utica/Watertown:** Chenango, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, and St. Lawrence.

Typical Producer Services to Clients

There was a remarkable level of similarity when producers were asked to describe their typical client services. All producers “spread-sheet” benefit plan options and premium costs for clients on an annual basis. A “spread-sheeting” exercise entails comparing different benefit plans side-by-side along several dimensions. One spreadsheet might compare the total premium costs of all plans under consideration, while a second sheet compares the key benefit features of the different plans. “Spread-sheeting” can be fairly complex and can involve any number of plan options across multiple carriers or within just one carrier. Exhibit C below shows only one page of an actual spreadsheet exhibit taken from a hypothetical rate and benefit proposal produced by a producer interviewed for this research.^{xiv} The producer developed a 16 page proposal for a hypothetical group of eleven employees. The proposal included multi-page spreadsheets on four different dimensions, comparing 21 plan options across multiple carriers. Generally producers will use a “spread-sheet” exercise to narrow down the plan options that most closely align with the employer’s goals and objectives. This can take several iterations and multiple meetings with the client. Most producers volunteered that this work is necessitated yearly due to average annual premium increases and the pressure these increased costs put on the employer’s bottom line. While the number of plan options proposed varied widely, most producers typically show the employer a comparison of six to eight different plan options on average, usually across two or three carriers. High deductible health plans (HDHPs) are increasingly presented to small employers as an option to their current plan offerings.

| EXHIBIT C : Example of "Spread-sheeting" | HealthPass/Oxford Oxford Liberty HMO 30/50-500 (1000 max)(HMO) | | Aetna Health Inc. OA EPO 4-10/10 HSA Compatible :ID 14011163(HSA) | | HealthPass/EmblemHealth CompreHealth HMO+ 30/50-1000 G(HMO) | |
|------------------------------------------|-----------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------|-------------|----------------------------------------------------------------|---------|
| | In-Network | | In-Network | Out-Network | In-Network | |
| Drug Card | | | | | | |
| Prescription Card | 15/35/75/Yes/100 | UCR=N/A | 15(Generic) 35(Brand) 70/Yes/Intrgd ded (d) | UCR=N/A | \$15 Generic Only | UCR=N/A |
| Major Medical | | | | | | |
| Deductible Ind/Fam | N/A | | \$3,500/\$7,000 | | N/A | |
| Co-Insurance | N/A | | 80% of \$12250 | | N/A | |
| Out-of-Pocket | N/A | | \$5,950/\$11,900 (incl. ded) | | N/A | |
| Office Co-pay | \$30 | | 80% after ded | | \$30/\$0 dep child | |
| DXL/Lab Fees | Lab-no charge; DXL-20% Colns up to \$100/procedure | | 80% after ded | | No charge | |
| Specialist Co-pay | | | 80% after ded | | | |
| Lifetime Maximum | \$50 Unlimited | | Unlimited per member lifetime | | \$50/\$0 dep child | |
| Hospital Benefits | | | | | | |
| Hospital In-Patient | \$500/day; \$1,000 max/admis | | 80% after ded | | \$1,000/admis | |
| Hospital Out-Patient | \$150 copay | | 80% after ded | | \$75 copay | |
| Emergency Room | \$150 copay (waived if admit) | | 80% after ded | | \$150 copay (waviwed if admit) | |
| Private Nursing | Not covered | | Not Covered | | Not covered | |
| Surgical Benefits | | | | | | |
| Surgical In-Patient | No charge | | 80% after ded | | \$1,000/admis | |
| Surgical Out-Patient | \$150 copay | | 80% after ded | | \$75 copay | |
| Mental Health | | | | | | |
| Mental Nervous In-Patient | \$500/day; \$1,000 max/admis 30 days/cal yr | | 80% after ded Bio- Unlimited d/mem/plan yr Non Bio-Unlimited d/mem/plan yr | | \$1,000/admis 30 days/cal yr | |
| Substance Abuse In- | \$500/day; \$1,000 max/admis Rehab-30 days/cal yr Detox-7 days/cal yr | | 80% after ded Detox-limited 7d/mem/plan yr Rehab- limited 30d/mem/plan yr | | \$1,000/admis Rehab- Not covered Detox- 7 days/cal yr | |
| Patient Mental Nervous | \$50 copay 30 visits/cal yr | | | | \$50 copay/\$0 dep child 20 visits/cal yr | |
| Out-Patient Substance | \$30 copay 60 visits/cal yr | | 80% after ded Bio- Unlimited vis/mem/plan yr Non Bio-limited 20v/mem/plan yr | | \$25 copay/\$0 dep child 60 visits/cal yr | |
| Other | | | | | | |
| Well Care(Up to 19) Routine Adult | No charge | | No Charge/Ded Waived | | \$0 copay | |
| Care Chiropractic | \$50 copay | | 80% after ded | | \$50 copay/\$0 dep child | |
| Care Home | \$30 copay; 40 visits/cal yr | | 75% after ded- 40v/mem/plan yr | | No charge; 40 visits/cal yr | |
| Health Care Non- | Refer to carrier | | Refer to Carrier Plan Information | | Refer to carrier | |

| | | | | | | |
|--------------------|-----|--------------|-----|-------------|-----|-------------|
| Single | 5 x | \$485.91 | 5 x | \$339.00 | 5 x | \$319.97 |
| EE with Spouse | 1 x | \$1,062.65 | 1 x | \$811.00 | 1 x | \$747.88 |
| EE with Child(ren) | 2 x | \$900.12 | 2 x | \$713.00 | 2 x | \$611.63 |
| Family | 3 x | \$1,503.43 | 3 x | \$1,103.00 | 3 x | \$989.94 |
| Medicare | 0 | \$0.00 | 0 | \$0.00 | 0 | \$0.00 |
| Monthly Cost | 11 | \$9,802.73 | 11 | \$7,241.00 | 11 | \$6,540.81 |
| Annual Cost | | \$117,632.76 | | \$86,892.00 | | \$78,489.72 |

It might also be noted that spread-sheeting multiple benefit plan options is a cleaner and less time consuming activity in New York than in many other states because New York requires the use of “pure” community rating in the small group market. In many other states, producers must collect detailed census information, such as employee age and sex, and any other data which will be used in the rate development process, such as industry type and location. In New York, rates for a given product (e.g., HMO with certain covered benefits and cost-sharing) vary only by the carrier’s rating region(s) and coverage tiers (i.e., employee only; employee plus spouse; employee plus child (ren) or family).

In addition to cost sensitivities, producers will generally make sure that any proposed benefit plan design and carrier network will first address the personal needs of the business owner and his dependents. For example, several producers volunteered the importance of reviewing a carrier’s drug formulary with an owner to make sure that current prescriptions will be covered if an employer changes carriers and how changes in cost-sharing tiers will apply to his/her household’s maintenance drugs. In virtually all cases, the producer will make sure that all providers used by the owner and his family are in the proposed network.

In a larger sense, this kind of personalized attention from the producer to the owner directly addresses one of the biggest perceived difficulties with health insurance, which is that most people have great difficulty understanding their health insurance policy. Recent consumer testing by Consumers Union confirms that people struggle to understand their health insurance choices.^{xv} Basic terminology, or insurance jargon as many people call it, can be very confusing and the small business owner often has no more expertise about health insurance coverage than his employees or the public in general. A second finding in

the Consumers Union testing found that most participants dread shopping for health insurance and that they will take “short-cuts” to get through the task. If the business owner is indeed perplexed about his own health insurance needs, it is not unreasonable to assume that his confusion will only be magnified by the number of employees that he must also consider when making a group policy decision. Hiring a producer is akin to taking a short-cut to understanding the multitude of available choices in the small group market. Clearly, one of the producer’s key roles is to reduce the decision-making anxiety on the part of the owner. Producers almost always are referred to as the business owner’s “trusted advisor” and this terminology directly addresses the underlying needs of the business owner.

Several producers interviewed expressed these same needs a little differently. At least four producers used essentially these same words: “The small business owner has enough to do running a business in these very challenging times. He doesn’t have the time or inclination to try to sort through health insurance on top of everything else he needs to do to run his business and make a profit. That’s why he has me, to make this stuff easier.” As a further testament to the general consensus that health insurance is particularly difficult to understand, one need only to look at the results of a recent poll conducted by the Kaiser Family Foundation (KFF) which asked people to reveal their most liked and disliked ACA provisions. The runaway winner for most favored provision is the requirement that health plans provide consumers with a short, easy to understand description of benefits and coverage. Favored by some 60% of individuals polled, it easily beat out the 33% of respondents who liked no cost-sharing for preventive services. In a blog post, KFF President and CEO Drew Altman notes that the most favored provisions share a common thread: “You do not have to be a health policy expert to understand them. They provide tangible help to people navigating the health insurance system and paying their health insurance bills.”^{xvi}

While the business owner (or other decision-maker at a small employer group) generally gets an extra level of personalized attention, most producers pay close attention to ensuring that all employee providers are also in the proposed carrier network. Depending

on the size of the employee group, the producer will either do this manually or he will ask the carrier to run a disruption report on the group that will identify any employees (or their dependents) who might need to change providers. For small groups, this process must almost always be done manually. Producers also reported that they (or a representative of their office when they enjoy a larger office staff) generally provide at least one on-site group benefits presentation each year at renewal (or open enrollment) time. If the employer has employees in remote locations, the producer may also accommodate these employees through webinars or phone-in meetings. All in all, this is a fairly labor intensive shopping and enrollment process.

Almost all producers surveyed report that they act as a clearinghouse for enrollment applications for initial enrollments or new sales, annual renewal periods, new hires, terms and dependent changes. When asked why producers would take on this function when not required by carriers to do so, several producers explained that many applications have missing or incorrect information and this screening process allows them to ultimately provide more timely and accurate enrollments for their small employer groups. Eligibility questions were referenced as a common inquiry, and assistance with COBRA requirements were mentioned by several producers. Two producers volunteered that they perform COBRA administration at no charge for their clients.

All producers are required to administer the underwriting guidelines of carriers (as permitted under NYS law). Underwriting guidelines are a critical tool employed by every carrier and they are primarily intended to reduce adverse selection, or the likelihood that the carrier will incur unmanageable risk that could reasonably be anticipated and therefore prevented. These guidelines may vary by carrier and product, and can cover a host of possible requirements, including but not limited to:

- minimum participation rules
- valid waivers
- employer contribution requirements

- availability of coverage to 1099 consultants (and other non-employees)
- determination of full time versus part time employment status
- availability of dual choice and/or triple choice plan offerings (i.e. when more than one plan option can be made available within an employer group)
- common ownership and multiple company requirements
- multi-site guidelines

While the carrier will always be the final adjudicator of all underwriting decisions, the producer is nonetheless expected to know and support the carrier's rules.

Virtually all of the producers interviewed report that providing Human Resource guidance is a typical service and one that requires time and attention throughout the policy year. Several producers offered that small employers, and particularly those with 25 or less employees, generally do not have any staff dedicated to staying on top of HR matters, insurance rules and regulations, and employment laws. Several producers offered that most small business owners generally have only two outside professionals at their disposal: an accountant and an insurance producer. And in addition to health insurance, most producers surveyed provided their small business clients with an average of two additional services from the following list: life insurance, dental, AD&D, property & casualty insurance, Health Saving Account (HSA)/Health Reimbursement Account (HRA), 401K or pension administration, COBRA administration and voluntary products (i.e., voluntary products are 100% employee paid benefits such as vision or legal services).

Perhaps one of the most significant services producers provide is (to paraphrase several producers) "persistent assistance" with solving the "ugly claim problem" that cannot be easily resolved by a call to Customer Service. Virtually every producer is accustomed to dealing with the claim problem that is not easily resolved and that generally requires escalated contact at the carrier, or persistence, to get resolved. Resolving such claim issues often represents a key opportunity for the producer to demonstrate his value to the small business owner who has neither the time nor inclination to pursue the issue with the carrier.

The reality is that the producer may have more leverage to resolve these sometimes complicated issues with the carrier. For example, the producer may call the VP of Sales and ask for the issue to be reviewed by a more senior service or claims specialist. The carrier will rarely (if ever) overturn a claims decision when unwarranted, but in certain respects, the producer plays a similar role for the small employer as compared to consumer assistance services available within DFS when complaints are escalated by the general public. When coupled with the producer's ability to seemingly resolve with ease and speed the more mundane claim, billing and eligibility problems a small group might see throughout the year, it is not difficult to understand why most small businesses find particular value in the role of the insurance producer anytime a claim issue arises.

Resolution of premium billing issues is another frequent service mentioned by the producers surveyed. Other common interventions included: obtaining "prior approvals" in time sensitive situations, notifying employee groups of pending network terminations, reviewing Explanation of Benefits (EOBs) for employees, intervening with providers to determine why a service was billed a particular way^{xvii}, recruiting needed or desired providers to the network, addressing out of network or out of area questions, helping with provider referrals, addressing inaccurate provider directories, and resolving balance billing issues.

Producers and the Small Business Tax Credit

One of the key provisions in the ACA is the availability of a tax credit to small business employers with less than 25 relatively low-wage Full Time Equivalent (FTEs) who pay at least one-half of the cost of health insurance coverage for their employees. Known as the Small Business Health Care Tax Credit, it was designed to encourage small business employers to offer health insurance to their employees. On 11/7/11, the Treasury Inspector General for Tax Administration issued a press release^{xviii} that substantiated

anecdotal reports that the volume of claims for the credit has been very low nationally. According to the IRS, who informed 4.4 million taxpayers who could potentially qualify for it, as of mid-May 2011, just more than 228,000 taxpayers had claimed the credit for a total amount of more than \$278 million. The Congressional Budget Office (CBO) had estimated that taxpayers would claim up to \$2 billion of credit for tax year 2010.

As producers are a natural fit for marketing this tax credit to small employers, and tax credits are considered a key driver for exchange enrollment, we asked several of the producers interviewed for this paper about their experience with the tax credit. Downstate producers generally cited the average annual wage cap of \$50,000 as the primary reason why the tax credit was not of greater interest to clients. The second most frequently cited reason for the low interest was the complexity of the processes to determine eligibility and to collect the credit. The upstate producers also generally cited the income limits as a major constraint but placed complexity before the income limits as the primary driver in lack of adoption.

This input from New York producers strongly suggests that small business tax credit usage in New York State will mirror the underperforming national results released in November. While the average annual income limitations may very well be the major culprit behind the low usage in New York City in particular, the lesson here for the exchange developers around the country may very well be one of simplicity. Complexity, like confusing health insurance jargon, will quickly dampen interest in the purchase of health insurance, the fundamental mission of both the individual and SHOP exchanges. This may be particularly relevant to subsidy calculators just inside the front door of the exchange.

Professional Employer Organizations

During several interviews with producers in the downstate market, the emergence of Professional Employer Organizations (PEOs) was raised as a potential threat to the small

group market. A PEO allows an employer to outsource the management of human resources, employee benefits, payroll and workers' compensation^{xix}. With regard to health insurance, PEOs provide the small employer with the opportunity to participate in one or more experience-rated health plans. To the extent the companies outsourcing to PEOs have younger and presumably healthier employees, the resulting experience-rated health plan offerings may be very attractive to the small employer who otherwise can only access more costly community-rated plans that reflect the health risks of all enrollees (young, old, healthy, sick and with or without dependents). The producers most concerned with PEOs maintain that some of these organizations are selectively marketing only employer groups with young employees, or are medically underwriting other employer groups, thereby producing the same result of only enrolling healthier than average populations. These producers argue that taking the good risk out of the small group market hurts all small employers and will eventually impact the SHOP exchange in a negative way as well. Since some (not all) PEOs commission producers, some producers are recommending that their small business clients consider the PEO option. Other producers are asking that exchange planners take a closer look at small employer participation in PEOs and evaluate their impact on the exchange if left unchecked.

Underserved Segments in the Under 50 Employee Small Group Market

Producers were asked if there are any segments in the small group market that might be underserved today, either by producers or by carriers. More than half of the producers suggested that the SHOP exchange might be of more interest to employers with 2-10 employees, and particularly micro-employers with 2-5 employees as these smaller group sizes are generally not aggressively pursued in the market today. The other segment identified by several producers as being underserved is the small employer with several employees who might qualify for publicly subsidized coverage, thereby increasing the likelihood that the remaining employees would meet the minimum participation requirements for coverage.

Most producers are not familiar with the intricacies of publicly subsidized coverage for two reasons:

1. The eligibility and enrollment rules in the public arena are starkly different from the rules in the private insurance market; and
2. The producer is not paid for enrolling individuals in public health programs like Medicaid, and Family Health Plus, and few carriers pay commissions on individual Healthy New York enrollments.

As a result, many producers avoid very small employer groups with several low wage earners. Brokers' compensation reflects the number of enrollees in the plan. If a producer pursues a group of say, seven employees, and two have coverage through a spouse, and two are very low wage earners who cannot afford their share of the premiums under the employer plan, the producer is not going to spend time on the remaining three potential enrollees. (The group must also meet the carrier's minimum participation requirements, an increasingly difficult task as carriers tighten up underwriting guidelines on non-HMO plans and require minimum enrollments). The role and responsibilities of the producer are complex; an expectation that producers will also master the rules of publicly-subsidized programs for little compensation is unrealistic. Similarly, an individual well-schooled in public insurance but lacking knowledge of commercial group insurance and small-employer human resources issues is likely to fail this business owner as well. Neither the producer nor public enroller can individually meet the needs of the small business with mixed wage earners in most cases. On the other hand, if the two are encouraged to collaborate then everyone wins...the employees, the owner, the producer, the public enroller and the state of New York, who ultimately benefits from the exchange goal of reducing the rolls of the uninsured.

Are Producers Interested in Working with New York’s SHOP Exchange?

Without exception, every producer indicated a strong interest in working with New York’s SHOP exchange. A few producers specifically indicated an interest in also working with the individual exchange but it should be noted that all interviews were completed before the final regulations on navigator compensation were released in March of 2012. The only caveat was an expectation that doing so would not put them at financial disadvantage. The overriding general consensus of producers is that the exchange should play by the same commission rules and on one level playing field. A few producers voiced concerns that the exchange might engage their services initially and then cut them out once the exchange membership had reached a critical mass.

As expected, producers were very vocal about the role “navigators” should play in the exchange. While the ACA uses the term “navigator” in a generic sense, many of the producers interviewed have already equated the term almost exclusively with publicly subsidized health plan enrollment assistors from various public and private entities and who are not licensed by the state or required to carry professional liability insurance (such as the errors and omissions coverage required of producers). (Producers also said enrollment assistors are not required to participate in continuing education credit programs but this belief fails to recognize that assistors are indeed required to attend refresher training sessions.) At least one third of the producers interviewed expressed their belief that navigators should be required to be licensed under the same terms and requirements as exist today for producers and agents (interviews were conducted prior to the release of final federal guidance precluding this practice).

When asked what they thought would contribute to a ***robust exchange marketplace***, producers offered the following comments:

- ↑ Level playing field; same rules inside and outside the exchange
- ↑ Same compensation for selling inside and outside the exchange
- ↑ Ease of communication and ease of doing business
- ↑ Easily understood products
- ↑ Allowing small employer to decide on the value of utilizing a producer
- ↑ Quality matters
- ↑ Maintaining choice of health plans
- ↑ Producers must continue to be licensed and navigators must be similarly trained and certified or licensed
- ↑ No red tape
- ↑ Exchange needs to actively market itself (against both misconceptions and ignorance)
- ↑ Standardization is good
- ↑ Focus on 8-10 plans in the exchange; anymore and people are too confused
- ↑ Need a high deductible HSA plan and at least one HMO plan
- ↑ Same plans in and out of exchange

When asked what they thought would contribute to a ***failed exchange marketplace***, producers offered the following comments:

- ↓ Do not want to see the exchange become a “1 800 Plan” where face to face meetings on the client’s premises are not readily available
- ↓ Carriers have reduced staff and service; if producers are also eliminated, service will suffer and the member will have no voice
- ↓ Can’t be just a click/web service
- ↓ Untrained and uncertified/unlicensed navigators
- ↓ Should not be new or higher taxes to support exchange
- ↓ Different mandated benefit requirements for in and out of exchange

Section II

General Agencies

A general agent (GA) acts as a contracted intermediary between carriers and producers, with the goal of providing producers with carrier-specific sales expertise and dedicated service support to grow their business. A GA can also be thought of as a single point of contact between a carrier and a producer. While in some states certain carriers require that producers write business through a GA, no carrier does so in New York. Instead, several NY health insurance carriers contract with one or more GAs for various market segments and the GAs compete for producer relationships by marketing a variety of services, all of which are intended to help the producer better manage his existing book of business and to sell more new business.

Producers can choose to have a relationship with one or (more) GAs or they can choose to work directly with a carrier. Small, independent producers tend to use one GA and do so when it is more cost effective to rely on a GA than to provide and pay for these services themselves. When utilized at all, mid-size agency producers may use more than one GA to better leverage their different kinds of expertise and the largest brokerage firms will have a tendency to partner with only one GA (if any) in a mutually beneficial partnership-type arrangement. Regardless of the market segment served, GAs prosper when they provide strong sales support and exceptional service; their goal is to make their particular services indispensable to the producer. One NY GA markets their agency by stating that they provide the tools to allow the producer to work smarter, not harder. Another GA touts that producers are their only client while a third positions themselves as a partner to carriers and producers alike. Regardless, the GA provides substantial back office support to keep the producer's own overhead costs to a minimum while increasing closed sales ratios and new sales opportunities.

Importantly, using the carrier appointed GA does not generally impact the producer's commission or bonus opportunity. In all but one case that we know of, the producer is paid commission without regard to the use of a GA. As to the difference between a commission and a bonus: A **commission** is paid on a per group basis (dependent on the number of enrollees and the resulting earned premiums) for new or renewing business, while a carrier's **bonus program** offers additional financial incentives for specific activities. A bonus program might offer the producer additional monies based on the total annual premium volume he places with the carrier, or perhaps the percentage of his business that remains with the carrier each year (referred to as a "persistency" bonus). New product launches are also an example of when a bonus program is used to incent a producer over and above standard commission levels. Any time a carrier needs to meet specific sales goals, a new bonus opportunity might be created.

GAs are more prevalent in downstate New York than in the upstate regions, largely due to historical market and competitive reasons. One GA interviewed for this paper explained that at the time of the small group reform movement in the nineties, there were far more carriers in the market overall and competition was particularly fierce in the downstate region where much of the state's population resides. Carriers were hard pressed to keep up with the sales and service demands of producers looking for the best deal for their clients, particularly at a time when rate quotations could not be produced with the ease and speed that is available today with rate quoting technology. Essentially, it might have been faster, better, easier and/or less expensive for some carriers to contract with GAs as opposed to hiring more staff to respond to the clamoring producer community. Over time and with small group reform (particularly community rating) competition lessened and the need for GAs subsided (downstate) or never took hold (upstate). Some argue that the use of GAs continues to decline today and will do so even more in the years ahead. In some instances, a carrier may still maintain a GA contract but not actively promote it. For example, one carrier provides producers with additional bonus opportunity monies if they choose not to use the contracted GA. From a descriptive perspective, the use of GAs in

downstate NY resembles a patchwork quilt – there are lots of different arrangements stitched together.

While each GA differentiates their firm by offering a somewhat different basket of services, there are certain “bread and butter” services that all GAs market to producers. Chief among them are rate quoting, sales proposal development and presentation support. Rate quoting refers to the ability to provide pricing for a given benefit plan for either an existing employer group or a prospective client. In New York, virtually everyone we talked to referenced HealthConnect as the on line quoting technology used across the state. Either a producer had direct access to HealthConnect (sometimes paid for by a carrier) or the producer was accessing HealthConnect’s quoting tool through a GA.

HealthConnect serves the GA market by allowing them to purchase their quoting tool and related services at a wholesale rate and distributing access at no charge to their client producers. The tool is accessed through the GA websites and the service is private labeled to match the look and feel of the GA’s own site and marketing goals. The GA has complete control over the access to the quoting tool, including which producers obtain access, which carriers are quoted and who has what level of access and for what period of time.^{xx} HealthConnect states that the tool “allows for the easy quoting of multiple carriers and an assortment of plans in a quick and efficient manner.”^{xxi} This was ably demonstrated during an interview when a 16 page customized report with 21 different health plan options across four different carriers for a sample small employer group of 11 employees was generated and emailed to the interviewer in less than ten minutes. Clearly, this fast and (by all accounts) accurate tool, provided at no charge by the GA, represents a highly valued service by a producer working either in his own office or even in a small business owner’s office during a sales call.

The GA provides the producer with strategic sales support, most often orchestrated by a dedicated team of professionals assigned to the producer when he signs up with the GA. The composition of the team varies across GAs but a typical team might include a licensed

sales professional that can accompany the producer on a client sales call; an inside manager fluent in problem solving and finding the right answers for any issues or questions, and third, an in-house representative who oversees the paperwork process from start to finish. This team might provide the producer with a sales proposal template and a PowerPoint presentation, or access to a host of digital marketing materials that can be customized with the producer's logo, color scheme and other personalization. It all depends on what the producer needs and wants. The GA respects the producer's ownership of the client relationship and will offer as much - or as little - support as the producer wants. In some cases, the producer has enjoyed a long term relationship with the client and there is a great deal of trust between the two. However, even though the producer may be licensed in accident and health, health insurance may not be his primary strength. Nonetheless, the client trusts him and he has sufficient health care knowledge to oversee the small business owner's purchase of health insurance. It is very common for one producer to manage all of the insurance needs of the small employer and a GA can offer invaluable assistance with product and carrier expertise across multiple lines, including the aforementioned insurance as well as life, dental, disability, 401k administration, and vision plans to name some of the more common products.

The typical GA will also offer producers access to a carrier library or documentation center, or one convenient site where the producer can find every participating carrier's rules and regulations, product descriptions, forms and frequently asked questions. The GA will usually provide this information in a format that allows the producer to zip through a given topic for all participating carriers in a side by side fashion. The GA strives to make their website "one stop shopping" for all of the producer's information needs, and the carrier documentation center is just one feature. Strong search functionality on the website is often touted by a GA to save the producer time.

All GAs work closely with producers to enroll a new employer group or to renew an existing group. This assistance frequently entails help with a long checklist of "must have's" or "must do's." For example, when enrolling a producer's small business client

(new or existing) with a new carrier, it is not untypical for the following list of activities to be tracked by the GA:

1. Producer must have a “Broker of Record” (BOR) letter on file from the employer group authorizing his services (carriers will not pay a commission without a BOR); producer must also be appointed by the carrier in order to sell their products
2. Producer must collect the first month’s premium check from the employer (which can be calculated differently by carriers)
3. Completed master (or employer) application
4. Completed employee applications (including dependent data)
5. Correct and complete waiver of coverage forms (i.e., if an employee has coverage through a spouse, the carrier will generally exclude this employee from part of the minimum participation calculation but the carrier wants documentation supporting the spousal coverage)
6. Collect all required tax documentation forms (for example, most carriers in NY require the producer to obtain an “NYS-45” form from the employer, which is the name given to the state’s quarterly withholding, wage reporting and unemployment insurance report. This form is used by virtually all carriers as the definitive list of eligible employees. This is the proof that carriers are looking for to make sure that enrollees are employees and not uninsured friends of the owner or other ineligible. Additional documents verifying eligibility may also be required depending on the carrier.)
7. Copy of the current carrier bill may be required

The GA will typically vet all of the forms and applications for accuracy and thoroughness as well as timeliness before submitting the package to the carrier for approval. The challenge of obtaining a “clean case” submission are such that at least one GA rewards producers for high quality submissions with a bonus when all paperwork is submitted on time, complete and without error (the bonus applies only to new small group [2-50] cases and ranges from \$25-\$200 depending on the number of enrolled lives). For employer groups renewing coverage with the same carrier, or staying with the same carrier but changing plan design, the forms and procedures will differ but the GA will review this paperwork as well. Throughout the plan year, the GA will also oversee the paperwork for new hires,

terminations and changes. All of this attention to detail allows the producer to focus on growing his book of business.

GAs differ in how they manage the enrollment process. Some collect paper from clients, enter it into their own systems and then transmit enrollment files to the carriers. Others enter enrollment data directly into the carrier's system and still others merely pass the paper on after vetting it for accuracy and thoroughness. In most cases, the GAs are not involved in premium billing but at least one GA researched offers to act as a billing administrator for the producers clients.

Beyond these basic services, GAs may begin to differentiate their service offerings. Some GAs provide extensive training on everything from carrier products to federal and state insurance laws. Other GAs provide free courses that meet the producer's continuing education requirements for licensure. For example, one GA offered almost 100 courses in 2010, which attracted 1,800 attendees. Given both the complexity of the health insurance industry and how changes can impact clients, most GAs spend a fair amount of time and money on some set of educational services. At least one GA offers its producers free access to HR Connect and HR 360. HR Connect, a Health Connect product, is an employee benefit website offered at no cost to the producer's clients with ten or more employees. HR 360 is an on line resource offering step-by-step guidance on how to comply with everything from complex insurance rules and employment laws to how to interview, hire and term employees. Both of these services will reinforce the producer's role as insurance expert and trusted advisor in the eyes of the small business owner and GAs understand this.

Most GAs will also deliver to the producer's inbox regular news announcements and as needed alerts with more time sensitive information. Some GAs offer video on demand training sessions and all GAs employ staff with expertise across aspects of the health insurance industry.

Support with ancillary products is another mainstay of the GA. Some GAs have an extensive list of vendors and other preferred partners that the producer can call upon for specialized services such as payroll administration, set up and administration of Health Spending Accounts (HSAs) and Health Reimbursement Accounts (HRAs), COBRA, Professional Employee Organizations (PEOs), third party administrators (TPAs), voluntary benefits and ancillary insurance lines (dental, life, disability, etc.).

Last, the GA advocates for all of their producers and their producer's clients. Resolving a claim problem or a billing matter falls under the service mantra that the GA wraps around every producer interaction. Successful advocacy saves the producer time and usually results in a better outcome when the GA has a large block of business with a carrier.

For its part, the carrier tends to focus dedicated resources on the GAs needs. One GA with 100,000 enrollees is much easier and less costly for the carrier to service than the fifty different producers that might have written this collective business. This is the primary reason a carrier utilizes a GA in its marketing model; it's simply more efficient, particularly when medical loss ratios are under the current level of scrutiny. In return, the carrier pays the GA a commission override on the premium dollars the GA brings in through their producers. Historically this override was 2% of the premium dollars but two GAs interviewed for this paper both indicated that there is downward pressure on this number and it is falling. One carrier has not only moved their GAs to a fixed per enrollee per month (PEPM) fee but has also reduced this fee recently from \$14 PEPM to \$10 PEPM. Funds for the GA override come out of the carrier's administrative costs. As with a producer commission, the GA override is not charged directly to those groups that may utilize these two types of assistors; rather, the costs for producers and GAs are built into base premiums and are therefore shared equally by all groups without regard to who benefits from the services.

In summary, the use of GAs is fairly prevalent in the more competitive downstate market, but unusual elsewhere in the state, where only two carriers tend to dominate in a given

region. Good GAs save the producer time and money in the servicing of his accounts and great GAs help the producer grow his business. Carriers pay the GA. Producers typically use a GA without paying a fee for these services (although some producers do share a piece of their commission with a GA in certain circumstances and sometimes the GA will share their commission with a producer). Presumably, using the GA system is less costly for the carrier than providing the same services to producers directly. Nonetheless, the role of the GA is yet another third party assistor that the state of New York will need to consider when planning for the marketing and distribution of the SHOP exchange products.

Section III

Chambers of Commerce and Business

In many states, chambers of commerce and business associations have historically enjoyed a major footprint in the health insurance distribution channel for small businesses (50 employees and under) and particularly for the 1-10 employee size market. However, in New York, at least, their role is in flux.

About twenty years ago (and in some areas, longer), various carriers and the chamber (and association^{xxii}) community came together to develop a new distribution channel for small group insurance. A chamber would market group coverage to small employers for the carriers, and in exchange, the chamber would add an administrative fee to carrier rates for certain services the chamber would provide as part of the offering. For example, the chamber almost always performed the premium billing and collection function for the carrier, resulting in many of these arrangements simply being referred to as “remittance agreements.” This partnering allowed the carrier (frequently a Blue Cross and Blue Shield plan) to support the many local chamber and association groups in their coverage area, thereby allowing them to be good corporate citizens while at the same time, gaining a free (or certainly low cost) distribution channel with a strong marketing reach into cities and towns everywhere. For their part, chambers and associations used the administrative fees

to supplement operating revenues. Additionally, some chambers promoted the availability of health insurance as a means to increase their membership revenue, which for most chambers represents the largest source of their operating revenue. For small businesses, paying chamber or association dues or an administrative fee was a small price to pay to access good, affordable health insurance not otherwise available.

The particulars of the arrangements varied. In some areas, the carrier directed all small businesses to the chamber or association and simply did not accept any direct sales, or at least not for micro-employers (generally meaning those with less than five or ten employees). Or the chamber was able to differentiate itself in the market by offering unique benefit offerings to its membership base. Generally, the chamber also provided administrative services to their membership, from enrollment support to customer service to premium billing and collection. In fact, even today, some chambers continue to bill and reconcile premium payments from small business members and remit the payments to carriers.

While the specifics varied by region (due to the different practices of the dominant small group carrier in each region as well as the number of chambers and the model each created), the business rationale was consistent. The reason for the seemingly unusual partnering lay in the inefficiencies of distributing group insurance to small purchasing units. The small group market - and the under-10 market in particular - has always been challenging for carriers from both the administrative cost and risk-selection perspectives, and the chamber and association entities capitalized on this mutually beneficial opportunity.

For many years, this arrangement worked reasonably well for all parties. In New York, two events intervened over time: producers began to compete for this business, once it became commissionable, and the advent of community rating in 1993 precluded any pricing advantages that chamber groups might have been able to previously provide. Since then, chambers have slowly lost their competitive advantage in this market and the current

chamber and association small group distribution channel is in decline across much of the state.

Unlike a possible administrative fee, utilizing a producer does not cost the small employer a direct fee, since commissions are “baked in” by carriers, spread uniformly across all premium rates in a market segment, and paid by the carrier. As this gave the small group producer a competitive advantage, many chambers and associations have elected to move to a commissioned approach. New York Insurance Law, however, requires that commissions be paid only to licensed producers and it is not sufficient for a not-for-profit chamber or association group to merely hire a licensed producer. As the Insurance Law is fairly complex on this matter, and there are a number of chambers seeking workable solutions within the regulations, the State is currently reviewing various compliance issues as they pertain to chambers and business associations. One model that may be compliant requires a chamber or association to establish a separate, licensed corporate entity to conduct insurance sales, with said entity engaging at least one licensed producer to write the business. For this model to fully comply with all required licensing requirements and regulations, other specifics must also be addressed. As just one example, the regulations stipulate that the insurance producer may not receive more than 10% of its aggregate net commissions from (1) policies under which the chamber is the group policyholder and (2) policies that insure risks and property of the chamber (the so-called “10% rule”).

Our research suggests that while many chambers are fully compliant with state law, others are struggling to find a workable model. Several chambers and associations have discovered a new operating niche in health care delivery and we review several of these success stories below. Other chambers and associations are hoping that they can carve out some kind of meaningful role as a navigator entity for the exchange. Still others are hoping that the exchange rules will clarify opportunities and create a reasonably sustainable model for the future.

The roles of chambers of commerce in New York State are evolving and a few things stand out. One, many chambers and associations groups need the revenue they collect today for their insurance program however it works, and for some, losing this revenue would be a major financial blow. All of these entities are highly motivated to find a way to sustain these revenue streams. Second, the statewide network of chambers and associations represents a significant marketing and distribution channel which a SHOP exchange, looking to capture the attention of the small business community, cannot ignore.

New York’s Statewide Chamber and Association Network

Chambers of commerce and manufacturers associations are located throughout New York’s urban and rural areas. They typically represent and promote the common commercial interests of a broad range of local businesses, large and small, across many economic sectors. Because they enjoy the trust of the business members they serve, have ready access to their membership, and understand the unique characteristics of their regions, their potential value in marketing a SHOP exchange is considerable. Taken together, chambers and associations offer an unrivaled access point and distribution network for products and services needed by the business community.

The Chamber Alliance of New York State (CANYS) serves as the collective voice for more than 85 chamber of commerce and regional employer associations, representing over 110,000 businesses and 3.6 million employees^{xxiii}. CANYS is an advocate of maintaining the health care distribution opportunities of their member organizations. CANYS suggests that^{xxiv}: (1) a NYS SHOP exchange should leverage the existing network to deliver health care products efficiently and cost effectively; (2) the desire to contain insurance costs through competition is fundamental to the mission of CANYS organizations; and (3) chambers and associations have decades of experience providing insurance education and helping businesses (and their employees) navigate insurance plans that best fit their needs. CANYS argues that leveraging the considerable resources and expertise of the distribution

channels provided by chambers and business associations will encourage competition and increase exchange awareness for the small business buyer.

CANYS offers two perspectives^{xxv} on how to compensate chambers and business associations that participate in exchange marketing. One, chambers and associations need to properly establish a for-profit brokerage agency with licensed producers to market plans and legally collect commissions if they have not already done so. Alternatively, CANYS suggests that the State consider changing insurance laws to permit business associations to directly receive commissions from insurance carriers and be regulated in a similar way as private insurance producers.

Not all chambers endorse these two perspectives. In a report published in April of 2011 by the Capstone Team at Columbia University's School of International and Public Affairs (SIPA) for the Brooklyn Chamber of Commerce, it was noted that opinions varied amongst chamber leaders as to how chambers should approach exchanges (both SHOP and the individual exchange) and one differing viewpoint embraced the role of navigator for chambers. In this instance, the navigator function assumed by the chamber would necessarily be compensated through a grant arrangement and the chamber would counsel both small businesses and individuals on exchange offerings.

The Columbia University SIPA research also offers some insight into how many chambers are typically working in both the small group and individual markets: of the six chambers and associations interviewed by the Capstone Team, two offered insurance plans to individuals and all six worked with small businesses and sole proprietors as shown in Exhibit D^{xxvi}. The two chambers working in the individual market are both involved in demonstration projects which use variations of the State's Healthy New York product as explained below. Otherwise, chambers are not active in the individual market (chambers do work with "sole proprietors" as part of the small group market while most producers do not). In this regard, chambers, associations and producers are aligned, as very few work in the individual market.

| Exhibit D: Columbia University SIPA Report for the Brooklyn Chamber | | | | | | |
|---------------------------------------------------------------------|----------------------------|---------------------------|---------------------------------|----------------------|----------------------------------------|-----------------------------------|
| NYS Chambers and Health Insurance | Provides Health Insurance? | Provides In-House Advice? | Has Separate for-Profit Entity? | Insures Individuals? | Insures Small Businesses & Sole Props? | Offers Healthy New York products? |
| Upstate Chambers of Commerce | | | | | | |
| Saratoga County Chamber of Commerce | Yes | Yes | No | No | Yes | Yes |
| Syracuse Chamber of Commerce | Yes | Yes | Yes | Yes | Yes | Yes |
| Orange County Chamber of Commerce | Yes | No | Yes | No | Yes | No |
| Fulton County Chamber of Commerce | Yes | No | No | No | Yes | Yes |
| Downstate Chambers of Commerce | | | | | | |
| Business Council of Westchester | Yes | No | Yes | No | Yes | No |
| Brooklyn Chamber of Commerce | Yes | Yes | No | Yes | Yes | Yes |

The Columbia University SIPA researchers found that, “Chambers are not competing with producers because the commission fee is so small that producers are targeting businesses with more than 25 employees. Chambers’ markets are the really small businesses with 1-10 employees.”^{xxvii} Wakely’s interviews generally found that while many producers prefer to target employers with 10 or more employees, a fair number are happy to pursue those with five to nine employees. If there is a dividing line, our interviews suggest that groups of five or fewer employees may be underserved by the producer community but not by the chamber channel. Given the number of firms in all three segments (1-4, 5-9, and 10 and over) as shown in Exhibit E below, there is reason to support both producers and chambers co-existing in the small group distribution channel.

Exhibit E^{xxviii}

Distribution of Business in NYS in 2008
(By Employer Size and Number of Firms)

| Employees Firms | 1-4 | 5-9 | 10-19 | 20-49 | 50-99 | 100- 249 | 250- 499 | 500- 999 | 1,000 + | All |
|--------------------------------------------------------------------------------------------------------|-----|---------|--------|--------|--------|-------------|-------------|-------------|------------|-----|
| | | 310,288 | 88,024 | 57,722 | 38,596 | 12,832 | 7,636 | 2,139 | 840 | 555 |
| Firms with < 20 employees accounted for 1.5 million jobs | | | | | | | | | | |
| There are over 1.5 million firms without employees in NYS (Sole Proprietors) <i>not included above</i> | | | | | | | | | | |

The scope and breadth of services offered to small business owners by producers and chambers relative to insurance may differ depending on the chamber model. A producer working outside the chamber sphere offers clients full time vocational expertise on all insurance matters, including other lines such as life and disability. A producer working within the chamber channel is similarly trained and equipped to provide the same services but might only actively work in the health insurance arena. For those chambers connecting small business owners with health insurance options without the involvement of a licensed producer, the services will differ. In this model, the chamber is most likely billing and collecting the premiums for the carrier and earning a carrier fee for doing so. And while this chamber’s role also includes a strong customer service orientation, it lacks the insurance advisor and expertise in HR matters and regulations that the licensed producer brings to the table. Conversely, chambers offer small businesses considerable expertise and many services outside of the insurance arena that are clearly valued by the small company owner looking for a trusted source of support and encouragement to grow his business.

The different chamber models across the state may illustrate how a “one size fits all” approach to distributing health insurance to very different business regions may not serve the best interests of the exchange. Chambers, as well as other intermediaries, have demonstrated considerable ability to not only adapt to new opportunities, but to build innovative solutions as well. In the next section, we turn to a few of the more interesting and diverse models that illustrate the range of different approaches and innovations in the distribution of health insurance. The success stories associated with this diversity suggest

there is value in the exchange taking regionally-customized approaches to working with chambers, associations and other intermediaries such as private health insurance exchanges.

Section IV

Chamber, Association and other Intermediary Innovations

The Brooklyn Chamber of Commerce and Brooklyn HealthWorks

To provide more affordable health insurance options for small businesses, the Brooklyn Chamber of Commerce, in partnership with the New York State Department of Financial Services (DFS) and GHI (an EmblemHealth company) launched Brooklyn HealthWorks in 2004. Brooklyn HealthWorks is a private-label version of the state's Healthy New York product which uses GHI's Exclusive Provider Organization (EPO) network. Healthy New York offers basic health insurance coverage to qualifying small businesses (2-50 employees), sole proprietors and working individuals at a reduced premium rate made possible by a State-subsidized reinsurance mechanism. To qualify for standard Healthy New York offerings, small businesses must pay at least 30% of their workforce less than \$40,000 per year, while the annual income of sole proprietors and working individuals must be less than 250% of the Federal poverty level (FPL).

Brooklyn HealthWorks differs from the standard Healthy New York program in five ways^{xxix}: (1) it provides an additional subsidy, reducing the monthly premium by almost 15% currently; (2) it offers an optional group rider allowing enrollees at a company to remove co-pays for hospital services; (3) it requires no mandatory employer contribution; (4) it enrolls independent contractors (so-called 1099 employees); and (5) it requires no primary care physician (PCP) referrals to see a specialist.

Initially, the program was marketed to Brooklyn businesses directly through the Chamber without the use of producers. Enrollment picked up after insurance producers were

brought in to help distribute Brooklyn HealthWorks throughout the borough. Despite the affordability of the product to the enrollee and the relaxed eligibility guidelines for the employer, less than 200 small businesses had enrolled in Brooklyn HealthWorks as of January 2008 and only 20 producers were actively marketing the program.^{xxx} Two factors contributed to the lower than expected enrollment: first, after exhausting HRSA federal subsidy dollars the program temporarily ceased enrolling new members in March 2006; and second, the Chamber believed that the marketing efforts to both small businesses and producers had been underfunded and therefore under executed. Enrollment was re-opened in October 2007 when new State subsidy dollars were secured and the New York State Health Foundation (NYS Health) provided a grant to the Chamber to more aggressively market the innovative program to both small businesses and to producers.

During the grant period, professional marketing materials were disseminated to approximately 5,000 producers in the Brooklyn borough and the Chamber further reached out to producers through producer seminars and informational meetings. Secondly, the Chamber took a number of steps to heighten awareness of the program within the business community, ranging from direct mail, radio and print advertising to website promotion, surveys, press opportunities and outreach activities at any business events the Chamber could influence. The results of this second effort were more encouraging and offer insight to exchange planners about the need for marketing resources and how chambers, associations and producers might assist in marketing the SHOP and individual exchanges. According to published grant results, the number of participating producers increased during the grant period from 20 producers in January 2008 to 55 producers as of 4/30/2009.

Secondly, between January 2008 and May 2009, 1,250 employees and dependents at 293 small businesses enrolled in Brooklyn HealthWorks, a 73% increase above the enrollment of 170 small businesses at the beginning of the grant period. The Chamber attributed the growth in membership to their direct mail campaign to small businesses and also cited the

intensive outreach to producers as the chief reason why producer representation more than doubled.

Today the Chamber partners with 98 producers to market Brooklyn HealthWorks (up from 55 at the grant's conclusion), and enrollment stands at 4,000 covered lives at nearly 800 active small businesses (up from about 450 at the grant's conclusion).

The Brooklyn HealthWorks experience suggests that a layered marketing approach might work best in promoting the SHOP exchange and that both chambers and producers are very viable third party assistors, particularly in the small business community. Secondly, as the subsidized Brooklyn HealthWorks product is somewhat akin to the subsidies, cost sharing assistance and business tax credits that will accompany the products in the individual and SHOP exchanges, the lesson learned is that affordable coverage alone is not sufficient to reduce the ranks of the uninsured. Affordable coverage must be coupled with effective outreach and marketing by individuals and entities who understand the needs of the target market and who are trusted by them.

As a side note, the Brooklyn Chamber of Commerce also markets health insurance options and provides related counseling to small businesses, sole proprietors and individuals who do not qualify for subsidized coverage. The chamber staff includes three licensed producers who work full time on insurance-related services.^{xxxii}

Greater Syracuse Chamber of Commerce ^{xxxiii} and Healthcore

A second demonstration project using the subsidized Healthy New York product was launched in nine upstate New York counties. In 2009, the Greater Syracuse Chamber of Commerce ^{xxxiii} was selected as the Healthy New York upstate administrator for the pilot project later branded and introduced to the market as *Healthcore*. Benefit Specialists of NY, a licensed brokerage, administers the program, and United Healthcare serves as the underwriting insurance carrier. While standard Healthy New York includes only two plans (both with and without a prescription drug benefit for a total of four options), the

Healthcore pilot project offers employers five plan choices (or ten in total since each plan is offered with and without a drug option). The plan options were designed in part to attract the “young and healthy” in an effort to help reduce the loss ratio and control health care premiums. Like Brooklyn HealthWorks, the Healthcore program offers eligible enrollees additional premium support and more basic benefits than are available in the standard Healthy New York offerings. Healthcore has enrolled over 2,800 subscribers since its inception and the January 2012 enrollment stands at 1,942, which includes small business employees, sole proprietors and working individuals (the vast majority of enrollees are individuals). Most of the subscribers who have dis-enrolled have left Healthcore for jobs with employer-sponsored insurance or coverage through a parent’s plan as a result of the expanded dependent eligibility of coverage to age 26. Healthcore continues to serve as an effective and affordable option to the uninsured, offering rates that are as much as 80% lower than direct pay non-group rates

The Syracuse model is administered by Benefit Specialists of NY, which currently employs six licensed insurance producers. Benefit Specialists states that Healthcore’s success is attributable to a “feet on the street, community advocacy” marketing approach coupled with a deeply subsidized portfolio of benefit plans designed to attract various population segments including the young, the underserved and the uninsured. Healthcore has returned a major portion of the subsidy back to the public in the form of premium reductions due to the program’s ability to collect commissions from carriers for brokered sales, administration services, accounting functions and marketing. As for the plan’s marketing approach, Benefit Specialists cited a strong referral relationship with community advocates including Facilitated Enrollers (FEs) as one reason for the program’s success. In New York, FEs are encouraged to educate eligible individuals about their publicly subsidized coverage options and assisting with any resulting application or enrollment requirements. Most FEs work for health plans (1,386) while about 41 FEs work for community-based organizations across the state.^{xxxiv} The plan’s enrollment success speaks to the need to partner commercial insurance and publicly subsidized coverage expertise in the small group community. For the exchange, this may best address the value

in creating opportunities, incentives or requirements for producers and navigators to work together on those small groups where employee needs are most optimally met by some enrolling in publicly subsidized coverage and others in a commercial insurance plan.

Both *Healthcore* and *HealthWorks* bill enrollees directly for coverage due to the state subsidies supporting the lower premiums. While *Healthcore* has in-house premium billing, collection and auditing capabilities, *HealthWorks* outsources this function to a third party administrator (TPA). Both programs also perform enrollment services. In the case of *HealthWorks*, the Chamber takes in all of the paperwork from enrollees and twice a week the TPA sends an electronic enrollment file to the carrier for processing. *Healthcore* manages all of functions from outreach and education to all aspects of sales and enrollment. Chamber membership is not a requirement for participation in either Brooklyn *HealthWorks* or *Healthcore*. The two chambers may approach their tasks differently but they nicely demonstrate the chamber community's ability to adapt and compete in a changing healthcare arena.

Bright Choices of the Hudson Valley

Nineteen chambers in New York are participating in a product offering marketed by Liazon Corporation, a company founded in 2007 intent on transforming the small employer market into one where defined benefit contribution strategies help control employer costs and compel employees to make more informed choices when it comes to health care. Called Bright Choices, the program promotes an employee choice model, albeit one that currently limits employees to choosing from several plans offered by one carrier as discussed in greater detail below. This choice model differs from the SHOP approach where employees will likely choose from plans across multiple carriers.

Bright Choices is offered as a four part solution^{xxxv} to small employers: (1) establish a fixed dollar contribution for each employee to purchase benefits; (2) offer employees a range of products, which can include the basics like health care and life insurance and let employees decide what choices best meets their needs; (3) use decision-support technology to help

employees choose what's best for them as individuals and will provide explicit recommendations for each employee based on their input; and (4) take care of everything once decisions are made – enrollment, consolidated billing, payroll deduction reports, customer service and all other interaction with the insurance carrier.

Not only does Bright Choices remove the small employer from most of the employee benefits process but it is also marketed to chambers along the same line. Chambers may limit their activities to only those interested small businesses and sole proprietors that are members of the chamber. Beyond marketing and promotion, the chamber's role is fairly limited. Certainly none perform any enrollment or billing administrative work, a time consuming and resource-laden administrative task that some chambers previously performed. Over 95% of Bright Choices enrollees submit an online application and the company accommodates a multitude of electronic enrollment feed preferences by the carriers. The chambers focus on relationship marketing and Bright Choices assumes virtually all of the administrative support work. To date, the concept has been embraced by several of the largest chambers in the eight-county Hudson Valley region. In addition, some of the larger participating chambers across the state include the Buffalo Niagara Partnership, Chautauqua County Chamber, Ulster Chamber, and the Chamber of Southern Saratoga County, for a total of nineteen chambers statewide as of February 2012.^{xxxvi}

Bright Choices markets their services both to chambers and to small employer groups directly. In the chamber space, their average group size is about four employees while the average group size of their non-chamber business is about ten employees. The company enjoys a particularly strong enrollment following from sole proprietors.

Bright Choices offers 6-8 different medical plan choices from a single carrier per region. So unlike the SHOP exchange where choice across carriers within a given employer group may be permitted, the Bright Choices model limits employee choice to selected plans from one carrier. Univera is the carrier in Western NY; MVP has been selected as the carrier for Central NY; Aetna has engaged with Bright Choices in the NYC market and three carriers

(MVP, CDPHP and Aetna) share the Capital District region (with each employer required to select only one carrier for his employees). A carrier's standard products are run through a series of analytics to determine which offer the best value proposition and then a second set of analytics looks at what people want in a benefit plan. Bright Choices takes the output from both processes and negotiates with the carrier to come up with a strategic product portfolio for each carrier in a given region.

Bright Choices employs a direct sales force and its use of producers over time reflects an evolved approach. Four years ago, 99% of sales were direct and 1% was producer-driven. Today, 10% are producer driven and the company expects to see this percentage increase to 40% by the end of the year due to producer interest. Bright Choices convinces producers to accept the reduced commission in exchange for a greatly reduced work load by the producer. A lot of the typical services a producer provides are done by the exchange and are not negotiable. The marketing pitch to producers is essentially, "With Bright Choices, you can sell more business faster. You bring your clients to us and let us do the rest of the work." The producer is essentially a relationship producer in this model. Compensation for producers averages about half of what carriers might otherwise pay, and less if the producer's involvement is limited to the most restricted level of services allowed by the exchange. A direct sales force is also employed by Bright Choices, which now works in 23 states (including NJ, CT, GA and CA).

HealthPass New York

HealthPass New York is a non-profit health insurance exchange featuring an employee-choice model for small businesses in the five boroughs of New York City, Nassau and Suffolk counties in Long Island and seven counties in the mid-Hudson Valley region. Sole proprietors in New York City and Long Island can also access the private exchange. Originally conceived in in the mid-nineties through a public-private collaboration between the Northeast Business Group on Health (NEBGH), the City of New York and the local health insurance industry, HealthPass has evolved into a self-sustaining commercial exchange

serving more than 3,500 small businesses and approximately 30,000 members. Approximately 85% of the small businesses enrolled are firms that employ 1-9 workers, which is the typical size group that is least likely to offer health insurance coverage to workers.^{xxxvii} According to HealthPass, approximately half of all participating employers did not offer health insurance before enrolling in the exchange, while one quarter of eligible employees across all employer groups did not have prior coverage.

HealthPass will be of interest to exchange planners not only because it is located in New York but also because it is thought to be one of less than a dozen exchanges that existed in the country at the time the ACA became law.^{xxxviii} As such, it offers both geographical relevance and a track record in operations, sales distribution and plan management.

The HealthPass model in many ways simulates the SHOP exchange envisioned under the ACA. Eligible small businesses in downstate NY elect HealthPass as the health insurance offering (and can also choose to provide their employees with access to ancillary offerings such as dental, vision, life, and long-term disability, which are not required under the ACA). The business defines the employer contribution and employees select from a menu of choices that include four categories of health plan options (in-network only; in- and out-of-network coverage; cost-sharing and consumer-directed health plans with health saving accounts [CDHP/HSA]) through four carriers (EmblemHealth, Oxford/UnitedHealthcare, Group Health Inc. (GHI), and HIP Health Plans of NY (GHI and HIP are Emblem companies). HealthPass reports that more than half of employers contribute benefit dollars equal to 50% of the lowest cost health plan. Employee choice is also featured in the ancillary lines when included in the offering by the employer. HealthPass also provides employers access to set-up a Section 125 premium-only plan (POP) to allow employees to pay for their plan with pre-tax earnings.

A common enrollment form allows all enrollees to use one application regardless of carrier and options selected, and HealthPass verifies eligibility and transmits enrollment data to the carriers. Seventy-five percent of eligible employees (defined as those working 20-40

hours per week) must enroll in a plan or provide proof of other coverage (i.e., through a spouse, publicly subsidized coverage, or Medicare). In 2008, the average group size was 4.26 enrollees, while as of 1/1/12 the average group size is up to slightly more than 5 enrollees (5.16). HealthPass provides all employer groups with a consolidated bill and pays the carriers the required net premium amounts. HealthPass also provides all groups with COBRA and New York State Continuation Coverage administration (with bills sent directly to the employee).

HealthPass utilizes a producer-driven distribution model through which 100% of all sales are attributed to producers. Approximately 800 producers write business with HealthPass, while seventy percent of this business is attributed to about 150 producers. HealthPass originally elected the producer model for two reasons: (1) management believed that the small group market in NY was dominated by producers and to circumvent or to financially disadvantage them would result in a significant loss of potential business; and (2) the marketing budget was nominal and in the words of one plan leader interviewed, “You need the producers.” The exchange also chose to support the General Agency model that tends to prevail in the downstate market and approximately 75% of the producer sales come in through one of the eleven contracted General Agents (GAs)^{xxxix}. The commission structure mirrors the compensation schedules of carriers but HealthPass pays the producers and General Agents directly. HealthPass premiums include the commission loads as well as a four percent administrative fee that is retained by HealthPass for plan administration. Like many of the health care entities in NY, HealthPass uses HealthConnect for premium rating and displaying available plans options through the exchange to producers.

HealthConnect private labels a portal for HealthPass and producers can obtain quotes, side-by-side plan comparisons and proposal templates from the portal. As HealthConnect represents the backbone of all quoting in NY, producers used the HealthPass portal without any reluctance. Other on line producer tools that HealthPass first attempted to deploy were not equally well received and HealthPass attributes this to the producers being accustomed to using a single source for quoting all options in the marketplace. A

competing exchange in NY reported a similar reluctance and offers that producers have a “status quo bias.”

HealthPass has always maintained relationships with the larger chambers of commerce operating within its service area, largely for purpose of brand recognition. In mid-2011 it began to work with these chambers to experiment with different kinds of relationships focused on co-marketing, lead generation and actual enrollment. Based upon the result generated by the Brooklyn Chamber’s HealthWorks program, the work of Benefits Specialists (Syracuse) and others throughout the state, HealthPass remains optimistic about the efficacy of such arrangements.

In November of 2011, HealthPass commissioned an on-line survey of 300 small business owners in NY. The results bode well for the exchange concept in general and for private exchanges in particular: (1) more than three-fourths of respondents (76%) would consider using an exchange when enrolling their employees in a health care plan; (2) among businesses that do not currently provide health insurance, 60% said they would be more likely to offer coverage if an exchange was available; and (3) by nearly a two-to-one margin, small business owners prefer a SHOP exchange run by the private sector over an exchange run by the government (52% to 28%)^{xl}.

Section V

Commission Trends

As part of the research for this paper, nine carriers were asked to provide blinded copies of their 2010, 2011 and 2012 commission schedules and bonus programs for the small group market. The first purpose of the review was to determine if commission schedules are changing in the New York market as was stated by the vast majority of producers interviewed for this paper. A secondary reason for the review was to better understand

any commission (or bonus) rules or trends that might impact how the exchange might consider compensating producers and any other third party assistors selected to assist with the marketing of the exchange.

Background

One of the first requirements imposed by the ACA was a limitation on the percentage of premium dollars that can go to profits and administrative expenses. Effective 1/1/2011, carriers across the country are required to meet an 80% (for small group business) or 85% (large group) Minimum Loss Ratio (MLR). For small group business, this means the carrier must spend at least 80% of earned premiums on medical costs (or rebate premiums to customers if they fail to do so). In New York, an 82% MLR applies to community-rated business (i.e., for groups of less than 50 employees), and as State law may exceed the Federal minimum MLR contained in the ACA, small group carriers in NY have been subject to the 82% MLR requirement since 2010^{xli}. As producer commissions are considered an administrative expense, producers have been concerned that carriers would cut commissions in order to help meet the MLR requirements.

Producer compensation opportunities encompass both standard commission schedules for new and existing business as well as optional bonus programs. While bonus programs can be very meaningful to producers in the large group market, they are generally insignificant to the small group producer, particularly those that focus on employers with less than 25 employees. When five producers interviewed for this paper were asked to estimate the percentage of total compensation from commissions versus bonus monies, all five responded that bonus opportunities represent less than 5 or 10% of the total compensation the average small group producer earns on health insurance sales. As most bonus programs are volume driven, these estimates would appear to be reasonable. As a result, we focus most of our review on commission trends.

All carriers provide their producers with a commission schedule for selling new business and retaining existing business. The schedules are carrier specific; are usually consistent

from one year to the next in overall design and generally change no more than once a year. Bonus programs are also carrier specific but are more likely to change from year to year depending on the annual sales goals, competitive environment or new product launches a given carrier is facing.

As outlined below in Exhibit F, a review of the documents does confirm that commissions have been scaled back by six of the nine carriers over the three year time frame studied. Much of the decline may well be part of a general decline across the country as national carriers adjust to the higher MLRs required under the ACA (NY carriers are subject to a 82% MLR in the small group market while nationally the ACA requires carriers in the small group market to spend at least 80% of premiums on medical costs). In general, the commissions have declined deeper and sooner in the downstate region, and national carriers have been more inclined to reduce commissions than regional plans. Also, three of the nine carriers have moved from commissions based on a percentage of premium sold to a fixed amount per employee per month (PEPM). The fixed amount often varies based on the product sold. Unlike premium-based commission payments, which can be inflationary because commissions increase as the cost of medical care increases, fixed dollar or PEPM commission payments offer the added benefit of stability. They do not automatically increase with increasing premiums.

| Exhibit F Producer Commission Trends 2010-2012 Overall Trend from Producer Perspective (Lower = Less Earnings Opportunity and Higher = Greater Earning Opportunity) | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------|
| Carrier | Program | 2010 | 2011 | Change (11/10) | 2012 | Change (12/11) | Overall Trend (12/10) |
| 1 | Commission | Percentage-based for New & Existing Business (varies based on annual premium) | Percentage-based for New & Existing Business (varies based on annual premium) | Same | PEPM (varies based on volume) introduced for some products and Percentage-based fee retained for other products (%-age varies based on annual premium); %-age appears to have dropped overall; schedule applies to New & Existing Business | Lower | Lower |
| 2 | Commission | Percentage-based for New & Existing Business (varies based on volume) | Percentage-based for New & Existing Business (varies based on volume) | Same | Percentage-based for New & Existing Business (varies based on volume) | Same | Same |
| 3 | Commission | Percentage-based for New & Existing Business (varies based on product & earned premium) | Percentage-based for New & Existing Business (varies based on product & earned premium) | Same | PEPM (\$ amt varies based on product and status level of producer[3 levels]) | Higher for Some & Lower for Most | Lower |

| | | | | | | | |
|---|------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------|-----------------------------------------------------------------------------------------------------------------------------------|-------|--------------|
| 4 | Commission | Percentage-based for New & Existing Business (varies based on participation level & presence of competitor products) | Percentage-based for New & Existing Business (varies based on participation level & presence of competitor products) | Same | Percentage-based for New & Existing Business but with greater limitations | Lower | Lower |
| 5 | Commission | 1)Percentage-based for New Business (varies based on annual premium) 2)Percentage-based for sole offering in Existing Business | 1)Percentage-based for New Business (varies based on annual premium) 2)Percentage-based for sole offering in Existing Business | Same | 1)Percentage-based for New Business (varies based on annual premium) 2)Percentage-based for sole offering in Existing Business | Same | Same |
| 6 | Commission | 1)Percentage-based for New & Existing Business | 1)Percentage-based for New & Existing Business | Same | 1)Percentage-based for New & Existing Business | Same | Same |
| 7 | Commission | 1)Percentage-based for New & Existing Business (% varies based on product) | 1)Percentage-based for New & Existing Business (% varies based on product) | Same | 1) Fixed PEPM for New & Existing Business (same for all products) | Lower | Lower |
| 8 | Commission | 1)Percentage-based for New & Existing Business (varies based on product) | 1)Percentage-based for New & Existing Business (varies based on product) | Same | 1)Percentage-based for New & Existing Business (varies based on product) | Same | Lower |
| 9 | Commission | 1)Percentage-based for New & Existing Business | 1)Percentage-based for New & Existing Business: %-age reduced mid-year | Lower | 1)Percentage-based for New & Existing Business | Same | Lower |

Other commission and bonus trend observations include the following:

- New York Insurance Law limits HMO commissions (and bonus monies) to no more than 4% of premium; several carriers now pay less than 4%.
- Commissions on non-HMO products tend to be higher than HMO commissions; commissions on High Deductible Health Plans (HDHPs) are the highest (most likely to compensate for the lower premiums and to encourage HDHP sales).
- Five of the nine carriers do not pay commissions on sole proprietor cases; one carrier does pay and two cannot be determined from information provided.
- At least two carriers do not pay a commission on any group if the enrollment has fallen below the minimum participation requirement based on the total number of eligible employees (commission can be restored if enrollment requirement is met).
- At least two carriers require a “sole-source offering” (i.e., no competitor products) for any commission eligibility or compensate producers at different levels when more than one carrier’s products are offered to a given employer group.
- At least three carriers appear to preclude chamber and association business from bonus program eligibility.
- More complexity is present on the bonus side of compensation.

As compensation arrangements are widely believed to drive producer behavior, constructing a well-designed commission structure will be critical to the marketing success of the exchange. Producers interviewed for this paper consistently voiced their support for a level playing field, defined as the same commission schedules inside and outside of the exchange.

Section VI

Options for Incorporating and Compensating Producers and Chambers of Commerce in the NYS Exchange

How the exchange uses, certifies, reimburses and generally relates to producers and chambers of commerce, both for individual (direct) buyers and for small employers, is an important and fairly complex issue. Addressing this question will help determine the success of the exchange in achieving its principal goals of reaching and enrolling eligible individuals and employers, improving their buying experience, and doing so at the most affordable premium rates possible. Without making any recommendations, we set forth below some key considerations for the exchange in developing productive working relationships with producers, including chambers of commerce operating through licensed brokerage subsidiaries and otherwise meeting all NY Insurance Law, and four “models” of producer compensation in both the individual and SHOP exchanges.

The roles and regulation of chambers of commerce are in transition: as described in a previous section, some chambers have moved their group benefits operations into licensed brokerage subsidiaries and are functioning much like producers, while other chambers seem to be weighing the pros and cons of doing the same, or migrating to some sort of different model. Chambers meeting NYS’ regulatory requirements may prove effective in attracting and serving small employers through the exchange.

How producers and the exchange should relate may play out differently for the SHOP and individual exchange, particularly in NYS, because producers currently have very little presence in the individual market (other than state-subsidized Healthy New York). The regulations issued in March 2012 on navigator compensation remove any earlier speculation that producers might in some way play dual roles. Instead, the regulations are clear that navigators cannot accept compensation directly or indirectly from carriers for

enrollment in either qualified health plans (QHPs) or non-QHPs. Effectively, this regulation requires that a producer select one role only; he can remain a commissioned producer or he can serve as a navigator but he must choose. From both a practical and economic perspective, the vast majority of producers will very likely choose to remain producers.

We offer five key considerations for the exchange in developing and evaluating its approach to producers:

1. Producers' current market presence and influence on buyers
2. The objective need for producers' services to assist buyers on the exchange
3. Current (and evolving) producer compensation rates in the non-exchange market
4. Federal requirements/prohibitions on navigator and producer compensation
5. The cost versus revenues generated for producer services

Producers' current market presence and influence on buyers

Taking these five variables in turn, it is reasonably clear that if producers "drive" much of the buying behavior in a segment of the market that the NYS exchange wishes to serve, the exchange would be "swimming" against strong market currents were it to by-pass producers or pay them less than they receive outside the exchange. In NYS, producers drive the small-group market and their commissions from HMOs are capped by regulation at 4% of premium. They represent a significant administrative expense, which is built into premiums and allocated across all enrollees in the markets they serve. Nevertheless, the exchange needs to work with producers in order to reach small employers. Otherwise, given the influence of producers on small-group buyers, the SHOP exchange runs a substantial risk of having to compete against producers.

On the other hand, the true, “direct pay” or individual market is miniscule in NYS and producers are almost never compensated by carriers for non-group business. (Some health plans do pay producers for individuals who enroll through Healthy New York.) Moreover, federal tax credits and cost-sharing subsidies for moderate-income households enrolling in qualified health plans confer a unique “marketing” advantage on the exchange. Therefore, the exchange may consider whether or not to use producers for direct buyers in the individual market, and how much to pay them, without necessarily feeling compelled to match the outside market. Conversely, the exchange could determine that both the magnitude of the individual market and the complexity of educating a previously uninsured population may merit an approach where producers are encouraged to work with direct buyers. The potential cost of doing so would need to be weighed against the value of using both navigators and producers in the individual market.

The objective need for producers’ services to assist buyers on the exchange

Second, it is often asserted and reasonably clear that producers do supply a host of services to small employers, whose need for such services will not disappear in the SHOP exchange. These services are described in the first section of this paper. Indeed, it is arguably more complex to move an employer into the exchange under an employee-choice model than to renew existing group coverage, or to tweak the group benefits and “spreadsheet” comparative costs from competing carriers. The element of employee choice actually complicates enrollment, case installation, the explanation of employer and employee contributions to multiple plans at different premium levels, and subscribers’ claims adjudication issues that can arise for multiple carriers. An effective SHOP exchange will take on much of the added complexity of an employee-choice model, but probably not all of it, nor will it replace the producer’s other administrative services functions for small employer clients.

On the other hand, for direct buyers, whether there is a need for producers as such to help individual households select coverage in the individual exchange is less clear. Certainly, the model of producer as an outsourced “human resources department” for the small employer

does not pertain; nor is the household typically dealing with multiple carriers; nor do most individual buyers currently receive help from producers in New York, where carriers rarely pay commissions for individual enrollees. That said, direct buyers who have previously been uninsured will need a “high touch” approach and producers are trained and set up to supply these services. Whether they are willing to do so at commission rates comparable to those for community-based organizations, paid as navigators, could be tested by an RFP process. In any event, the need for producers, as such, merits separate analysis and justification in the two market segments.

Current (and evolving) producer compensation rates in the non-exchange market

Third, producer commissions represent a significant administrative expense. In NYS, producer commissions paid by HMOs are capped by regulation at 4% of premiums but now average less than 4% across small groups. (Empire recently reduced its producer payments in all small group products to a very modest \$5 per subscriber per month fee; it is not yet clear that other carriers will follow Empire’s strategic retreat from the small-group market.) Commissions for non-HMO products tend to range from 3-4% with High Deductible Health Plan (HDHP) commissions from at least one carrier running as high as 6-8%. While Wakely does not have weighted enrollment data by carrier and by product to develop the average commission across all products and all carriers, we did review commission schedules from nine carriers. Overall commission estimates made by producers interviewed for this paper range from 2.5 – 4.5% on the average small group book of business, which is consistent with the schedules reviewed. Assuming that the midpoint of 3.5% represents the norm in the small-group market, and assuming the exchange will require another 2-3% to support its own operating costs, the total represents a significant load on top of medical claims costs, plus the health plan’s administrative costs and margin. While there may be some overlap or duplication of functions between the exchange and what producers do to guide their clients in selecting a health plan, where producers drive the market, the exchange must work with them. Were the exchange to reduce producer commissions below market, claiming that the exchange replaces some

producer functions, it would probably undermine the brokers' incentive to promote the exchange.

In the individual market, premium costs today generally reflect exceedingly low producer commission costs as most carriers do not pay producers to counsel and enroll individuals into direct pay plans. Should the exchange decide to include producers in the individual exchange marketing channel, doing so will represent largely net new costs

In general, the exchange as a distribution channel for health insurance can no more "afford" to underpay (or overpay) producers than can most health plans. However, given their cost, the exchange should assess the value of producer services in both the small group and individual markets, and how much the exchange will depend on producers for outreach. The answers to these questions may differ for the small-group and individual segments.

Federal requirements/prohibitions on navigator and producer compensation

Fourth, the ACA and related HHS regulations seemingly ascribe distinct roles and forms of payment for producers as opposed to navigators: one is the conventional "producer" role, under which producers collect from the carrier a percentage commission or dollar fee per subscriber per month, based on the volume of covered lives produced for the carrier; and the other is a "navigator" role, to be compensated by grants, not commissions. While producers are specifically named in the ACA as one of eight kinds of entities that an exchange *may* use as navigators, navigators are explicitly prohibited by the ACA from accepting payment by carriers for QHPs or non-QHPs, which presumably means commissions on plans either inside or outside of the exchange. This regulation would seem to bar most producers from being navigators. Given the federal regulations, the exchange might be forced to not use producers as navigators at all, or to require producers who become navigators to not accept compensation from carriers. Permitting producers to serve as (and be compensated as) producers in both the direct pay and small group markets is certainly one way of negating any need for producers to accept a navigator role in the exchange in order to participate in the outreach and educational effort.

The cost versus revenues generated for producer services

Fifth, the cost of using and compensating producers should be weighed against their efficacy in marketing the exchange and helping customers. The cost of producers will be reflected in premiums, but the differential cost of the exchange's policy could be modest, even invisible if, for example, producers are utilized in only the small group market. Under community rating, if the same carriers participate in and outside the exchange, the cost of brokers' commissions in the exchange will be spread across the entire market segment. For example, if (a) virtually all small-group business is sold through producers, (b) the SHOP exchange were to account for 10% of small-group enrollment, and (c) producers are paid on average 3% of premiums across the outside market, then paying producers 3% in SHOP would not increase premiums for small-group community rates; conversely, the savings from not paying producers in SHOP would be spread across the entire small-group market, representing only 3/10ths of 1% of premiums in and outside the exchange. On the other hand, if the exchange were to account for 75% of individual enrollment in New York State and the exchange decides to pay producers 3% commissions for direct enrollees, this new, incremental cost will add up to a 2.25% administrative load across the entire community-rated non-group market. (It could be less than 2.25% in this example if some individuals buy coverage without a producer.)

As for producers' effectiveness, they appear to be very helpful to small employers, but many commercial producers do not serve the non-group market and most are not well-versed in helping low income populations navigate publicly subsidized programs. Conversely, most Facilitated Enrollers working with the Medicaid and CHIP programs, are simply not experienced in or able to reach small-group insurance buyers, and they presumably lack the required licensure to sell insurance under New York statutes. Moreover, the two groups of intermediaries operate under different compensation formulas in New York State^{xlii}. An informal cost-effectiveness calculation may well suggest a business rationale for the exchange to treat commercial producers and navigators as two distinct channels for reaching different populations. Exchange grants to navigators cannot

be funded by federal grants, and producer compensation can be a significant administrative cost, so both forms of financial support should be evaluated as a business expense against the returns they generate.

These five considerations help inform our development of various approaches that New York State's exchange might take to producers. We set forth below four different "models" for paying producers and managing the exchange's relationship with them. In developing these options, we recommend that New York State consider their suitability separately for the individual and SHOP exchanges. That is, it may be advantageous to adopt different models for the two exchanges.

1. Carriers pay exchange-appointed producers, the same rates in the exchange as they pay for individual enrollment outside the exchange and as they pay for small-group enrollment outside the exchange. If issuer A (participating in the exchange) generally pays 3.5% of premium, plus a bonus for increasing volume, to a producer for small groups, and issuer B (also participating in the exchange) generally pays a flat \$15 per subscriber per month to that same producer for small group, then issuers A and B would include in their respective compensation calculations the SHOP exchange's enrollment for cases where the producer has a producer of record letter. Similarly, if issuer A elects to pay 1% of premium to a producer for individual exchange enrollment and 4% for small-group enrollment, and issuer B pays no commissions for individuals and 5% for small-group, then these rates would also prevail inside the exchange. This approach would seem to ensure equal compensation for producers whether they place business inside or outside the exchange. Presumably, it would align their financial interests with the needs of their clients, regardless of compensation, and therefore would promote the exchange for clients best suited to it. This model promotes "market-driven" producer compensation. For example, where a carrier has decided to compensate producers in the small-group market at rates below other carriers', and for those carriers

which do not pay producers at all for non-group enrollment, this approach would automatically level the playing field between the exchange and the outside market.

If commission rates for individual enrollment are left to the discretion of the carrier, they may not approach the level of commission rates for small group business, since carriers do not now generally pay commissions on non-group enrollment and they are not looking to increase administrative costs. Nonetheless, this approach allows a carrier that wants to compensate brokers in the individual market to do so, on a level playing field in and out of the exchange, and it keeps the exchange out of the compensation decision-making process.

However, leaving the exchange out of the producer compensation process gives it less direct influence on producers. The exchange would have to develop a more active role with producers through its contracts with qualified health plans and/or NYS' licensure and regulatory standards for carriers and producers. Not only would the exchange (or New York's DFS) require participating issuers to pay producers comparably in and out of the exchange, but it would also have to develop a mutually acceptable process for identifying, training and certifying producers in the exchange. For example, as producers are generally not appointed to represent all carriers, each exchange-certified producer should be appointed by all the issuers in the exchange for the geography served by that agency. Doing so will require somehow "harmonizing" the participating carriers' and the exchange's producer appointment practices, at least for the subset of producers appointed by the exchange.

2. Exchange pays producers directly, the same rates (on average) as carriers pay outside the exchange for individual enrollment and as they pay for small group business. This approach also maintains equity and "neutral" financial incentives for producers, whether they place business in or outside the exchange. In addition, it places the exchange squarely in the middle, between carriers and producers, as a direct influencer of producers. However, if different carriers use different

compensation formulae, strict comparability will require the exchange to mirror their various compensation policies. This could become administratively complex, especially if a market “shake-up” with the full implementation of the ACA generates further changes in carriers’ producer compensation policies. It would also require the exchange to increase its assessment for administrative costs sufficiently to run producer commissions through its own books. While the impact on individual and small group premiums may be the same, whether producer commissions are paid directly by carriers or by the exchange, the appearance of larger numbers in the exchanges’ operating costs and revenues probably will not go unnoticed.

Whether the exchange or the carriers pay producers for small group business in the two models above, carrier-specific commission schedules should not reward producers for selling only “sole-source” business (i.e., meaning all plan options available within one employer group are from only one carrier) unless the exchange elects to endorse this choice model. (Two of the nine carriers studied tie compensation schedules to sole-source and/or overall carrier penetration rates, which reflect shared enrollment between carriers). Also, small group compensation tied to minimum enrollment percentages should either be consistent among all exchange carriers or removed from commission schedules. Both provisions help ensure a level playing field in and outside of the exchange and reduce potential conflicts in the producer role.

3. Exchange pays producers directly, at a "discounted" rate from commercial carriers. As a way to reduce administrative costs, position the state on the side of the consumer, and reflect the exchange’s role in organizing options and saving time and effort for producers, this approach may have some appeal. However, the SHOP exchange will not simplify the brokers’ tasks initially, and their dominance of the small-group market gives them leverage in marketing the SHOP exchange.

Therefore, a “government discount” for SHOP may prove problematic, unless the exchange can truly save producers time and effort, thereby allowing them to service more clients with the same effort. Even if the exchange believes that it will assume some of the tasks which otherwise fall to producers—for example, working with qualified health plans to resolve claims adjudication issues—the exchange will need to demonstrate to producers that this is truly the case in order to present a credible case for a discount. Even then, the exchange may simply have to match the outside market in order to win producer support.

In New York’s individual market, carriers do not typically compensate producers and therefore a “discounted” rate is not really meaningful. The exchange would effectively set the “going” rate for producer compensation in non-group. For carriers that either currently commission non-group business or wish to do so in the future, the exchange could nonetheless “discount” these rates if it wanted to do so.

4. Exchange appoints producers as navigators and supports them with grants. Under this approach, producers and all other navigators would function on equal footing and be compensated comparably for their efforts in the exchange. Assuming that navigators will be paid by the exchange based on a fee per enrollee or annual grants tied to enrollment volume, this approach would result in producers being compensated very differently and would require them to give up compensation from carriers. As such, this is a risky proposition for both producers and the exchange, and is unlikely to appeal sufficiently to recruit producers for the SHOP exchange. On the other hand, a fee per enrollee recognizes the agent’s upfront investment of time and effort – appropriate for clients who, because of high churn rates in publicly subsidized coverage programs, may well dis-enroll in less than one year. Again, this may be appropriate for the individual exchange, for which high churn rates are also projected, but inappropriate for the small-group market.

These four models represent a considerable range in how the NYS exchange might incorporate and compensate producers. We have only sketched the approaches described above.

Variants and details of any of these four compensation models would need to be filled in by the exchange. For example, when a small group employer has employees who do not qualify for group coverage because of part-time status, or who cannot afford group coverage, the exchange might require certified producers to refer such individuals to the exchange or to a navigator for the eligibility determination and enrollment under individual coverage. “Triaging” employees through the exchange or to navigators allows both small groups and individual employees to be most effectively served by the exchange and the “third party assistor” most appropriately trained and situated to meet their needs.

Additional operational specifics will need to be worked out by the exchange. For example, whether producers are paid by the exchange or by carriers, they will need detailed training on how the exchange works. Other elements of producer management need to be fleshed out, such as how to solicit and certify producers, how to generate leads and track them, how to incorporate brokers’ market knowledge into SHOP design features and QHP standards, how to monitor their productivity and ensure their advocacy of the exchange, etc. Again, both the basic approach and many of these other features should be separately considered for the individual and the small-group market segments of the exchange.

Section VII

Utilization of General Agencies & other Intermediaries in SHOP

General agencies (GAs), HealthPass, Bright Choices and some chambers of commerce currently serve as “intermediaries.” While each type of organization plays somewhat different roles from the others and serves a particular geography, they overlap

considerably in function. They generally work with producers and/or employers to help them organize and compare group health plan options available from different carriers. Their roles overlap substantially with the role of the SHOP exchange. Indeed, HealthPass is a private SHOP exchange, offering the kind of employee-choice model that could serve as a model for SHOP. They also know “their” markets and enjoy established relationships with small employers.

Therefore, the SHOP exchange might consider outsourcing a significant set of its functions to one or more of these intermediaries. (Other than outsourcing, SHOP is likely to end up competing with them.) The advantages of outsourcing are (1) the potential speed and efficiency of adapting existing functionality, rather than building it anew; (2) taking advantage of the market knowledge, contacts, influence and experience of existing intermediaries, including the trust that their client producers and employers already have in them; and (3) avoiding the inefficiency of adding a public competitor to the robust mix of private intermediaries that already exist. Working in alignment, an experienced intermediary can provide the SHOP exchange critical advice on which services to develop, how to structure plan offerings, how to support producers as an effective field sales staff to the exchange, and so forth.

Before deciding whether and how to outsource, however, the SHOP exchange should consider carefully which functions these intermediaries are best at performing and which functions must be retained in the exchange. For compliance and strategic reasons, the exchange will likely prefer to retain such functions as reporting to the State and to the US Secretary of Health & Human Services, adjudicating appeals, and certifying qualified health plans.

On the other hand, it may be more efficient to contract with existing private-sector firms for transactional and service functions which they already perform. The challenge in doing so, of course, is to contract at competitive rates for performing such functions well, and coordinating outsourced functions with other retained elements of the SHOP and

Individual exchange. For example, eligibility determination in the individual exchange and reporting to employers when their employees qualify for tax credits will require information interfaces between the two exchanges. This is just one example of the multiple points of integration that would be required between outsourced “intermediary” functions and the exchange.

Should the SHOP exchange decide to outsource to an existing intermediary, a preliminary list of functions for outsourcing might include the following:

1. **Producer management:** this function entails the training, certification, sales support, and performance tracking of producers who are working with small employers considering and/or purchasing through the shop exchange. (Because of an intermediary’s pre-existing relationships with particular producers, it may be prudent not to task intermediaries with selecting producers.)
2. **Employer qualification (eligibility determination):** if outsourced at all, this function should be delegated to properly trained producers, but an intermediary could quality check and function as an authoritative source of information on whether the employer meets size, location and other eligibility criteria. (Employee qualification or eligibility determination remains the exclusive responsibility of the exchange and cannot be outsourced.)
3. **Customer service:** just as producers and employers have many questions for general agencies, chambers, business associations and carriers throughout the enrollment period and the ensuing year, they will have similar issues with the SHOP exchange. In an employee choice model, because there is no single carrier for the employer (or producer) to ask for assistance, even more issues are likely to find their way to the SHOP exchange call center than would be the case for sole-source, group insurance in which one carrier handles each entire group of employees.

4. **Premium billing, collection and enrollment:** invoicing each employer on behalf of multiple carriers, ensuring timely collection or remedial action when payment is delayed, and remitting and reconciling employer payments to each carrier monthly is a critically important function. Whether existing, local intermediaries have the information systems and expertise to handle this function for the SHOP exchange, and how to integrate billing and collections with other exchange functions would have to be carefully assessed in the procurement process.

5. **Ancillary employee benefits lines:** small employers will look to their producer or some other source for life, disability, and other insured benefits, as well perhaps for 401(k), FSA, and other related services. For the producer's and employer's convenience, having an intermediary supply and manage these ancillary employee benefits lines would significantly enhance one-stop shopping. Conversely, not being able to offer ancillary lines of employee benefits would put the SHOP exchange at a significant disadvantage compared to competing distribution channels in the small-group market.

6. **Supplementary HR services for employers:** again, in order to be a full-service channel for small employers and producers, the exchange will want to match the portfolio of support services producers and employers can now access through general agents and private exchanges. However, as with ancillary employee benefits, the kinds of HR support and educational tools which are currently available from some intermediaries and would be helpful in serving small employers are outside the core focus of the SHOP exchange on group health insurance.

The coordination challenge will be far easier to meet if the exchange can find a single entity (or integrated network of entities) to which it can outsource a well-defined set of functions, either for the entire state or a major region, such as New York City or “downstate.” At the

other extreme, outsourcing tasks to multiple, competing subcontractors would make a complex task even more challenging. Moreover, a competitive procurement process for outsourcing any such functions should be open to all qualified respondents, including entities operating outside New York State. Of course, the selection criteria can include such factors as local market knowledge and established relationships with producers, in addition to scale economies, systems capabilities and breadth of experience.

Finally, we note the diversity of arrangements and innovative efforts being made by chambers of commerce and other business associations across the state to help small groups select and enroll in group coverage. While difficult to fit under a single approach, these diverse efforts could help New York's SHOP exchange to connect with employers and employees. The SHOP exchange should consider ways to customize outreach efforts in partnership with effective local business associations, without adding unnecessary administrative costs or violating NY statutes on "selling" insurance.

Moreover, some chambers and associations may be well-suited to working with enrollees in the individual exchange, particularly if such individuals are sole proprietors currently enrolled as small groups. Because the ACA defines small group as having a minimum of one employee, sole proprietors will not qualify for group insurance in 2014, nor be eligible to enroll through the SHOP exchange. As chambers already serve many sole proprietors, chambers are nicely positioned to ease the transition of this market segment into the exchange environment.

ⁱ F. Blavin et al. *ACA Implementation in NY: Using the Health Insurance Policy Simulation Model (HIPSM) to Estimate Coverage and Cost Implications.* The Urban Institute. February 2, 2012.

ⁱⁱ M. Cadogan et al. *Healthcare Reform at the Local Level: Framework for a Navigator Program in NYC.* NYC Human Resources Administration Office of Citywide Health Insurance Access. April 2011.

- ⁱⁱⁱ One key section pertaining to producers, §155.220, was issued as an interim final rule and HHS is soliciting comments on this section.
- ^{iv} Data provided in January 2012 phone calls and emails by the New York Department of Financial Services to Wakely Consulting.
- ^v A fee is not a commission. As used here, a fee is a charge submitted by a producer and paid by the client (not an insurer).
- ^{vi} As the broker is ultimately paid a commission by the insurer, and not the client, there are some that will challenge who the producer actually “works” for when advising small employers on carrier selection. This point is not going to be resolved here and is simply raised in the interest of full disclosure of competing viewpoints.
- ^{vii} NYS DFS website for Accident & Health agent/producer licensing requirements
- ^{viii} We use the term “carrier” to apply to four types of entities, referred most commonly by the article of NY Insurance or Public Health Law under which they are licensed: Article 42, 43, or 44 companies and PHSPs (Prepaid Health Services Plans). A carrier is frequently organized under multiple companies and licenses but as used here, carrier represents all of the licensed companies perceived by the public as one carrier identity.
- ^{ix} Carrier Data Call conducted by NY DFS (12/11-1/12). The request for data included 16 companies whose combined enrollment covered 80% of the small group markets in downstate and upstate New York. The 16 companies represent nine carriers (a carrier may be organized and file as several companies but we use the term carrier to reflect the combined entity generally known to the public under one name).
- ^x P. Newell, *“The Big Picture III: Private and Public Health Insurance Markets in NY, 2009,”* United Hospital Fund, April 2011
- ^{xi} Table 1: Annual Estimates of the Resident Population for Counties of New York: April 1, 2000 to July 1, 2009 (CO- EST2009-01-36), US Census Bureau, Population Division, Released March 2010.
- ^{xii} Where identification of a given interview subject is made, it is done with the explicit approval of the interviewee.
- ^{xiii} Provided by NYS DFS, Health Bureau, 10/27/11
- ^{xiv} Producer created and approved use of the spreadsheet in this document; document was produced by HealthConnect application.
- ^{xv} L. Quincy. *“What’s Behind the Door: Consumers’ Difficulties Selecting Health Plans.”* Health Policy Brief. January 2012. www.consumersunion.org
- ^{xvi} K. Butler. *“Kaiser poll for most popular PPACA provision yields runaway favorite.”* Kaiser Family Foundation. Posted 12/1/11.
- ^{xvii} Producers are well aware of HIPAA privacy requirements and obtain written employee approval before intervening in such situations.
- ^{xviii} *“The Number of Claims for the Small Business Health Care Tax Credit Was Much Lower than Anticipated.”* Press Release. Treasury Inspector General for Tax Administration. November 7, 2011.
- ^{xix} <http://www.napeo.org/peoindustry/index.cfm>
- ^{xx} HealthConnect website: www.healthconnectsystems.com.
- ^{xxi} HealthConnect website: www.healthconnectsystems.com.
- ^{xxii} For the purposes of this paper, the term chamber is intended to refer to both chambers of commerce and business associations, and chamber is used only to simplify the writing style.
- ^{xxiii} T. Trantum. *“Business Associations and a Viable Insurance Exchange: A White Paper on the Role of Associations in Health Care Reform.”* Chamber Alliance of New York State (CANYS).
- ^{xxiv} T. Trantum. *“Business Associations and a Viable Insurance Exchange: A White Paper on the Role of Associations in Health Care Reform.”* Chamber Alliance of New York State (CANYS).
- ^{xxv} T. Trantum. *“Business Associations and a Viable Insurance Exchange: A White Paper on the Role of Associations in Health Care Reform.”* Chamber Alliance of New York State (CANYS).
- ^{xxvi} L. Bosio, H. Lee and S. Pederson. *“NYS Health Benefit Exchange and the Role of Chambers of Commerce.”* Columbia University’s School of International and Public Affairs (SIPA). A report for the Brooklyn Chamber of Commerce. April 2011.

- ^{xxvii}L. Bosio, H. Lee and S. Pederson. *"NYS Health Benefit Exchange and the Role of Chambers of Commerce."* Columbia University's School of International and Public Affairs (SIPA). A report for the Brooklyn Chamber of Commerce. April 2011.
- ^{xxviii} *"The Role of Small business in New York State's Economy."* Office of the State Comptroller, Public information Office. September 2010.
- ^{xxix} *"Brooklyn HealthWorks: A Model of Affordable Health Insurance Coverage for Small Employers."* Grant Outcomes Report. NYS Health Foundation. February 2011.
- ^{xxx} *"Brooklyn HealthWorks: A Model of Affordable Health Insurance Coverage for Small Employers."* Grant Outcomes Report. NYS Health Foundation. February 2011.
- ^{xxxi}L. Bosio, H. Lee and S. Pederson. *"NYS Health Benefit Exchange and the Role of Chambers of Commerce."* Columbia University's School of International and Public Affairs (SIPA). A report for the Brooklyn Chamber of Commerce. April 2011.
- ^{xxxii} Greater Syracuse Services Corporation d.b.a. Benefit Specialists of NY is a wholly owned subsidiary of the Centerstate Corporation for Economic Opportunity (CEO), which is the former Greater Syracuse Chamber of Commerce. For ease of name recognition, we use the Greater Syracuse Chamber of Commerce nomenclature in this paper.
- ^{xxxiii} Contracted party is the Greater Syracuse Service Corporation
- ^{xxxiv} T.Deyung et al. *"Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York."* Prepared by Empire Justice Center. New York State Health Foundation. September 2011.
- ^{xxxv} Much of the information for the Bright Choices Exchange overview came from an interview conducted on 1/30/12 with Alan Cohen, Chief Strategy Officer and Co-founder of Liazon. Mr. Cohen provided the interviewer with permission to use virtually any information from the interview in this paper and volunteered to be identified as the source of this information. Additional information was taken from www.liazon.com and the individual websites of a few of the participating chambers in the Hudson Valley.
- ^{xxxvi} Bright Choices provided Wakely with the following list of participating chambers on 2/2/12: Alden Chamber of Commerce, Belgian-American Chamber of Commerce, Buffalo Niagara Association of Realtors, Buffalo Niagara Partnership (BNP), Eden Chamber of Commerce (BNP Affiliate), Gowanda Chamber of Commerce (BNP Affiliate), North Collins Chamber of Commerce (BNP Affiliate), Canandaigua Chamber of Commerce, Chautauqua County Chamber of Commerce, Guilderland Chamber of Commerce, Harlem Valley Chamber of Commerce, Kenmore-Tonawanda Chamber of Commerce, Queens Area Chamber of Commerce, Rochester Business Alliance, South Buffalo Chamber of Commerce, Southern Saratoga Chamber of Commerce, Chamber of Commerce of the Tonawandas, Ulster County Regional Chamber of Commerce, and West Seneca Chamber of Commerce.
- ^{xxxvii}G. Claxton et al. *"Employer Health Benefits 2011 Annual Survey."* The Kaiser Family Foundation and Health Research and Educational Trust. 2011.
- ^{xxxviii} B. Schilling. *"Purchasing High Performance Health Exchanges: Choice Without Hassle and the Heart of Reform."* The Commonwealth Fund. May 3, 2010.
- ^{xxxix}Contracted GAs according to the HealthPass website include: American Corporate Benefits, Benefit Mall, Emerson Reid & Company, Filco, Financial Liberty Group, First National Administrators, Island Group Plans, Savoy Associates, Professional Group Plans, Professional Group Marketing and Managing Agency Group.
- ^{xl} *"Majority of New York State Small Businesses Embrace Health Insurance Exchanges, HealthPass New York-Commissioned Survey Finds."* Press Release. Ed Emerman, Eagle Public Relations. December 5, 2011.
- ^{xli} New York's 82% MLR requirement for community rated business is contained in the State's "Prior Approval" law passed on 6/8/2010 (see: http://www.dfs.ny.gov/insurance/health/prior_app/prior_app.htm).
- ^{xlii} For more on compensation of Facilitated Enrollers in NY, the reader is directed to the September 2011 report *"Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York."* Prepared by Empire Justice Center. New York State Health Foundation.