

Wakely  
Consulting Group



# Concept and Operational Considerations in Illinois' SHOP Exchange

Wakely Consulting Group, Inc.  
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## Section I: Exploring Models for Employee Choice in Illinois' SHOP Exchange

The Affordable Care Act (ACA) requires the establishment of a Small Business Health Options Program (SHOP exchange) in each state. The purpose of the SHOP exchange is to help small businesses find and purchase health insurance for their employees.

One unique feature of the SHOP exchange is the concept of employee choice. Currently, in the small group market, most carriers offer a “sole source” arrangement: employers choose a single carrier, and employees decide whether or not to participate in the plan (or plans) offered by the one carrier. In contrast, the ACA requires that SHOP exchanges offer a model whereby employers would specify an actuarial value tier of coverage (platinum, gold, silver, or bronze, reflecting the “richness” of the coverage).<sup>1</sup> Employees would then be able to choose any of the qualified health plans (QHPs) offered on that tier.

Having a choice of health plans is currently relatively uncommon in the small group market. A 2008 survey by America's Health Insurance Plans (AHIP) found that only 9% of small group enrollees had a choice of two or more benefit plans.<sup>2</sup> However, this percentage appears to be increasing: the 2010 survey found that 24% of small group enrollees had a choice of plans.<sup>3</sup> In the current market, when a small employer offers a choice of health plans, employees are usually choosing between different plans offered by the same carrier. However, there are precedents for employee choice that extends across carriers: both the Connecticut Business and Industry Association (CBIA) as well as the Utah Exchange allow employees to choose plans from different carriers.

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<sup>1</sup> Actuarial value represents the percentage of approved claims for covered services which a health plan covers, as distinct from the enrollee's share (the two should add to 100 %.) The four actuarial value tiers range from 60% at the low end to 90% at the high end. For example, the qualified health plans at the bronze level should cover (on average) approximately 60% of expected claims for a typical commercial population; silver 70%; gold 80%; and platinum 90%. Premiums will increase to cover the higher expected claims costs to the health plan for “richer” coverage, as one moves up from bronze toward platinum.

<sup>2</sup> America's Health Insurance Plans Center for Policy and Research. Small group health insurance in 2008: a comprehensive survey of premiums, product choices, and benefits. March 2009. Available at: <http://www.ahipresearch.org/pdfs/smallgroupsurvey.pdf>.

<sup>3</sup> America's Health Insurance Plans Center for Policy and Research. Small group health insurance in 2010: a comprehensive survey of premiums, product choices, and benefits. July 2011. Available at: <http://www.ahipresearch.org/pdfs/SmallGroupReport2011.pdf>.

While the ACA requires exchanges to offer this model of employee choice (employee choice of plan on an actuarial tier selected by the employer), recently issued federal regulations allow states to also offer other models of plan choice. We illustrate four models of employee choice—the required model as well as three other possibilities—in the diagrams below.

**Figure 1 Employee choice of plans on actuarial tier pre-selected by employer (required under ACA)**

	Health Plan A	Health Plan B	Health Plan C	Health Plan D
Platinum				
Gold				
Silver				
Bronze				

**Figure 2 Single plan**

	Health Plan A
Platinum	
Gold	
Silver	
Bronze	

**Figure 3 Employee choice of any plan, any tier**

	Health Plan A	Health Plan B	Health Plan C	Health Plan D
Platinum				
Gold				
Silver				
Bronze				

**Figure 4 Employee choice of plans from single carrier pre-selected by employer**

	Health Plan A
Platinum	
Gold	
Silver	
Bronze	

The Illinois exchange will need to decide which, if any, of these additional choice models it wants to offer. The degree of choice offered by an exchange is important for several reasons. First, employee choice of plans (and particularly plans from different carriers) is typically not available in the commercial market, and therefore may add value for employers and employees that could draw them to the exchange. In addition, allowing different employees to choose different plans could provide new entrants (such as lower cost or limited network plans, that might not appeal to everyone in a group, but that hold value for some members of the group) the opportunity to gain a share of the small group market.

The degree of employee choice also has implications for the operational costs and complexity of the exchange, and the likelihood of confusing employers and brokers. Some models of choice will be especially complex to administer and this should be taken into account in designing the exchange.

Finally, offering employee choice, particularly choice across tiers, could increase the potential for adverse selection across plans, since people who are sicker and expect to utilize more benefits may be more likely to choose plans with “richer” benefits. This adverse selection, or even fear of adverse selection, could result in carriers increasing premiums for richer plans in the SHOP exchange.

We review some of the factors that Illinois should consider in exploring the different employee choice models.

### 1. Account Set-up and Support

The employee choice model is a complicated employer set-up feature. The SHOP exchange will need to have a two-phased application process, in which the employer first applies to

join the exchange, selects a model of employee choice (assuming more than one model of choice is offered), selects an actuarial value tier and/or plan(s) (depending on the employee choice model selected), and enters a contribution level. Each employee then needs to be notified, so that the employee can log into the exchange, compare plans, and select a plan. The exchange website should display to the employee only those plans that are available in their geographic area and within the employee choice model selected, and allow employees to easily compare the plans, including what their premium contribution (net of any employer contribution) would be for each of the displayed plans.

From an account set-up perspective, it may be simplest to support just one model of employee choice—employee choice of plan on a tier pre-selected by employer, as required by ACA. This is shown as Figure 1 above.

However, employers and employees will not be familiar with this model, and therefore the exchange will need to plan for adequate customer support in implementing this employee choice model. This includes close collaboration with and training for brokers. Moreover, the only way that small employers can access the special small business tax credits under the ACA, as of 2014, is through the SHOP exchange.

Therefore, for those employers who wish to do so, having a simple, conventional “model” available i.e., allowing the employer to select only one QHP to offer to his/her employees, may make these tax credits more appealing to small employers in Illinois. This is shown in Figure 2 above.

On the other hand, research elsewhere suggests the appeal (in theory) of facilitating broad employee choice among QHPs from different issuers and actuarial levels—much as the individual exchange permits (See figure 3 above). Depending on what Illinois’ market research with small employers yields, this is a third “model” that may have some appeal. While health plans are anxious about risk selection when small groups are split between carriers, some insurance carriers are offering small employers a choice of plans for their employees, but only within that one carrier. This model of employee choice is illustrated in figure 4, above.

## **2. Employer Contribution Rules and Rating/Billing Practices**

The SHOP exchange is responsible for invoicing the employer monthly and disbursing his/her consolidated monthly premium payment among the various QHP issuers in which his/her employees are enrolled. Consolidation of employer billing and QHP premium payment is a critical enabler of employee choice in the small group market, since small

employers generally lack the administrative capabilities and interest in dealing with multiple issuers. How to establish contribution rules in SHOP is an important decision, which should be made by the exchange in the context of common practice in the outside small-group market.

Two methods are used in small-group markets: “list” and “composite” rating.

Under list billing, employers receive a monthly invoice from the carrier with separate rates listed for each employee, generally reflecting the age, plus other permitted individual rating factors (e.g., gender, where allowed). Commonly, the employer pays a fixed percentage of each employee’s list bill, but because of differences in individual rating, the premium and dollar contributions will differ from one employee to the next. Both the employer and employee contributions will be lower for younger than for older workers, and for men than for women. Through the year, as employee composition and enrollment changes, the employer’s bill will also change because of changes in employee demographics. While the employer’s bill may change month-to-month, this practice more accurately adjusts the premium to the costs, and can prevent “rate shock” at annual renewal, due to significant shifts over the prior year in employee demographics.

Under composite rating, the far more prevalent billing practice in Illinois, the carrier averages the individual rating factors across the group to develop one composite rate for each rating basis type (single, family), and those rates apply for the year. The employer who contributes X% toward that fixed composite rate is somewhat insulated from premium variations during the year as employee composition changes, but may experience a significant rate change for the next year that reflects the accumulated demographic shift of his/her workforce over the current year. List billing more accurately reflects the expected variation in service utilization and claims costs across the individual beneficiaries than composite rating, but composite rating provides more certainty to the employer about his/her contributions during the year.

With the introduction of employee choice among various QHPs in the SHOP exchange, and the likelihood of systematic risk selection among various QHPs, the case for list billing is strengthened. Absent list billing, QHPs with broader networks and better-known brand recognition will likely attract older, more costly employees, for which they will receive only composite premiums, and select-network plans with little brand recognition are likely to attract the young healthy beneficiaries, for which they will nonetheless collect average, composite premiums. Under such circumstances, the first category of issuers will be reluctant to participate in SHOP, hurting the SHOP exchange’s appeal to small employers.

However, there are disadvantages to list billing, especially in markets that are not accustomed to it. For example, it is more complex, entailing many more premium rates for a group than one composite rate for singles, one for two-adult families, etc. Even when the employee contribution toward list-bills for the employer’s “benchmark” plan is made the same (by varying the employer’s contribution), the experience at the Massachusetts Health Connector with list billing was that both employers and employees were confused by seeing different employee contributions required of a 30-year-old and a 60-year-old to buy “up” or “down” to same, alternative plan.

The ACA requires that employers not discriminate against older workers in their contribution strategies. Yet it allows premiums to vary with age, by a 3-to-1 ratio, meaning older workers can be charged three times as much as younger workers. Clearly, if the employer makes a flat dollar contribution toward list billed premiums that vary by age, this requires the older employee to pay a larger percentage of his/her premium than the younger employee for the same coverage.

Whatever billing method is used, employers’ contribution toward employee coverage cannot discriminate against older workers. There are two methods by which the employer in the SHOP exchange can meet the non-discrimination test under list billing: (1) contribute the same percentage of premium for each employee (or for dependent coverage) as is commonly done under list billing; or (2) contribute a higher percentage for older workers toward a benchmark plan, such that the employees’ premium contribution will be the same dollar figure toward that benchmark plan, regardless of the employees’ ages. The two approaches are illustrated below.

The simpler approach is to have the employer contribute a fixed percentage (for example, 50% for employees) of the total monthly premium for each employee. However, in an employee choice model, the individual employee’s plan choice would change the dollar amount of the employer’s contribution. This model may appeal to employers because they would share in the savings if an employee were to pick a lower cost plan, but they would also share the extra cost of more expensive premiums, and this approach also makes costs less predictable.

Example: Employer contributes 50% of the list-bill premium of the plan selected by the employee

**Table 1**

Plan W	Plan X	Employee	Employee	Employer	Employer
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			Contrib. W	Contrib. X	Contrib. W	Contrib. X
<b>Employee A</b>	\$500	\$600	\$250	\$300	\$250	\$300
<b>Employee B</b>	\$600	\$700	\$300	\$350	\$300	\$350
<b>Employee C</b>	\$600	\$700	\$300	\$350	\$300	\$350
<b>Employee D</b>	\$800	\$900	\$400	\$450	\$400	\$450

Alternatively, the exchange could ensure that the employer’s bill doesn’t change based on the plan selection of the employees and that older employees are not discriminated against. This can be achieved with use of a benchmark or reference plan, whereby the employer and employee each contributes a fixed percentage to the average (i.e. composite) cost of the benchmark plan, but the employer’s contribution is more for older workers (with higher benchmark-plan list bills) and less for younger workers (with lower benchmark-plan list bills). As a result, all employees – older or younger- pay the same amount toward the list bill for the benchmark plan. Employees who move from the benchmark plan to a more or less expensive plan pay this same benchmark contribution, plus or minus the difference between their list bill for the benchmark plan and their list bill for the plan they select. These types of arrangements have been discussed in more detail in guidance issued for the small business tax credit.<sup>4</sup>

Example: Employer contributes 50% of the benchmark (or reference) plan composite-rated premium, no matter which plan employee selects.

**Table 2**

	Plan W (Reference plan)	Plan X	Employee Contrib. W	Employee Contrib. X	Employer Contrib. (W OR X)
<b>Employee A</b>	\$400	\$500	\$250	\$350	\$150
<b>Employee B</b>	\$500	\$700	\$250	\$450	\$250
<b>Employee C</b>	\$500	\$700	\$250	\$450	\$250
<b>Employee D</b>	\$600	\$800	\$250	\$450	\$350
<b>Composite rate</b>	\$500				
<b>Average contribution, based on composite rate of reference plan</b>			\$250	\$425	\$250

<sup>4</sup> Internal Revenue Service. Section 45R. Tax credit for employee health insurance expenses of small employers. Notice 2010-82. Available at: <http://www.irs.gov/pub/irs-drop/n-10-82.pdf>. Accessed on March 18, 2012.

As illustrated in the table above, all employees would contribute the same \$250 toward the benchmark plan (column 3); the employer contributes, *on average \$250 per employee* – more for older workers, less for younger workers – regardless of which plan the employee picks (column 5); and the employees who pick a more expensive health plan pay the difference (column 4).

While list billing is effective in reducing the impact of adverse selection associated with various models of employee choice (across tiers or carriers), current market rating practices in Illinois may discourage adoption by the exchange. cursory research into Illinois small group rating practices suggest that few small employers are familiar with this employee rating and billing practice, and those that are, are generally the so-called micro-employers (or those with fewer than 10 employees). If the exchange were to introduce this complex rating change, older employees would consistently pay more for the same coverage than younger workers under the first method described above, and the second method – while “fairer” – is more complicated to explain. Employers and producers would need to address the resulting confusion. For example, under the second approach, two employees of different ages buying the employer’s benchmark plan would pay the same, but if they both “buy up” to a more expensive plan, each might pay different amounts for that plan. When asked by employees why this occurs, employers will have trouble explaining it.

Under list billing, most employers would also see the changes on their billing statements and would need to ensure that their payroll vendors are in sync with any age-related deductions. This is particularly if an employee’s birthday during the policy year triggers a premium adjustment.

Using list billing inside the exchange and not outside the exchange, or using both methods as options for the employer adds further complication, may confuse employers, and/or can result in “gaming.” (The employer could “game” the rating system by calculating his premiums from each carrier under both methods and always select the one that costs the least; if so, carriers will have to raise their overall rates to compensate for such “gaming.”) Work is in progress at CCIIO and by the states moving forward with operationalizing their SHOP exchanges to develop detailed options for rating and contribution strategies that can mitigate the impact of adverse selection under employee choice, comply with federal non-discrimination rules, and not confuse the market. And importantly, HHS has yet to issue final regulations on rating specifics for exchanges. Future guidance from CCIIO is expected to address allowable options.

### **3. Administrative burden to employers**

One recurring theme in market research on employers and interviews with brokers is the burden that the selection and purchase of health insurance places on employers. In some ways, models that offer employees more choice (such as Figure 3, employee choice of any plan on any tier) could decrease the burden on employers, because they would not be responsible for having to select a plan to suit everyone's needs and preferences.

However, employees often turn to their employer with questions or problems about group coverage. If employees are confused about the selection and enrollment process, they may go to their employer with questions or complaints. Unless the exchange provides adequate support, the employee choice model has the potential to increase the amount of questions and problems that employers need to handle during enrollment. This is especially problematic for mini-employers (<10 employees) for whom brokers often do not perform onsite enrollment.

#### 4. Employer and employee preferences

In deciding whether to offer additional models of employee choice, a key consideration is to understand the preferences of the employers and employees within the state. If employees and employers strongly favor having a particular model, whether that is sole source or a choice of any plan offered, then it would make sense for the state to offer those desired models.

Most private exchanges that started offering employee choice across the country in the 1990's have folded, however, a new wave of private exchanges are under development. Some are "defensive" efforts by issuers to offer a choice of only their own offerings and some are benefit consultants displaying multiple offerings and looking to strengthen their services; all are untested in the market. The state is currently undertaking research to understand employer and employee preferences around choice. The findings of this research will be important to take into consideration in the exchange planning process.

#### 5. Market competition

Models with more employee choice allow each employee to choose the plan that is best for them, rather than forcing the employer to choose a single plan that is "one size fits most." A natural consequence is that plans with more "niche" appeal may be better able to compete in an employee choice environment compared with a sole source environment. For example, an employer who must choose just one plan to cover 10 different employees might want to offer a broad network product that would appeal to most of the employees.

In an employee choice model, however, some of those employees might be willing to choose a limited network option, if it were less expensive. Thus, the employee choice model might be able to increase competition among carriers in the small group market and, in particular, allow lower cost carriers to gain market share.

## 6. Adverse selection

Offering employee choice, particularly choice across tiers, could increase the potential for adverse selection across plans, since people who are sicker and expect to utilize more benefits may be more likely to choose plans with “richer” benefits. Wakely takes a closer look at the impact on premiums from various employee choice models in Section II below, where we estimate a range of impact from adverse selection, depending on how much employee choice is offered and other assumptions. Overall, we estimate the impact to be relatively modest, in the range of 1-4% of premiums.

Obviously, models that have more choice (such as employee choice of any plan, on any tier) will be most vulnerable to adverse selection. Mitigation strategies could include limiting employee choice to choice within a tier (as is done in the required model of employee choice) or allowing employees to buy only one tier up or down from the “benchmark” plan offered by the employer.

### Summary

In reviewing different options for Illinois’ SHOP exchange, the simplest approach would be to only offer the model of employee choice required by ACA. In this case, the state would maintain the potential advantages of expanding choice for employees and encouraging new entrants, while needing to support only one model of choice. In addition, while there may be some risk of adverse selection, the requirement that employees pick plans on a pre-selected tier would help limit the risk of adverse selection.

A second option for the state to consider would be to offer both the mandated model as well as a “sole-source” arrangement i.e. one QHP from one carrier. By offering a sole source option, the state exchange would be providing an option that is already common in the small group market, and therefore one that may be more familiar to employers and brokers. A disadvantage to offering both models is that the exchange would need to support both options, and educate employers, employees and brokers about the different options available.

In determining which models of employee choice the Illinois exchange wishes to offer, the state will want to obtain employer, employee and broker input. Illinois will also want to evaluate the potential impact of adverse selection in the different models on premiums in small group market, and consider the administrative and operational requirements for operating the model or models of interest. We address these issues in section II below. These strategic and analytic approaches will help to further inform Illinois' decision-making around employee choice.

## Section II: Employee Choice Model and Impact on Premiums

How Illinois allows employers and employees to purchase small employer coverage in the SHOP is an important policy decision that will help determine the success of the Exchange. Key policy decisions include participation requirements, contribution requirements, the number and type of health plans from which employees may choose, and how these requirements apply to coverage purchased outside of the Exchange as well as through the Exchange.

Wakely has evaluated that employee choice across all actuarial value (AV) tiers and all carriers will result in an impact to small employer premiums of less than 2%, with our best estimate being approximately a 1% increase. Allowing employee choice within a chosen AV tier for each employer group will result in a smaller premium impact, an increase less than 0.5%. These estimates assume that 20% of the small group market will enter the SHOP exchange. Sensitivity of this assumption is discussed later in this document. These estimates solely represent the expected rating impact due to adverse selection resulting from allowing employee choice in the SHOP exchange. There are many other ACA issues that affect rating and should be considered when pricing small group products for 2014 and beyond. The estimated premium impact of those considerations are not addressed in this document.

Estimates of the impact of adverse selection take into account the required aspects of the ACA, including having a single shared risk pool for the small group market in and out of the SHOP exchange, guaranteed issue with no rate variation due to health status, and risk adjustment. However, there are several other key facets of the ACA that are optional and undecided by Illinois at this time. Such items include whether the individual and small group markets will be pooled, the number of carriers participating in the SHOP, and stop-loss regulation. The premium impact of adverse selection due to employee choice in the SHOP exchange may be influenced by these issues, other key provisions of the exchange, and factors influencing the outside marketplace.

In addition to the rating impacts, the policy decisions surrounding employee choice will impact the functionality of the exchange, specifically regarding the calculation of contributions and the amounts that employees will have in applying employer contributions to other QHP selections. We present a more complete discussion of the issue below.

## Background

The ACA allows qualified employers to offer one or more coverage options to their employees through the SHOP. Per the notice of proposed rulemaking (NPRM) CMS-9899-P, an Exchange may:

1. Allow employers to select a single QHP to offer employees.
2. Allow employees to select a QHP from one specific employer-chosen metal level
3. Allow employees to choose a QHP from a selected number of metal levels
4. Allow employees to choose any QHP offered in the SHOP at any level<sup>5</sup>

Allowing employee choice increases risk selection, meaning that that employees are more able to make decisions that benefit themselves, to the detriment of the insurance market in general or to a specific health insurer. Adverse selection occurs when healthy people decide not to purchase insurance or purchase the minimum coverage necessary, or when sick individuals only purchase insurance when they know they will need it, or when sick individuals purchase policies that offer more coverage for their conditions.

The NPRM (CMS-9899-P) notes that “allowing a qualified employee to purchase any plan across levels raises some potential for risk selection. A portion of any risk selection among plans and issuers due to employee choice of QHPs ... may be mitigated through the risk adjustment program.” Our analysis evaluates how the adverse selection impacts the overall premium rates in the Illinois market even with the risk adjustment program in place.

## Current Practices

To understand how employee choice could impact plan selection, we believe it’s helpful to first review the a) choices offered, b) how employers set contribution rates, and c) current participation and contribution requirements. Although we have not surveyed the practices specific to Illinois, discussions with carriers indicate that the Illinois small group market generally aligns with small group market practices in most states. The following points discuss these practices.

**Health Plan Choice.** Employers choose the carrier and plan design option(s). This decision is made for the entire group. Only one option is generally selected. However, in a minority of situations, a carrier may allow multiple benefit options to be chosen for the small group. For the small group market it is very rare that an employee will get to choose between two different carriers.

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<sup>5</sup> CMS-9989-P

**Employer Contribution Methodology.** In 2010, employers (both small and large combined) pay about 81% of the insurance premium for their employees, and about 70% of the premium for their employees' dependents, with small employers generally paying less. This contribution will vary by state and employer group size, among other variables.<sup>6</sup> Premium rates for small employers are generally calculated based on the age and family composition (and potentially other factors) of the employees who are electing coverage. For larger employer groups, these rates are converted to composite rates for billing purposes. Smaller employers can be list billed, whereby the various premiums depending on the age of employee are communicated to the group (for example, a 60 year-old member's rate would be different than a 25 year-old rate).

It's important to realize that each of the billing approaches – list billing and composite rating – are intended to result in the same amount of revenue. The uniformity of premiums for employees, the simplicity in displaying composite-rated premiums to employers, and budget consistency for an employer have greatly contributed to the widespread use of composite rates over the list billing rates.

Although it varies from state to state, composite rating is the predominant manner in the small group market that premiums are communicated to employees and employer/employee contributions determined. For example, the table below shows the composite rates and a sample split of employer and employee contributions.

**Table 3: Employer Contribution (75% of Empl rate + 50% of Dependent Rates)**

	Empl	Empl+Sp	Empl+Child(ren)	Empl + Fam
<b>Total Rates</b>	\$363.74	\$727.48	\$636.54	\$1,454.96
<b>Employer Contributions</b>	\$272.80	\$454.67	\$409.21	\$818.41
<b>Net Employee Cost</b>	\$90.93	\$272.80	\$227.34	\$636.54

**Contribution and Participation Requirements.** Carriers generally require minimum participation and contribution requirements. The purpose of minimum participation rules is to protect the issuer against adverse selection related to healthy employees either remaining uninsured or obtaining coverage in the individual market, and older and sicker individuals may be more prone to participate in the insurance plan or enroll in the most comprehensive coverage.

<sup>6</sup> Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.," the Kaiser Family Foundation, Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010 The Kaiser Family Foundations' HRET Survey of Employer-Sponsored Health Benefits

- Health carriers that offer coverage in the small group market require a minimum percentage of employees to enroll in coverage as a pre-condition for selling group coverage. An employer with five or fewer employees is typically required to enroll all of his/her employees in the group’s health plan, unless an employee is covered as a spouse or as a dependent under another employer’s plan. For groups of six or more employees, the participation requirement is generally 75 percent. If an employer cannot meet these enrollment thresholds, the health carrier will not sell the policy to the group.
- Carriers also require employers to contribute a minimum amount of the monthly premium – generally 50 percent of the premium for single coverage – as a pre-condition for insuring a group. Employers unable or unwilling to contribute at least 50 percent of the premium are not allowed to purchase group insurance.

### Under the ACA

Our modeling analyzed the following four scenarios:

1. Single QHP – One Carrier, One Plan. This model reflects the traditional way that small employers purchase insurance where the employer selects a carrier and a health plan, and the employees are allowed to enroll in the plan.

**Monthly Premiums for Single Coverage - Based on Composite Rate**

Plan Choice	Carrier Choice			
	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	\$546	\$533	\$518	\$555
Gold	\$485	\$473	\$460	\$493
Silver	\$425	<b>\$414</b>	\$403	\$432
Bronze	\$364	\$355	\$345	\$370

A composite rate could be developed for the group, and the employer’s and employee’s share for the premiums could be set in the traditional manner.

2. Employer-Chosen Metal Level– All Carriers, One Plan Level. Under this model, the employer would choose a plan level (Platinum, Gold, Silver, or Bronze) and allow the employees to enroll in any of the QHPs in that level.

**Monthly Premiums for Single Coverage - Based on Composite Rate**

Plan Choice	Carrier Choice			
	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	\$546	\$533	\$518	\$555
Gold	\$485	\$473	\$460	\$493
<b>Silver</b>	<b>\$425</b>	<b>\$414</b>	<b>\$403</b>	<b>\$432</b>
Bronze	\$364	\$355	\$345	\$370

3. Employer-Chosen Carrier – Employer selects carrier, employees select plan level. Under this model, the employer would choose a carrier and allow employees to enroll in any of the plan levels (Platinum, Gold, Silver, or Bronze) offered by that carrier. Alternatively, the employer could limit the available options to certain plan levels (such as Silver and Gold). The table below shows the potential premiums when employees are eligible to enroll in any of the metal levels.

**Monthly Premiums for Single Coverage - Based on Composite Rate**

Plan Choice	Carrier Choice			
	Carrier A	<b>Carrier B</b>	Carrier C	Carrier D
Platinum	\$546	<b>\$533</b>	\$518	\$555
Gold	\$485	<b>\$473</b>	\$460	\$493
Silver	\$425	<b>\$414</b>	\$403	\$432
Bronze	\$364	<b>\$355</b>	\$345	\$370

4. All Carriers, All Plan Level. Under this model, the employer would choose multiple plan levels (Platinum, Gold, Silver, or Bronze) and allow the employees to enroll in any of the QHPs in those levels.

**Monthly Premiums for Single Coverage - Based on Composite Rate**

Plan	Carrier Choice			
	Carrier	Carrier	Carrier	Carrier

Choice	A	B	C	D
Platinum	\$546	\$533	\$518	\$555
Gold	\$485	\$473	\$460	\$493
Silver	\$425	\$414	\$403	\$432
Bronze	\$364	\$355	\$345	\$370

Although the NPRM (CMS-9899-P) doesn't specify other alternatives, these tables allow us to visualize other options where only select carriers and select plan choices are allowed, or potentially an option where all plan choices within a single carrier might be allowed for employee choice.

**Employer Contribution.**

The employer contribution calculation has the potential to become more complex than in the current market because of a variety of issues.

1. *Open-ended employer contributions.* The most simplistic calculation would be that the employer would pay a flat percentage of the rate for each employee's plan choice. However, a flat percentage requires an open ended commitment on the part of the employer, which likely will be unattractive for employers.
2. *Adequacy of premiums.* The composite rate presented in the tables above for any carrier may not be adequate if a cross-section of the single employees did not select the plan. For example, suppose the oldest employees select Carrier D, Platinum plan because it has the broadest network and best benefits. In this case, the \$555 rate would not be adequate to cover the cost.

One mechanism to help remedy issue 1 would be that the carrier could choose a "reference plan" from which to calculate their contribution. This concept is presented in the IRS notice 2010-82 and seems like a very likely solution that the SHOP may be able to accommodate.

Illinois will need to consider how its SHOP will assist the employer groups with these calculations. The NPRM (CMS-9899-P) "encourage(s) a SHOP to consider options to calculate and display the net employee contribution to the premium for different plans and different family compositions, after any employer contribution has been subtracted from the full premium amount."

**How Employee Choice Impacts Cost**

Allowing plan selection by employees as described in the previous section would indicate that selection of the high cost plans would lead to higher pricing for these plans and the

low-cost less rich plans might be more aggressively rated. This would be the logical consequence resulting from adverse selection in the market. However, the ACA has provided for risk adjustment between carriers, which will encourage carriers to price various benefit plans based on average risk. Since the risk adjustment mechanism transfers payments from plans with low risk members to those with higher than average risks, pricing benefit plans based on the expected health status or claims experience of the employees that choose the plan may “duplicate” the effects of the risk adjustment mechanism and potentially put the profitability of the issuer at risk.

Furthermore, differences among base premium rates for a carrier in a given geographic area should be based solely on the differences in the benefit design, except as otherwise permitted under the ACA. Differences should not be based on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

Therefore, we believe that the adverse selection resulting from the employee choice model will increase premiums in the small employer market. To analyze the current selection in the small group market, we looked at the relative costs by benefit plan for several small group and individual carriers, including the experience supplied by Illinois for the data call, to understand the existing adverse selection in the small group and individual market. For small group, we were looking for adverse selection resulting from small group employers’ selections. For individual market, it is the adverse selection of each individual that leads to the selection. Not surprisingly, in both markets, we found that the allowed cost was positively correlated to the benefit richness of the plan design. That is, higher benefit plans enrolled members with higher average allowed claim costs.

Using this relationship, we have simulated the potential impact on overall premiums that would result from employer selection in the SHOP. We have modeled various scenarios with the following assumptions:

- Various levels of employee choice. We evaluate the scenarios of the most restrictive (based on a single QHP employer choice) to least restrictive (based on full employee choice).
- We assume the participation and contribution requirements are applicable to the group as a whole (similar to the current environment), but not applicable to any specific carrier and QHP.
- Various levels of employer contributions. We have assumed that lower employer contribution rates result in greater adverse selection. The best estimate impacts assume average employer contribution rates of 80%. The highest estimates of

adverse selection impacts result from assuming 50% or less employer contribution rates.

- Spread of SHOP membership by actuarial value tier and carrier. Wakely assumed that the information supplied by Illinois small group carriers in the data call reflects the scenario in which employers choose the plan and carrier for employees. Approximate actuarial value tier levels were determined based on historical information supplied in order to estimate the distribution of membership by actuarial value tier when employers choose the plan offered to employees.
- Based on the experience of a large employer group that incorporated a model of full employee choice (benefit levels and carriers), generally, the health status for those enrolled in the highest premium plans were twice that of the health status for those enrolled in the lowest premium plan. This assumption has been incorporated in modeling the full-employee-choice option for Illinois.
- We have not assumed any propensity of a group or employee to pick a specific carrier based on quality of that provider or history of coverage with that provider.

The Appendix shows the results of our analysis. Results are summarized in Table 4 below.

**Table 4: Impact to Overall Premiums Based on Employee Choice, Assuming the Entire Small Employer Group Market is Sold through the SHOP Exchange**

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
<b>Description</b>	One Carrier, One QHP per Employer Group	Employee chooses carrier; employer pre-selects the actuarial tier	Employee chooses actuarial tier; employer pre-selects the carrier	Full Selection of QHPs by Employee
<b>Best Estimate Impact</b>	0%	0.3%	2.6%	2.8%
<b>Range of Possible Values</b>	0%	0%-1%	1% - 4%	1% - 4%

It is important to consider that employee choice as described in this analysis would only be available in the SHOP. Therefore, the impacts displayed above are applicable for the scenario if 100% of the small group market would be enrolled in the SHOP. The results would also be applicable for any carrier that only offers small group coverage through the SHOP and has no small group product offerings outside SHOP. Because the ACA requires that premium rates for small employer groups must be actuarially equivalent in and out of SHOP, the impact of adverse selection noted above for SHOP products would be muted for

carriers offering small group coverage outside SHOP as well. This of course implies that the small group products offered outside of SHOP would be subsidizing the SHOP products with regard to this specific pricing consideration.

Table 5 provides examples of how high, low, and best estimates of premiums would vary based on the percent of carriers’ small group business that is offered in and out of SHOP due to the interaction of single risk pooling requirements and adverse selection created by employee-choice.

**Table 5: Employee-Choice Adverse Selection Impact on Small Group Premiums Based on Carrier-Specific Percentage of Small Group Business in versus outside of the SHOP**

<b>% of business in SHOP</b>	<b>Low</b>	<b>Best Estimate</b>	<b>High</b>
<b>0%</b>	0%	0%	0%
<b>10%</b>	0%	0%	0%
<b>20%</b>	0%	1%	1%
<b>40%</b>	0%	1%	2%
<b>60%</b>	1%	2%	2%
<b>100%</b>	1%	3%	4%

## Section III: Producer Strategy for SHOP

How the exchange uses, certifies, reimburses and generally relates to producers 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. To inform this thinking, we first take a closer look at the services producers typically provide small employers today. Second, without making any recommendations, we set forth some key considerations for the exchange in developing productive working relationships with producers and four “models” of producer compensation in the SHOP exchange.

Background information for this section was drawn from interviews with four general agencies (GAs) in Illinois that all work closely with producers in the small group market as well as research and broker interviews that Wakely has conducted on the producer channel in several states over the last 6-8 months.

### Typical Producer Services

There is a remarkable level of similarity when producers are 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. 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. This work is generally necessitated yearly due to average annual premium increases and the pressure these increased costs put on the employer’s bottom line. The number of plan options proposed by producers varies widely, and high deductible health plans (HDHPs) are increasingly presented to small employers as an option to their current plan offerings.

Spread-sheeting multiple benefit plan options is a time consuming activity in Illinois because 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 health status, industry type and location. In Illinois GAs report that rate requests must be

individually forwarded to specific carrier rating portals as carriers do not provide their rating formulas to a central source for “one stop” rate quotations. In other states, particularly those with pure community rating, a private entity might be in place to provide either the producer or GA with an all-carrier rate quoting application to simplify this process.

In addition to cost sensitivities, producers will generally make sure that any proposed benefit plan design and carrier network will address the personal needs of the business owner and his/her dependents. 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.<sup>7</sup> 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.

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 employees’ providers are also in the proposed carrier network. For small groups, this process must almost always be done manually. Producers (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.

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<sup>7</sup> L. Quincy. “*What’s Behind the Door: Consumers’ Difficulties Selecting Health Plans.*” Health Policy Brief. January 2012. [www.consumersunion.org](http://www.consumersunion.org)

Many producers 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. The GAs in Illinois confirm that the vast majority of the small group market is still on paper enrollment and either the producer or GA scrubs the paperwork for accuracy and thoroughness.

All producers are required to administer the underwriting guidelines of carriers. 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
- minimum employer contribution requirements
- availability of coverage to 1099 consultants (and other non-employees)
- determination of eligibility based on 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 is the final arbiter of underwriting decisions, the producer is nonetheless expected to know and support the carrier's rules. (Of course, under a SHOP exchange and federally compliant small-group underwriting guidelines, these decisions should be much more standardized than is the case currently.)

Producers universally state that providing Human Resource guidance is a typical service and one that requires time and attention throughout the policy year. 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. Most small business owners generally have only two outside professionals at their disposal: an accountant and an insurance producer. In addition to health insurance, most producers provide their small business clients with 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 resolution of claim issues 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 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.

Resolution of premium billing issues is another frequent service. 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<sup>8</sup>, 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 businesses with less than 25 Full Time Equivalent (FTEs), paid on average below \$50,000, for whom the employer contributes at least one-half of the cost of group health insurance. Known as the Small Business Health Care Tax Credit, it was designed to encourage small business employers to offer health insurance to their employees. It is available to corporations filing income taxes and non-profit employers as a credit against their contributions toward payroll taxes. It is currently available to such employers, but it will be modified so as to encourage the use of SHOP. As of 2014, it will only be available through SHOP exchanges, and it will increase in value over the current tax credit. However, it will expire for any employer that uses it through SHOP after the second year of use.

On November 7, 2011, the Treasury Inspector General for Tax Administration issued a press release<sup>9</sup> that substantiated anecdotal reports that the volume of claims for the credit has been very low nationally. According to the IRS, some 4.4 million taxpayers could potentially qualify for it, but as of mid-May 2011, just over 228,000 had claimed the credit for a total amount of more than \$278 million. By comparison, the Congressional Budget

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<sup>8</sup> Producers are well aware of HIPAA privacy requirements and obtain written employee approval before intervening in such situations.

<sup>9</sup> “*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.

Office (CBO) had estimated that non-profit and for-profit employers would claim up to \$2 billion in Small Business Health Care Tax Credits for 2010.

As producers are a natural channel for marketing this tax credit to small employers, and tax credits are considered a key driver for SHOP exchange enrollment, we asked several of the general agency representatives interviewed for this paper about their experience with the tax credit. Both the average annual wage cap of \$50,000 and the complexity of the processes to determine eligibility and to collect the credit were typically cited as the primary reasons why the tax credit was not of greater interest to clients.

This input from Illinois GAs suggests that small business tax credit usage in Illinois will mirror the underperforming national results released in November. Nonetheless, on a go forward basis, small employer education of the availability of tax credits in the SHOP exchange will be needed and producers could fill this role. It is clear that utilization of the small-business tax credit will need to increase significantly to support substantial SHOP enrollment. The exchange should consider how to structure outreach, education, and assistance through brokers (and other channels) to increase small employers' awareness and use of the tax credit for 2014. For example, the web site might include a calculator that would help the employer and his/her broker determine eligibility for the credit or otherwise educate the employer on how the tax credit works. The exchange might also promote the tax credit directly to small employers, in order to create employer awareness and demand that their brokers help them estimate the value of the credit.

### **Key Considerations in Developing Productive Working Relationships with Producers**

Clearly, the more than 77,000 licensed resident producers in Illinois play a key role in the State's small group market today. Further, based on estimates made by all four GAs interviewed, it appears that a high percentage of the small group market is brokered (when 3 of the 4 GAs were asked what percent of this market is brokered, the responses were: "95-98%," "99.9%," and "the vast majority"). Small employers apparently strongly favor the use of a producer, and the SHOP exchange must consider, and may very well decide to embrace producers in the group insurance shopping process. Without making any recommendations, we set forth below five key considerations for the exchange in developing productive working relationships with producers and four "models" of producer compensation in the SHOP exchange.

The ACA requires all exchanges to establish a navigator program,<sup>10</sup> and also allows each state to permit agents and brokers (referred in this paper collectively as producers) to

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<sup>10</sup> §155.210 Navigator program standards. March 2012 Exchange Regulations.

enroll individuals, employers and employees in any qualified health plans (QHP) offered in the individual or SHOP exchange<sup>11</sup>. The final 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 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.

As this paper is focused on SHOP considerations, we limit the discussion accordingly and simply acknowledge that the producer strategy may play out differently for the SHOP and individual exchange given the requirements for a navigator program. We offer five key considerations for the SHOP 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 Illinois 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 Illinois, producers clearly drive the small-group market. They also 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.

### ***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.

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<sup>11</sup> §155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs. March 2012 Exchange Regulations.

These services are described above. While the SHOP exchange could “take on” some functions conventionally provided by brokers, such as resolving employees’ claims issues and employers’ billing issues, SHOP could continue to rely on brokers to handle such issues. Employers in the SHOP exchange may well be best served by relying on brokers to perform most of their conventional service functions.

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 “spread-sheet” 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 some 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. For example, the SHOP exchange will make it easier to compare different plans by standardizing plan designs and facilitating an easier “apples to apples” comparison, but the employer (and employee) still need to decide what plan best meets their needs. Shopping for health care is widely regarded as difficult and while the process will be easier, it may still not be easy for many. If employees are struggling, they will ask their employer for help, and most employers prefer to have the producer address specific questions and concerns.

When the choice model allows employees of the same company to select different health insurance carriers, many elements of plan design across carriers will be standardized but some differences will remain. For example, the exchange can require carriers to structure their prescription drug plans so that cost-sharing features are the same or easily comparable but the exchange can’t expect that the formularies for the different carriers will be the same. Or, one carrier might approach Behavioral Health needs one way and another carrier has a different care management philosophy. Or, carriers may have different processes to approve continued coverage for handicapped dependents...all carriers may do it, but the paperwork and decision-making process may be different. So, while expanding choice has many advantages, it will also create employee and employer questions that the SHOP exchange may well decide are best left to the producer.

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

Third, producer commissions represent a significant administrative expense. In May and June of 2011, Wakely surveyed six of the largest small group carriers in Illinois and found that the average 2010/2011 small group commission was 6% (the low was tagged at 5% and the high at 6.8%). Since that time, commission schedules across the country have

typically fallen and many have changed from a percent of premium basis to a flat fee arrangement based on enrollment (typically referred to as a flat fee per employee, per month, or PEPM). All of the GAs interviewed for this paper report that commissions in Illinois have dropped and have been based on a “per card” or per enrollee basis since early 2011. One carrier indexes the flat rate to the size of the small group and further differentiates the rate based on whether the coverage is for an employee only (“single” coverage) or an employee with dependents (“family coverage”).

While none of the GAs wanted to publicly share specific commission rates as of the 1/1/12 policy period, two suggested that a 25% drop over the last year would be a reasonable assumption. Applying this factor to the 6% average of a year ago pegs the new average at 4.5%, a figure that Wakely finds credible given data collected in other states. Assuming that the 4.5 average represents the norm in the small-group market, the total represents a significant load on top of medical claims costs, the health plan’s administrative costs and margin, plus the operating costs for the exchange. 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 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 whether producers truly add value and how much the exchange depends on producers for outreach.

#### ***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 final exchange regulations from accepting payment directly or indirectly from carriers for QHPs or non-QHPs, meaning that navigators cannot accept commissions or fees on plans inside or outside of the exchange. This regulation would seem to bar most producers from being navigators. Given the federal regulations, the exchange will have to forego using producers

as navigators at all, or require producers who become navigators not to accept any compensation from carriers.

***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 impact of their cost on premiums for QHPs in the exchange could be modest, even invisible. 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 4.5% of premiums across the outside market, then paying producers 4.5% 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 less than half of 1% of premiums in and outside the exchange.

These five considerations help inform our development of various approaches that Illinois' SHOP exchange might take to producers. We set forth below four different "models" for paying producers and managing the exchange's relationship with them. One of these four is not to use and pay producers, but we do not recommend this theoretical option.

1. Carriers pay exchange-appointed producers, the same rates in the exchange as they pay for small-group enrollment outside the exchange. If issuer A (participating in the exchange) generally pays 4.5% 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. This approach, allowable under §155.220 of the final regulations issued in March, 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 above or below other carriers', this approach would automatically level the playing field between the exchange and the outside market. However, in an employee-

choice model, it also introduces the complexity of different fees/commissions for employees within the same employer group who select different QHPs, and the added complexity collecting fees for each group from multiple carriers. (A common collection/distribution function could be set up, by carriers, the exchange or a third party.)

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 Illinois' licensure and regulatory standards for carriers and producers. The exchange (or Illinois Department of Insurance) would have to require:

- a. participating issuers to pay producers comparably in and out of the exchange,
- b. producers be trained and certified for the exchange
- c. all exchange-certified producers, who are generally not appointed to represent all carriers, be appointed by all the issuers in the exchange for the geography served by that producer agency.

Doing so will require “harmonizing” the participating carriers’ and the exchange’s producer appointment practices, at least for the subset of producers appointed by the exchange. For example, the SHOP exchange might ask carriers how they appoint producers, identify any differences, and then come up with a common approach acceptable to all carriers and the exchange. This could be done either by a regulation issued by the Insurance Department or through the exchange’s certification criteria. To the extent that some carriers are national, they may not like having different practices in different states, but other states are likely to have the same needs.

This model is strongly favored by Illinois producers, based on feedback received by the State’s exchange planners and in proposed legislative amendments

2. Exchange pays producers directly, the same rates (on average) as carriers 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. Alternatively, the exchange or Insurance Department could calculate an average producer commission or fee and pay that flat rate. While establishing equity among the issuers offered in an employee choice model on the SHOP exchange, averaging is unlikely to be “neutral” across brokers on the exchange.

Either mimicking current broker compensation arrangements or averaging them 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 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. Also, small group compensation tied to minimum enrollment percentages should either be consistent among all exchange carriers or removed from commission schedules.

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.

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 Illinois 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.