



Health Insurance Agents and Brokers in the Reformed Health Insurance Market

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Summary

Health insurance agents and brokers, collectively called “producers” by insurance companies, assist consumers and small employers in choosing and enrolling in health insurance products. Producers are licensed and regulated by the states. Traditionally, the federal government has had no role in regulating producer activities outside of federal programs such as Medicare Advantage. The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA), as amended, creates a limited federal role in developing standards for the use of producers in the health insurance exchanges, which are competitive regulated markets effective January 1, 2014. The additional regulation of producers and alternative health insurance information (e.g., the online insurance portal) and assistance services available to consumers may limit the traditional demand for producers’ services. PPACA also has a minimum medical loss ratio provision requiring plans to pay rebates to their members if a certain percentage of their premiums are not spent on medical costs. This provision may provide an incentive for health insurance companies to reduce their compensation to and/or utilization of producers as they seek to reduce their administrative costs in relation to their medical costs.

This paper will be updated to reflect relevant legislative and regulatory activity.

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Introduction

In one survey, a large majority of consumers have reported that the health insurance market is very complex and that they required assistance in choosing a plan.¹ Health insurance agents and brokers, collectively called “producers” by insurance companies, assist consumers in choosing and enrolling into insurance products, generally sold in the individual and small group markets.² According to the Bureau of Labor Statistics, producers held about 434,800 jobs in 2008, with about 73% being independent, meaning that they are either self-employed or working for an independent agency or brokerage, and about 21% being “captive agents” that are direct employees of an insurance carrier.³ The remainder work for banks and other companies within the financial services industry that have an insurance business segment.

Captive agents may also receive a salary, but all producers generally are paid sales commissions that are usually higher in the first year of a new sale, but continue to accrue each year the individual or family remains enrolled.⁴ The commission is a percentage of the premiums paid by the enrollee or policyholder. The base commission percentage generally is in the 6%-8% range on average, but can vary substantively between different types of health insurance and geographic regions; it is also generally higher for initial enrollments.⁵

Approximately 24 million Americans are expected to enroll in individual and small group qualified health plans (QHPs) offered through the health insurance exchanges established by the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) as amended.⁶ This could represent a new market for health insurance producers. However, their role in the exchanges is not guaranteed by law, and other information sources, such as the mandated consumer web portal, could provide alternatives to the traditional relationship between producers and health insurance consumers.⁷ The exchange is to standardize information on insurance options and provide

¹ Assurant Health, “Agents and Individual Medical Insurance: Empowering Informed Choices, Enhancing Consumer Experiences,” July 2009.

² The terms “individual insurance” or “individual market” mean health insurance coverage offered to individuals (and potentially their dependents) that is not in connection with a group health plan (§2791(e) of the Public Health Service Act). The term “small group market” refers to the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year (§2791(e) of the Public Health Service Act). These are the terms as amended by PPACA. Previously, a small employer had been defined as at least 2 but not more than 50 employees.

³ Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2010-11 Edition, Insurance Sales Agents, available at <http://www.bls.gov/oco/ocos118.htm>.

⁴ Mark Hall, “The Role of Independent Agents in the Success of Health Insurance Market Reforms,” *The Milbank Quarterly*, vol. 78, no. 1, 2000.

⁵ Leslie Jackson Conwell, “The Role of Health Insurance Brokers: Providing Small Employers with a Helping Hand,” Center for Studying Health System Change Issue Brief no. 57, October 2002. For specific examples of commission policies in market see United HealthCare Services, Inc., “Overview of Producer Compensation,” 2010, available at http://www.uhc.com/legal/overview_of_producer_compensation.htm. Aetna Inc., “Commission schedules,” 2010, available at <http://www.aetna.com/insurance-producer/producer-compensation.html>.

⁶ Congressional Budget Office March 20, 2010, letter to Speaker of the House Nancy Pelosi, available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

⁷ Section 1103(a) (as amended by 10102(b)) of PPACA requires that a web portal be established by July 1, 2010 to assist individuals and small businesses in identifying health insurance coverage options in each state. The new Office of Consumer Information and Insurance Oversight (OCIIO), in the Department of Health and Human Services, is (continued...)

independent helpers for prospective enrollees called “navigators.” One could argue therefore, that the exchange itself may reduce the demand for assistance from producers by making it easier to shop for different health insurance for individuals and small employers. Moreover, the minimum medical loss ratio (MLR) requirements of PPACA will place downward pressures on administrative expenses, including the use of insurance producers.⁸ Thus, there will be an incentive for insurance companies to cut back on the use of producers or reduce their commissions in order to rein in their administrative expenses. Some observers, including associations of producers, have suggested that the regulatory and market changes resulting from PPACA could put producers out of business.⁹

This report provides a brief background on the federal and state roles in regulating insurance producers and the potential impact of the relevant PPACA provisions on the use of producers by health insurance companies.

Regulation Impacting Producers

State Regulation

With the exception of government sponsored insurance programs (e.g., Medicare Advantage) producer activity is generally regulated by the states.¹⁰ States usually regulate producers by prohibiting unfair sales practices and requiring producers to meet standards to obtain licensure. Most states have adopted the National Association of Insurance Commissioners (NAIC) Model Unfair Trade Practices Act, or a similar statutory framework, which defines unfair methods of competition including misrepresentations and false statements regarding the benefits, false statements and entries about the consumer, failure to maintain marketing and performance records, failure to maintain complaint handling procedures, and misrepresentation in insurance applications for the purpose of obtaining fees or commissions.¹¹ With respect to licensure, states have standardized their regulation through adoption of NAIC’s Producer Licensing Model Act to create a system of reciprocity for producer licensing and uniform standards requiring that a producer be at least 18 years of age, pass a criminal background check, have pre- and post-licensure specialized training in the insurance product being sold, have a record of compliance

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responsible for implementing this provision. The website healthcare.gov was launched on July 1, 2010, and is expected to be updated with additional information in October 2010. For more information see <http://www.hhs.gov/ociio/gatheringinfo/index.html>.

⁸ For more information on PPACA and private health insurance, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind, Bernadette Fernandez, and Mark Newsom.

⁹ Julian Pecquet, “Insurance Agents Fight for Survival in World After Health Reform,” *The Hill*, August 22, 2010. Kate Pickert, “The First Victims of Health Care Reform,” *Time Magazine*, August 26, 2010.

¹⁰ Even in government sponsored programs such as Medicare Advantage the state role in regulating producers directly is generally maintained. In other words, federal regulators hold insurance companies accountable for the behavior of the producers they use rather than the producers themselves. For more information on Medicare oversight of producers see Centers for Medicare and Medicaid Services, “Chapter 3 – Medicare Marketing Guidelines For Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans, and Section 1876 Cost Plans,” June 2010, available at http://www.cms.gov/ManagedCareMarketing/Downloads/2011_MMG_060410.pdf.

¹¹ National Association of Insurance Commissioners, “White Paper on Regulation of Medicare Private Plans,” September 2008.

with unfair methods of competition standards, and pass a test of knowledge regarding standards of practice for the producer.¹²

As part of their oversight of both health insurance companies and producers, states have developed complaint reporting systems that tend to be substantively similar, but may have some variation in procedure, such as the methods of submission (e.g., hardcopy paper versus online submission).¹³ Generally, once a complaint is filed it is investigated by the state insurance regulator, and if the claim has merit actions are taken against the insurance company or producer, usually beginning with an order to resolve the matter that caused the complaint. Available data suggest that producer issues rank relatively low on the list of concerns that consumers have about their insurance coverage. NAIC’s aggregate national summary of reported complaints data indicates that marketing and sales complaints (direct producer actions and their marketing management) ranged from 4.32% to 4.66% of total insurance complaints per year between 2007 and 2009, and only two specific categories of producer complaints were ranked in the top 20 (in terms of frequency) of complaint categories in 2009 (see **Table 1**).

Table 1. Insurance Complaints, by Category and Subcategory, 2009

Rank	Complaint Category	Complaint Subcategory	2009 Count
1	Claim Handling	Denial of Claim	25,736
2	Claim Handling	Delays	24,971
3	Claim Handling	Unsatisfactory Settlement/Offer	20,441
4	Claim Handling	Other	8,072
5	Underwriting	Premium & Rating	6,817
6	Underwriting	Cancellation	5,788
7	Policy Holder Service	Coverage Question	5,053
8	Policy Holder Service	Premium Refund	3,888
9	Policy Holder Service	Other	3,638
10	Policy Holder Service	Premium Notice/Billing	3,481
11	Policy Holder Service	Information Requested	3,214
12	Policy Holder Service	Delays/No Response	2,707
13	Marketing & Sales	Agent Handling	1,958
14	Marketing & Sales	Misrepresentation	1,914
15	Underwriting	Nonrenewal	1,734
16	Claim Handling	Adjuster Handling	1,497
17	Claim Handling	Medical Necessity	1,418
18	Underwriting	Surcharge	1,396
19	Underwriting	Other	1,111
20	Policy Holder Service	Cash Value	825

Source: National Association of Insurance Commissioners, “Reasons Why Closed Confirmed Consumer Complaints Were Reported,” August 2010.

Note: Counts are across insurance product lines.

¹² National Association of Insurance Commissioners, “State Licensing Handbook,” 2009.

¹³ For more information on complaint submissions by state, see National Association of Insurance Commissioners, “File a Consumer Complaint,” 2010, available at <https://eapps.naic.org/cis/fileComplaintMap.do>.

State and Federal Roles Regulating Producers in the Exchanges

Sections 1311(b) and 1321(b) of PPACA require, that by 2014, each state establish a health insurance exchange to facilitate the purchase of qualified health plans (QHPs).¹⁴ Essentially, the exchanges will be government-regulated marketplaces that, among other things, are to provide standardized comparisons between QHPs in accordance with rules established by the Secretary of Health and Human Services (hereafter referred to as the Secretary). QHPs are health plans that are certified as meeting a specified list of requirements related to marketing, choice of providers, covered benefits, value of coverage, and other features.¹⁵

PPACA establishes a federal role in developing standards for producer activity in the exchanges by requiring that the Secretary promulgate procedures under which a state *may* allow producers to enroll individuals and employers in QHPs and assist eligible individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an exchange.¹⁶ PPACA also requires that the Secretary promulgate regulations establishing criteria for the certification of health plans as QHP. The certification criteria must include marketing requirements.¹⁷ Thus, federal standards for the behavior of producers may be established by regulating how QHPs use them for marketing purposes. The states' traditional role in licensing producers is not changed by PPACA. A state may also establish additional rules for its exchange, but the state rules may not conflict with or prevent the application of regulations promulgated by the Secretary.¹⁸

PPACA also establishes the “navigators” program in the exchanges to assist individuals with enrollment.¹⁹ Specifically, navigators are to conduct public education activities concerning QHPs, distribute fair and impartial information concerning enrollment and the availability of premium tax credits and cost sharing reductions, and facilitate enrollment into QHPs. Navigators may be licensed producers, but any individual or entity serving in this role must be independent of any health insurance issuer in connection with a QHP and must comply with standards developed by the Secretary, in collaboration with states, that ensure that information made available by the navigators is fair, accurate, and impartial.²⁰ Thus, if producers act as navigators they will not have their traditional role as being employed or directly compensated by health insurance companies.

Potential Impact of Minimum Medical Loss Ratio Requirements

While not a direct regulation of producer activity, the minimum medical loss ratio (MLR) standards established by PPACA will likely have an impact on the use of producers. The MLR refers to the percentage of premium revenues spent on medical claims. Thus, if a plan received \$100 of premiums and spent \$85 on medical claims its MLR would be 85%. Beginning no later than January 1, 2011, PPACA requires a health insurance issuer to provide an annual rebate to

¹⁴ If a state fails to meet the requirements for establishing an exchange then the HHS Secretary is required to operate the exchange in that state.

¹⁵ For more information, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind, Bernadette Fernandez, and Mark Newsom.

¹⁶ §1312(e) of PPACA as amended by §10104(i)(2).

¹⁷ §1311(c)(1) of PPACA.

¹⁸ §1311(k) of PPACA.

¹⁹ §1311(i) of PPACA.

²⁰ §1311(i)(2)(B) and §1311(i)(4) of PPACA.

each enrollee on a pro rata basis if the ratio of the amount of premium revenue expended by the issuer on clinical claims and health quality costs, after accounting for several factors such as certain taxes and reinsurance, is less than 85% in the large group market and 80% in the small group and individual markets.²¹ States are permitted to increase the percentages, but the Secretary may adjust the state percentage for the individual market if it is determined that the application of 80% would destabilize the market.

In 2008, health insurance companies that report to NAIC in aggregate spent 2.02% of their premiums on producer commissions, which represented 17.43% of their administrative expenses.²² Commission ranked only behind staff salaries and benefits among the expense categories. However, substantive variation can be found in these expense figures at the plan level based on factors such as geographic location, size of the plan, and the benefits complexity of the plan. The strength of a health insurance company's brand also matters. For example, plans under the Blue Cross and Blue Shield (BCBS) marketing name generally have lower expenses for commissions.²³ The BCBS plans can pay lower commissions because they have the most known brand name among health insurers, thus they have less need for producers to market their products to drive sales.²⁴ The minimum MLR standards will likely provide an incentive to health insurance companies to reduce their costs from managing and compensating producers, if they are at risk for missing the target.

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²¹ §1001, as amended by §10101(f) of PPACA: §2718 PHSA. For more information, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind, Bernadette Fernandez, and Mark Newsom.

²² The percentage of total premiums spent on commissions is lower than the base percentage of premium commission rate per enrollee because some enrollments do not involve producer sales requiring a commission such as self-enrollments and sales by producers not paid a commission. The actual total administrative cost of producers is higher because the commissions category on the accounting report does not include producers paid by salary or the administrative infrastructure managing the producers. National Association of Insurance Commissioners, "Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2008," 2009.

²³ Linda J. Blumberg and Karen Pollitz, "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals," April 2009.

²⁴ Harris Interactive, "Blue Cross/Blue Shield Highest Ranked Health Insurance Company Among Consumers," July 2010, available at <http://www.harrisinteractive.com/vault/HI-News-Release-EQ-Managed-Care-2010-07-07.pdf>.