Producer Advisory Committee
Report and Policy Recommendations on Requirements for Producers to Sell Insurance in DC Health Link Including Training and Appointments
July, 2013

Introduction

The Producers Advisory Committee (PAC) is a standing advisory committee of the DC Health Benefit Exchange Authority. It has been meeting since March to develop recommendations for the DC Health Benefit Exchange Authority Executive Board policies regarding requirements for producers wanting to sell insurance on DC Health Link, the DC health Benefit Exchange website. As a part of this, PAC discussed training and other requirements. Below are the recommendations of the PAC and background on how these recommendations were reached. The recommendations are being forwarded based on a consensus of the PAC.

In a separate discussion the Producers Advisory Committee and the Consumer Assistance and Outreach Advisory Committee jointly met, discussed and provided consensus recommendations on the roles and responsibilities of producers as compared to in-person assisters or navigators in the District. Those recommendations and the working group report on that joint meeting can be found at http://hbx.dc.gov/node/481352.

Committee members

The members of the Producer Advisory Committee are:

Lee Bethel – Committee Chair	Comprehensive Benefit Services, Inc.
David Chandra	Center on Budget and Policy Priorities
Stephanie Cohen	NFP Golden & Cohen, LLC
Margaret Flickinger	Keller Benefits Services, Inc.
Robert Clark	Price Waterhouse Coopers' Health Research Institute
David Smith	United Healthcare
David Natori	Aetna
Wes Rivers	DC Fiscal Policy Institute
Antoinette "Toni" Young	Community Education Group
Rob Poli	Insurance Marketing Center
Sanford Walters	Kelly Administrative Services for Kelly & Associates Insurance Group
Janet Trautwein - Facilitator	National Association of Health Underwriters

Committee focus

Since March, there have been five committee meetings to discuss the nature and scope of training and certification, and the appointment process. [1]

In addition to appointed committee members, members of the public joined the sessions and provided input.

DC is distinct in both the relatively small size of the exchange population and the close proximity to two other states that has implications for producers and carriers. It is likely that many, if not most, producers will want to be able to work in Virginia (federally facilitated) and Maryland (state-based) exchange as well as DC. Thus, the focus of the discussion in the committee meetings was largely around how to best ensure producers were adequately trained in the particular requirements of the DC Health Benefit Exchange and the District's licensing requirements without needlessly duplicating training or requirements that may be required by other jurisdictions. Moreover, the discussion was necessarily qualified because some related issues, such as IT functions, have not been fully resolved.

Summary of primary issues regarding role of producers

The committee discussions focused on a few basic issues: training and other requirements for brokers to selling DC Health Link and how to address real or perceived steerage of the sale of health plans by brokers. This discussion included a specific discussion on the current contracting and appointment process between carriers and brokers.

Training

There was extensive discussion about the process and content of training. Carriers explained how they provide training and require tests, primarily on their products. Producers described numerous avenues of learning provided by carriers to ensure strong knowledge of carrier products. The producers also explained how professional organizations provide continuing education opportunities and requirements, including online and in-person training. These courses generally focus on changes in laws and regulations affecting insurance. The content is varied and generally the producers choose what training courses are most appropriate for their needs. Consumer representatives discussed the need for training in areas producers haven't previously focused on such as the individual and employer responsibility requirements, qualification for advance payment tax credits, cost sharing reductions, and eligibility for Medicaid.

[1] Meetings were held on March 20, March 26, , June 4 and 17, 2013. There was an additional meeting with the Consumer Assistance and Outreach Committee on April 10, 2013, to discuss the role of IPAs verses producers in the small group and non-group markets.

In addition, there was extensive discussion about what would be appropriate for the DC exchange. From the beginning, there was a general agreement among all stakeholders that there are distinct requirements of the DC Exchange that producers should be required to know that training should not be burdensome or duplicative of other training requirements that producers may be required to obtain.

In summary, the meetings included extensive discussion about existing training requirements for producers:

- What should be included in the training;
- Who provides it, who pays for it, and how much is required (and by whom—regulators versus carriers);
- How it is developed and approved;
- Differences, if any, between resident and non-resident producer requirements;
- How often and how much must producers have; and
- How records of completed training are maintained.

All mentioned that the cost of training not be a barrier, and that if training could be made available through traditional CE channels, that would be easiest. Moreover, there was general agreement that there should be an online option for DC Health Link specific training, though other venues would also be acceptable (e.g., CE courses at conferences). There is a general agreement that annual training should only be required if changes necessitate it.

Licensing

The carriers and producers on the committee, as well as staff from DOI, provided detailed background on current procedures for licensing of producers in general as well as DC specific requirements.

Appointment process

There was extensive discussion about the appointment process by carriers, including the procedural process (i.e., the paperwork flow and responsibilities) and the substantive standards (i.e., the level of understanding carriers require of their products and how they provide the information to producers).

A carrier appointment consists of a current license, adequate E&O insurance, and training on carrier products (carrier training is typically a continuous process of updating producers on new products or product changes). In addition, if the recommendations below are adopted, producers will have to complete DC Exchange specific training.

The committee assumes that most producers currently active in the DC market have appointments with most or all of the carriers that will be in the DC Exchange.

Initially, committee members discussed requiring producers that want to participate in the Exchange to be appointed by all carriers in the Exchange at the point of making a sale. However, after extensive discussion, the committee's view evolved to an upfront requirement that producers be appointed with all carriers before being eligible to sell plans in the exchange.

This latter approach seemed to be more consistent with current practice and will provide critical consumer and carrier protection by ensuring all producers that sell a plan have appropriate errors and omissions insurance and minimize potential delays and confusion for producers and consumers

Recommendations for requirements all brokers selling coverage in DC Health Link must meet

(The PAC approved the following recommendations by unanimous consent at the June 17, 2013 meeting.)

The DC Health Benefit Exchange Authority is taking an open door approach to brokers selling qualified health plans in DC Health Link.

- Brokers must hold a resident or non-resident license in the District of Columbia.

- Brokers must register with the DC Health Link and successfully complete training as required.

- Brokers must be contracted or appointed with all health insurance carriers who offer their products in DC Health Link, and carriers shall accept such contracts and appointments from brokers that meet their licensure and insurance requirements. The objective of this requirement is:
  1. Consumer protection and program integrity - errors and omissions coverage is a broker requirement of appointment with carriers in the District market;
  2. Knowledge of qualified health plans – carriers will be in contact with and know all brokers participating in DC Health Link and will promote education of their specific health plan offerings with those brokers;
  3. Protection from real or perceived steerage – brokers will have a relationship with and knowledge of all carriers and their plans.

  This requirement shall be implemented in a manner to meet these objectives as feasible and creating the least burden on brokers and carriers.

Recommendations on Training:

- Training for resident producers should cover:
  (1) ACA reforms and the market structure and rules for non-group and small-group insurance,

(2) Eligibility rules for Premium Tax Credits and Cost-Sharing Reduction subsidies and small business tax credits,
(3) Eligibility and referral protocols for Medicaid and the DC Healthcare Alliance,
(4) Application of the individual responsibility requirement as it relates to small businesses,
(5) SHOP eligibility and rules and the employer responsibility requirement,
(6) How to use DC Health Link, including the broker portal, to serve clients, to share resources, and to enroll clients in qualified health plans in the Exchange,
(7) Appeals rights and processes for individuals and small groups,
(8) Procedures and contacts for referrals, and
(9) District specific policy and information from general training in 1-8.

- Training for non-resident producers who are certified to sell in another state-based exchange or a federally-facilitated exchange should have training that covers District specific policies from the general training categories of 1-8 for resident brokers.

- Producer training requirements for DC Health Link should fulfill continuing education (CE) requirements currently in place for licensure, to the extent feasible.

- Training costs should not be a barrier to producers selling coverage through the exchange.

- Resident, non-resident, and any additional annual training should be available on-line and may also be offered in person, to the extent feasible. Such training should utilize existing distribution channels including third party administrators, wholesalers, and general agents where feasible.

- Ongoing training will only be required if District or federal policy or IT changes necessitate it. If needed, such training should fulfill continuing education requirements, to the extent feasible.

The committee explicitly recognizes that these recommendations may need to be modified slightly, but there is a strong consensus that these recommendations embody the best overall approach to achieving the Board's open door policy.

Additional Background and Summary of work group discussions

The following is additional background and more detail on some of the discussions during the PAC's meetings.

Training: DC resident producers are required to take 24 hours of CE every two years; there is a system that tracks it. Prior to becoming licensed they must satisfactorily pass an exam. There is not specific training requirement for the exam, but many brokers take training courses in order to prepare for the exam.

Continuing education courses vary by topics and are self-selected by brokers based on their areas of interest and work. Costs vary, depending upon the group providing it and whether a producer is a member of the association. Currently, there are no DC specific courses required before obtaining a DC health insurance producer license.

Producers, carriers, and consumers suggested that some DC Health Link specific training may be appropriate.

Resident and non-resident broker statistics: The resident license is a function of where the producer resides. The following are the number of producers licensed in DC with health insurance authority:

- Resident producers selling to individuals 806
- Non-resident producers selling to individuals 33,772
- Resident producers selling to business entities 61
- Non-resident producers selling to business entities 2,796

The high number of non-resident producers is a result of the unique nature of the DC metropolitan region.

There was considerable discussion about non-resident requirements. Initially, the committee members were concerned that formal training of out-of-state producers might be burdensome and duplicative. The carriers and producers talked extensively about how producers often work in multiple jurisdictions, particularly in the DC metropolitan area. Although there is much common practice and requirements among various jurisdictions, there are also some state specific rules, as well. Consumer and producer representatives ultimately came to the conclusion that non-resident and resident producers should meet the same requirements with regard to DC Health Link specific training because the focus should be on the DC consumer, regardless of the producer's residency.

Carrier appointments and product training: There are essentially three components to the appointment process: a) a current license; b) adequate E&O insurance; and c) completion of training requirements.

This led to extensive discussions about how producers get appointments with each carrier—how producer licenses and E&O insurance are verified, and how carriers train producers about their specific products, as well as ensure general training requirements have been met. The carriers gave examples of how they handle these matters today (the process typically takes 10 days to two weeks to complete), and the producers described how they ensure that they are current with all carriers in their appointments. The consumer representatives frequently asked about the checks in the system.

There are also variations in carrier training of producers about their particular health plan products. Although training approaches vary among carriers, they and the producers agreed that both have strong incentives to be knowledgeable about products. Broad

product knowledge allows the producers to build a broad base of business, and misinformation or outdated information can cause serious problems for the producer and carrier.

Many producers currently have appointments by the carriers that will be in the DC Exchange. The question is how to complete the appointments of those who are not currently appointed by all the carriers and ensure all appointments are current on a continuous basis.

The initial thought was to initiate the appointment process at the point of a first sale (i.e., if a producer does not currently have an appointment with carrier X, then she would submit the necessary documents for appointment when she made her first sale with carrier X). After considerable discussion, the carriers, producers and consumers on the committee concluded that this would not be optimal administratively and could put consumers at risk (i.e., delays while the appointment approval is pending).

Producers, carriers and consumers agreed that it was critical that a broker's E/O insurance be checked before that broker was allowed to sell a carrier's health plan. Requiring appointments with carriers after a sale leaves carriers and the exchange potentially liable for any mistakes made by the broker and fails to protect the consumers in a way that generates confidence in exchange health products and brokers selling them.

Thus, the committee agreed unanimously that the appointments should be upfront—i.e., a producer's appointment should be completed before he or she engages in selling a specific carrier's products.

A carrier representative suggested that all appointment paperwork might be kept in one location on the exchange. Staff said they would discuss this with the IT to determine whether that would be feasible. However, at a minimum, the Exchange will make available on its site a link to carrier pages for information on the appointment process.

All committee members agreed that the requirements should be implemented in a manner to minimize burden on producers and carriers while trying to accomplish the objectives.

Plan steerage: Exchange staff raised the next question for PAC discussion, whether there was a possibility of producer steerage of business—i.e., producers, intentionally or unintentionally, directing good risks or poor risks to particular health plans or only selling specific health plans.

Staff provided information on how other state exchanges are considering addressing the steerage issue. Most state exchanges have yet to fully resolve this issue, but the approaches being considered include: establishing a compensation structure for all brokers in the exchange; having the carrier paying the commission for products sold in the exchange; requiring the same compensation inside and outside the exchange. Finally, a few state exchanges are requiring all brokers to be appointed by all carriers and all carriers to appoint all brokers.

The steerage issue was discussed at length, but all stakeholders—carriers, consumers, and producers—agreed that the open door, all appointment policy would largely mitigate the risk of steerage. Because of the relatively small market and the all appointment requirement, producers have a strong incentive to help the consumer make the right choice. This is an issue that carriers and Exchange staff should monitor over time, but the consensus of the committee is that the proposed policy will provide sufficient checks in the system to minimize any real or perceived steerage and the up-front appointment process should reflect this as an objective.

Final consensus

The policy recommendations represent the outcome of extensive and robust discussions about requirements for brokers selling insurance in DC Health Link and creating a cooperative working relationship with brokers. The discussions sometimes went into great detail about how things work today and how and where adjustments should be made to accommodate the requirements of the ACA and DC law. There was comity throughout the discussions among committee members, staff, and the public that attended, and the policy recommendations represent the consensus that emerged from the committee's work.