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Connecting Immigrants to Commercial Health Coverage

A survey of existing and potential strategies

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Executive Summary

Noncitizens residing in New York make up a disproportionate share of the uninsured. In discussions about more universal health care coverage, the challenge of covering immigrants has largely been addressed as a matter of the rules governing public coverage, ignoring, for the most part, the significant role of employer-based and private coverage in our current and future system. This issue brief finds that commercial insurers to varying degrees have already recognized the need to engage with the immigrant market. Their approaches include development of specialized products and enhancing the cultural and linguistic competence of their own operations and their provider networks. We find that the most successful model has not relied on special products, but has joined cultural competence with creation of a type of "connector" rooted in a particular community, integrating linguistically and culturally appropriate educational and social service functions with the marketing of coverage. This brief also examines different models of independent "connectors" for their likely success in enhancing immigrant enrollment. We recommend that connectors be rooted in affinity groups, play an active educational and social service role (perhaps located at existing community social service agencies), be able to relieve small employers of administrative burdens, and have capacity to direct both employers and individuals to a full range of public and private coverage options, including where appropriate enrollment of family and group members among different programs.

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INTRODUCTION

As the national debate about broadening health coverage begins in earnest and States participate in that discussion and anticipate how to take advantage of the results, the question of how to provide health coverage for immigrants is one of the issues that must be addressed and resolved. This is particularly true in New York, where non-citizens are about three times more likely than citizens to be uninsured (35 percent versus 12 percent, respectively),[1] and where they comprise more than a quarter (28 percent) of the State's uninsured under the age of 65.[2]

In an earlier issue brief,[3] we examined the extent to which various proposals for broadening coverage would promote or inhibit immigrant enrollment, with a particular emphasis on current and prospective barriers to immigrants enrolling in the public programs which are the cornerstones of so many expansion proposals. In this issue brief, we turn to commercial insurance – how it works now for immigrants, and how its role may be enhanced in an expanded system.

In order to assess how commercial insurers accrue immigrant enrollment now, we surveyed the largest insurers by market share. We found that insurers active in New York's commercial health insurance market vary significantly in the degree to which they have cultivated immigrant communities as distinct markets and in the strategies they have developed to penetrate those markets. They hold different philosophies about what is likely to succeed, arising in part out of the varying paths by which they have become conscious of immigrants as a market to be pursued. From their experience, we hope to derive lessons about how insurance can cover a much greater number of the immigrants who need it, particularly those with significant health needs arising out of disability or serious illness.

As a complement to our examination of the marketing efforts of individual insurers, we also considered what measures might be taken by the State or other entities to promote enrollment in commercial coverage. Particularly if purchasing insurance remains voluntary, the significant number of middle and higher income people who remain uninsured suggests that new and creative ways will have to be sought to promote enrollment in private coverage. While policy makers have talked about "connectors" as a helpful conduit for individual and small business enrollment, there is no single definition of the term nor is there clear agreement on what would make a connector effective, particularly for the immigrant population.

A note on terms: for the purposes of this report, when we discuss immigrants we are referring to foreign-born individuals who permanently reside in the United States and who were not born with U.S. citizenship. In New York State, more than 40 percent of the State's 4.2 million immigrants have successfully completed the process to become naturalized U.S. citizens. The remaining foreign-born population is comprised of non-citizens, who primarily consist of lawful permanent residents (LPRs, or "green card holders"); individuals in transitional statuses who may become LPRs (such as applicants for asylum, or immediate family members of U.S. citizens who have applied for lawful permanent resident status); and unauthorized ("undocumented") residents who entered the country without permission, or who entered with permission and overstayed their non-immigrant

1. Cook, A., Williams, A., and Holahan, D. "Health Insurance Coverage in New York, 2005-2006," United Hospital Fund, May 2008. Figures are from the 2006 and 2007 March supplements to the Current Population Survey. Statistics on uninsurance rates differentiate only between citizens (which include both U.S.-born and naturalized citizens) and non-citizens, rather than between U.S.-born citizens and immigrants. Relevant categories of non-citizen immigrants are set forth in Appendix II to this issue brief.

2. ibid.

3. Scherzer, M. and Rejeske, J., "Analysis of New York State Coverage Expansion Proposals: Potential Impact on Immigrants" (New Yorkers for Accessible Health Coverage and New York Immigration Coalition) March, 2009

visas. In addition to immigrants, there is another category of foreign-born individuals who are temporarily present: non-immigrant visa holders, most typically students, workers, and visitors.

Why study commercial insurers?

Many of the participants in the health care reform debate seem to agree that no proposal for expanding health coverage will succeed if it undermines or threatens the integrity of existing coverage which the currently insured population perceives to be serving its interests. Thus, President Obama's vision for health care reform, as articulated in his campaign, was that nobody would have to surrender coverage they now have if they would prefer to keep it.

The imperative of preserving existing coverage almost guarantees that major expansion initiatives will leave in place the current employer-sponsored and private insurance market for a significant segment of the population.[4] In the past, this route to coverage has not worked as well for immigrants as for native born citizens, because a disproportionate number of immigrants work in jobs where employers are unlikely to offer coverage. Although immigrants in New York work in all sectors and occupations,[5] they disproportionately work in low-wage jobs, for small firms, and in occupations and industries in which offers of insurance are less common (e.g. agriculture, service, construction, labor).[6]

Even where coverage is offered, the concentration of immigrants in the lower end of the wage scale means they are less likely to take up the coverage because the employee contributions are unaffordable. Further, they may lack understanding of how private insurance works and why it should be purchased, either because their country of origin had only a rudimentary health insurance system or because it had a universal, government-run system. Some immigrants may also lack the English language proficiency to obtain information needed to make decisions about participating in the complex insurance system. About 2.3 million New York State residents have limited English proficiency ("LEP"), including one quarter of New York City's residents.[7] LEP individuals account for 42 percent of New Yorkers below the poverty level.

The combination of working in small businesses, generally lower wages, information barriers, and the exclusion of most unauthorized immigrants from government health coverage programs like Medicaid, Family Health Plus and Medicare goes a long way toward explaining immigrants' disproportionate lack of coverage. These circumstances also suggest that the small group health insurance market may offer opportunities to significantly expand coverage to immigrants through commercial insurance. New York's small group market is subject to rigorous regulation by the State. It does not permit insurers to compete through applying different underwriting rules to select the risks they would like to assume. Rather, it is a "guaranteed issue" market

4. There is much current debate over whether there should be a public insurance plan operating alongside the private plans and in competition with them. Some believe that over time the public program's competitive advantages could or should drive out the private plans. By examining how private plans might increase their enrollment, we are not taking a position in this debate. We believe that the insights arrived at by studying immigrants and private health insurance will be directly applicable to public health insurance programs as well.

5. Dyssegaard Kallick, D. "Working for a Better Life: A Profile of Immigrants in the New York State Economy," Fiscal Policy Institute, November 2007.

6. Alker, J. and Ng'andu, J. "The Role of Employer-Sponsored Health Coverage for Immigrants: A Primer," The Kaiser Commission on Medicaid and the Uninsured, June 2006.
Ku, L. "Why Immigrants Lack Adequate Access to Health Care and Health Insurance," Migration Policy Institute, September 2006.
Capps, R., Kenney, G., Fix, M. "Health Insurance Coverage of Children in Mixed-Status Immigrants Families." Snapshots of America's Families, 3:12, 2003.

7. Dyssegaard Kallick, D. "Working for a Better Life: A Profile of Immigrants in the New York State Economy," Fiscal Policy Institute, November 2007.

where any bona fide business can purchase coverage. It is also a "community rated" market, in which premiums are set uniformly within a product, regardless of the age, sex or health status of the individual members.

Because of our guaranteed issue rules, private insurance sellers, unlike public health coverage programs that categorically exclude significant numbers of immigrants based solely on their citizenship status, cannot make citizenship or lawful permanent residence a criterion of eligibility for coverage.[8] In the small group health insurance market, the only criterion is that an individual be working at least 20 hours per week for the employer, generally demonstrated through the employer's state withholding tax returns. Although the latter underwriting requirement may indirectly have the effect of restricting coverage to those with the legal right to work here, there is no doubt that small group coverage may be extended to significant numbers of people who could never satisfy the legal requirements for public coverage,[9] including people who are undocumented immigrants.[10]

That immigrant small businesses may provide significant business opportunities for insurers has not gone unnoticed. A number of insurers have tried to penetrate this market. Taken together, the existing programs provide useful instruction on how the large remaining numbers of uninsured immigrant New Yorkers might be approached to increase their enrollment in commercial coverage. They also offer lessons for how marketing of insurance coverage might more effectively be approached in non-immigrant communities. One program, United HealthCare's, stands out as a potential model for an effective community-based insurance connector. By providing a range of services, activities and information keyed closely to the needs and interests of the community it serves, it can be seen as a community institution, akin to a small town bank or school system, which if replicated in other communities could help change public perceptions of insurance coverage from an unattainable luxury to integral social expectation.

Methods

To ascertain which health insurance plans had the most developed programs for enhancing immigrant enrollment, we conferred with the major trade associations representing the insurers, the New York Health Plan Association and the New York State Conference of Blue Cross and Blue Shield Plans. Through these associations, Aetna, Empire Blue Cross, Excellus and United HealthCare were identified as appropriate plans to examine. EmblemHealth was added in order to cover all the largest insurers in the State.

Information regarding the programs at each insurer was gathered through interviews with top corporate executives at the plans or those they designated as having principal responsibility for programs affecting immigrant enrollment. Those interviewed are identified in the text associated with each health plan, and we are grateful for their generosity in spending time discussing their programs, reviewing the information as reported, and responding to follow up questions. In addition, corporate websites were reviewed and, where provided, enrollment materials or consumer information reviewed. One site visit was conducted, to the Chinatown community outreach office of United HealthCare.

8. The individual insurance market is similarly open. The only requirement is that one show current residence in New York. Proof may be through evidence that does not come from a governmental agency, but may consist of a lease, utility bill, or similar documentation.

9. These could include, for example, individuals working under special nonimmigrant work visas

10. Undocumented immigrants in some cases may be legally employed because their employment date preceded the imposition of an employer obligation to check immigration status. That obligation was not imposed until the enactment of the Immigration Reform and Control Act (IRCA) of 1986 (Public Law No. 99-603, 100 Stat. 3359). They may also be covered as the spouse dependents of individuals who do have legal status that enables them to work. Employers are not obliged to and generally do not ask about dependents' immigration status when making hiring decisions.

With respect to connectors, officials and counsel for HealthPass were interviewed and the HealthPass and Working Today websites studied. Public documents describing proposals for New York's Enrollment Center were reviewed, as were the legislation enabling Massachusetts's Connector and reports of its operations.

After a description of the strategies of New York's leading insurers, we will suggest which strategies seem most pertinent to any initiative to attract immigrants to coverage and how those strategies might be institutionalized in a connector mechanism.

I. ANALYSIS – INSURERS CONNECTING DIRECTLY TO IMMIGRANTS

Aetna[11]

Overview

Aetna's principal approach to New York's immigrant communities has been through the creation of a specialized product that it believes fits the needs of the sorts of purchasers found in those communities, namely, small businesses seeking an economical product. The product, NYC Community Plan (NYCCP), is offered only in the five boroughs of New York City. NYCCP has been in evolving to meet the challenges of the current market.

Lines of Business

Aetna is a diversified national health care company headquartered in Connecticut with over 17 million members nationally and over one million in New York. It participates in the New York commercial group and individual markets and offers Healthy New York, Medicare Advantage and Medicare Drug plans, but does not participate in the public programs such as Child Health Plus, Family Health Plus and Medicaid Managed Care.

Marketing and Current Enrollment

Aetna's website points to its involvement in the most rapidly growing segments of the insurance market - among African Americans, Asians and Hispanics. NYCCP was introduced at the beginning of 2008, but it was informed by a longer term corporate concern for disparities in care. In 2000 the company began to gather racial and ethnic data with respect to health care access and outcomes which confirmed the existence of significant disparities. Since that time, Aetna has made efforts of various sorts to address those disparities, including programs funded by the Aetna Foundation at medical schools and teaching hospitals to enhance providers' cultural competency and sensitivity.

The NYCCP arose, however, out of a hard look at business realities in conjunction with the noble goals of reducing health disparities. Katherine Begley, who took over as head of small group operations for the Northeast Region (New Jersey to Maine) in 2006, perceived New York as a particularly challenging place to increase business because of three factors: (1) the high prices of coverage in New York, (2) barriers to enrollment created by such a diversity of cultures, language, and insurance access points, and (3) a trend toward high deductible plans to address cost that were structured in such a way as to impede access to primary and preventive care. She resolved to build a more affordable product but with a richer benefit design, achieved through smaller networks rooted in communities where the providers were willing to negotiate favorable rates. She addressed the challenge of cultural diversity by hiring multilingual, multicultural sales representatives, and brought in Miguel A. Centano from the Small Business Administration, an administrator with a history of significantly increasing the issuance of loans to small, often minority-owned businesses.

Mr. Centano reviewed statistics on minority-owned small businesses and saw very significant creation of small businesses by Asians, Hispanics and African Americans, among the smallest in the small business sector. They determined to target these markets, and brought Mandarin and Spanish-speaking staff. They approached community partners, starting with anchor hospitals (initially 22 in New York City) and community physicians,

11. Based on interviews with Susan Tully Abdo, Aetna Senior Director of Government Relations for the Northeast Region, February 4, 2008, and Katherine N. Begley, Small Group General Manager, Northeast Region, and Miguel Centeno, Vice President, Strategic Market Development, March 14, 2008, as well as follow up emails.

a high percentage of whom are board certified and culturally and linguistically competent (about 50 percent are multilingual) to deal with the populations they serve. In addition they designed a special benefit package (with four variations in co-payment and deductible plans) for this market. By January 1, 2009, they had increased the number of anchor hospitals to 34 and increased the number of participating doctors.[12]

The plan design[13] is in some senses similar to that of Healthy NY, as was the initial cost. However, unlike Healthy NY, NYCCP provides all the mandated benefits required under New York's insurance law. Thus, it includes such benefits as inpatient mental health and drug and alcohol rehabilitation, occupational rehabilitation, and chiropractic care. It offers access to preventive care with no co-payments. On the other hand, it has comparatively high deductibles (such as a choice of $750 or $1,000 for an inpatient hospital deductible) and has a $3,000 annual cap on prescription drugs (chosen because that amount would be sufficient to cover the average annual bill for drugs for asthma or diabetes, two of the most common chronic diseases in the targeted communities).

Perhaps most unusual is the plan's cost control structure, which might be described as "in-network point of service" (the author's term). While co-payments are low or nonexistent for visits to one's primary care physician ("PCP") or in-network physicians to whom the PCP has referred the patient, they are significantly higher, with annual and lifetime limits on reimbursement, for visits to in-network physicians or facilities without a PCP referral. There are no benefits at all for out of network providers.

The key to NYCCP's favorable rates, however, is the restriction of network size. Aetna determined through focus groups and a formal survey that its target market would prefer to trade network size for lower premiums. The restricted networks allowed Aetna to negotiate highly favorable rates with its providers, although apparently the initial rates were not as far as Aetna could have gone. On January 4, 2009, Aetna announced that it was lowering rates for the NYCCP to as low as $243 per employee per month, and that it was accomplishing this price reduction through favorable deals with "the committed group of doctors, hospitals and other providers who are participating in the NYC Community Plan network," and particularly through developing "reimbursement arrangements that help keep health care costs in check."

NYCCP places strong emphasis on wellness initiatives. Not only does it lower barriers to preventive care, but it also makes both web-based and printed materials available in Spanish and Mandarin as well as English. The Aetna Foundation sponsored a health fair in conjunction with the American Diabetes Association in a public park in the South Bronx attended by over 2,500 people. Health screening there detected twenty previously undiagnosed cases of diabetes, eight of whom required hospitalization. It has also sponsored health literacy training in conjunction with Magic Johnson Enterprises. Still, the plan must contend with cultural barriers, such as employers not convinced of the merits of buying insurance, employers whose employment arrangements were informal and could sometimes not demonstrate that employees were working "on the books" (i.e., listed as employees and paid through regular payroll, with employment taxes withheld) for sufficient hours to qualify for coverage, and employees who may have different attitudes about seeking medical care than the "preventive" attitude encouraged by the plan design.

Marketing for NYCCP includes not only a multilingual sales force, but also community brokers, county and ethnic chambers of commerce, other business organizations, civic groups and churches. Aetna anticipated that between 40 and 60 percent of the small businesses purchasing would not have had prior coverage.

12. Email communication, Katherine N. Begley, February 15, 2009

13. Details of the plan design can be viewed on the NYC Community Plan website, http://www.aetna.com/plansandproducts/smallgroup/states/newyork

That projection has been borne out in its enrollment experience. Aetna attributes the preponderance of first-time purchasers to its extremely competitive price points, targeted outreach to populations most likely to be uninsured, and working with many first-time brokers.

By the beginning of 2009, NYCCP had taken tentative steps to integrate its marketing with public coverage programs, by holding a joint seminar with Family Health Plus (FHP) and Child Health Plus (CHP) providers and planning a second one. It was also considering cross-training for enrollment purposes. Given the low overall enrollment in NYCCP, it is impossible to say whether linkage with public programs has provided a major boost to enrollment.

Aetna did sense that it had some marketing disadvantages with which it would have to deal. Because of regulations applicable to Health Maintenance Organizations (HMOs), it was restricted to paying four percent commissions to brokers, while a competitor's product with somewhat similar targeting, Empire's Prism product, as an Exclusive Provider Organization (EPO), could pay six percent.[14] (Empire, for its part, is unaware of any particular success in enrolling immigrants, whom it neither targets nor tracks as a category. Its new market focus, as described below, has been more generally on "underserved" communities, regardless of immigration status.)

Also, purchasers could be deterred by some aspects of the product design, including the need for Primary Care Physician (PCP) referrals and the limits on pharmacy reimbursement. Unlike plans sold by other companies, there was no ready link with Medicaid managed care or FHP plans, because Aetna did not participate in those markets.

Nevertheless, NYCCP hoped to enroll 8,000 members in its first year. It did not come near to meeting this goal, with executives describing the enrollment as of early 2009 as being "very modest." It attributed the disappointing enrollment in part to competitors who marketed similar products at similar prices, but with a broader network.

Future Strategy

To respond to market conditions, NYCCP introduced two new product designs in January, 2009, including one with unlimited generic prescription coverage and discounts on brand name drugs. These measures, in conjunction with lowering premiums while competitors increase theirs, were anticipated to produce more positive enrollment results, and reports in early June, 2009, suggest that they indeed have succeeded. Aetna feels confirmed in its view that partnering with trusted community organizations is an effective marketing strategy.

Aetna's experience to date does suggest that restricting network size to achieve affordability, a strategy which would seem sensible for appealing to a highly cost-sensitive community, is not the full answer to penetrating the immigrant market. Plans which can offer a broader network, where consumers have a greater assurance of finding providers who meet their needs, will do better if their premiums are still within reach.

14. An HMO, or Health Maintenance Organization, generally restricts its members to using one of a network of enrolled or employed providers . The member must only pay a copayment for a service. Although regulated by the State Insurance Department under the same regulations as apply to non-profit insurers, it is also licensed by the New York State Department of Health, which requires that it demonstrate an adequate network for the health needs of its members. An EPO, or Exclusive Provider Organization, allows its members to go to any provider, with different payment scales, is licensed solely by the State Insurance Department as regulator of commercial insurers. It is not evaluated for the adequacy of its network and is exempt from many of the requirements of New York's Consumer Managed Care Bill of Rights. Because Aetna's HMO is subject to the rules for non-profits and Empire's EPO is subject to commercial insurance rules, the rates they may pay their brokers differ.

EmblemHealth (HIP/GHI)[15]

Overview

EmblemHealth, Inc. is the parent company of HIP Health Plan of New York ("HIP") and GHI, which merged in 2006.[16] Both companies are based in New York City. Together, they enroll over 3.4 million members in 28 counties in downstate and eastern New York. HIP and GHI between them insure a substantial majority of New York City public employees. HIP, a mixed model HMO, has developed a marketing program in one immigrant community – Chinatown. GHI, primarily a Preferred Provider Plan (PPO),[17] serves immigrant groups not due to a marketing strategy targeted deliberately at immigrants, but rather coincidentally through underwriting certain groups where immigrant populations are heavily represented. Both companies have undertaken to include provider groups in their networks that are able to meet the needs of their diverse membership.

Lines of Business

EmblemHealth sells small group, large group and individual insurance. It is an insurer in the State's public CHP, FHP, and Healthy NY programs. It is the only major insurer in the New York City metropolitan area to be involved in Medicaid Managed Care in some counties. GHI has for years offered sole proprietor coverage through an association group, and the combined company has more recently offered Healthy NY through the Brooklyn Chamber of Commerce. The company also sells Medicare Supplement, Medicare drug plans, and Medicare Advantage plans.

Marketing and Current Enrollment

HIP's marketing program in the Chinese-American community has focused primarily on public programs, including Medicare, FHP, CHP and Medicaid managed care. HIP's Government Programs marketing team can communicate with prospective members in nine languages and many different dialects. HIP has also endeavored to ensure that its enrollers as well as its facility are linguistically and culturally competent, paying careful attention to facilitated enrollers who assist individuals to apply for public coverage and creating partnerships with some community-based organizations. HIP engages a Chinese-language advertising agency to assist with these efforts and has advertised its products in a variety of media, including print, television, direct mail, and advertising in public venues.

HIP has also targeted some commercial business. Marketing strategies have included print advertising in community newspapers, engaging a Chinese advertising agency, networking with community business leaders, participating in health fairs, sponsorships of community organizations, and direct marketing. Five years ago, HIP set up a sales and administration office at 41 Elizabeth Street in Manhattan's Chinatown, staffed with Chinese-speaking sales representatives, who also provide help with customer service problems. A similar marketing setup was established at one of its centers in the Flushing, Queens, Chinatown neighborhood. Since 2000, HIP has translated marketing materials for its Medicaid and other government lines of business into Chinese. In 2008, it conducted focus groups to ascertain the unique concerns of the Chinese community,

15. Interviews with Ilene Margolin, Esq., Senior Vice President, Public Affairs and Communications, August 5, 2008, George Babitsch, Senior Vice President, Sales and Account Management, August 6, 2008, and Jennifer Dymerets, August 7, 2008, and follow up emails.

16. EmblemHealth has an application pending before the New York Insurance Department, initiated prior to the merger, to convert from non-profit to for-profit status, an application which has not yet received final approval.

17. A PPO, or Preferred Provider Plan, is very similar to an EPO. PPOs, however, do not generally encourage use of a primary care doctor and do not generally pay for preventive care, which are managed care features found in most EPOs.

testing benefit packages, brand recognition, and messaging with brokers and small business owners. It found a particular concern with the availability of in-language support services.

Building on its experience with the Chinese community, HIP also switched a significant part of its advertising budget from major daily papers to ethnic and community-based media in 2007. It advertised its public insurance FHP, CHP and Medicaid managed care products in Haitian Creole, Korean, Russian and Spanish. It is appropriately explicit in its advertising that immigration status is not an issue for CHP enrollment. HIP has also done direct mail marketing for its Medicare products in Spanish.

On the GHI side of EmblemHealth, some predominantly immigrant populations have been insured through issuance of Healthy New York coverage to a union, UNITE HERE, which has a significant number of immigrants in its membership, and through issuance of a Healthy New York PPO product to local chambers of commerce and Brooklyn Health Works. By virtue of its location in the immigrant-heavy borough, the roughly 1,500-member Brooklyn HealthWorks enrolls numerous small businesses and sole proprietorships owned by immigrants, as well as individual immigrants purchasing personal policies.

Other than foreign language advertising in community print media, EmblemHealth has not developed a marketing program directed at any particular immigrant group or immigrants as a group for its broker-sold commercial products.

Future Strategy

EmblemHealth now plans to strengthen its staff model HMO for the commercial market as a way of lowering costs for a community in which cost is a paramount concern in enrolling for health insurance coverage. It considers a highly restricted network as the best way to bring down provider costs and thereby premiums. Whether that will be effective, in light of Aetna's shift away from reliance on that strategy, remains to be seen. Highly restricted networks do raise considerable concerns about whether the network will have the capacity necessary to provide for members who face serious illness or disability. On the other hand, expansive networks that lack providers who can communicate in languages spoken in the community have little to recommend themselves to New York's diverse workforce.

Empire Blue Cross and Blue Shield (WellPoint)

Overview

One of the newer programs likely to affect immigrant enrollment, still very much in development, is WellPoint – Empire Blue Cross and Blue Shield.[18] Empire's 28 county service area of New York City, its suburbs, the Hudson Valley and eastern New York, encompasses the regions in the State with the greatest concentration of immigrants. With over 5 million enrollees, including employees of its national accounts, it is the state's largest health insurer.

18. Based on interview with Mark Wagar, M.D., Empire's CEO, and Sean Doolan, of Hinman Straub, an outside consultant to Empire, September 10, 2008, and follow up emails..

Lines of Business

Empire sells small group, large group and individual insurance. It is a provider in the State's public CHP and the Healthy NY programs, but not FHP or Medicaid Managed Care. It sells traditional Medicare Supplement products as well as providing Medicare Advantage and Medicare drug plans.[19]

Marketing and Current Enrollment

Empire's focus has been on creating programs responsive to cultural and linguistic diversity, but not seen through the prism of immigrant status. Its first corporate recognition of the need for special programs came from recognizing the special needs of some of its employees in the wake of the September 11, 2001 World Trade Center attacks. Empire's headquarters were in the World Trade Center, but its mailroom was in nearby Chinatown and staffed principally by Chinese employees. In reconstituting its operations after the attack, Empire moved its entire mailroom staff to an operations center in Albany. In so doing, Empire executives came to recognize the importance of issues of cultural competency as its employees were displaced to a culturally alien place.

Since that time, it has devoted efforts to increasing the cultural and linguistic competency of its staff, based on the populations it serves. Empire's aim is to have coverage materials available in nine languages besides English; it has materials in Spanish and Russian so far. It also has a Spanish-language website where subscribers can search for Spanish-speaking providers. Empire has set up a corporate diversity council, staffed by Empire employees, to promote diversity both within the corporation and with its business partners, including network providers and subscribers.

The chair of the diversity council is Luis Esteves, M.D., who has led an effort to address health disparities. As part of the effort, Empire is measuring health status and access to care among various populations it insures in every county and borough. It runs a health bus to various neighborhoods to provide health information and screening. Empire has tried to address disparities in health access through its providers. It has trained its clinical associates, including medical directors and nurse case managers, in cultural competency and diversity. A provider portal on its website also serves as a resource center in matters of cultural competency. It has tried to accommodate the needs of its undocumented immigrant subscribers by, among other things, providing its own identification numbers to enrollees who do not have social security numbers.

Through the WellPoint Foundation, Empire has already disbursed $9,500,000 of a total of $22 million grant to address racial and ethnic disparities in health care. Foundation grants have supported the Arthur Ashe Institute for Urban Health, providing funding to hire a seasoned educator and evaluator for a pre-college science education program for under-represented students interested in pursuing health careers. Funding has also supported the NYU Langone Medical Center - Banishing Obesity and Diabetes in Youth (BODY) Project to help decrease the prevalence of diabetes in students at two New York City high schools with substantial Hispanic majorities: Norman Thomas (74 percent Hispanic, 21 percent African American, 5 percent Asian), and Brooklyn's Franklin K. Lane (69 percent Hispanic, 29 percent African American, 9 percent Asian).[20] The Fund for Public Health in New York - Primary Care Information Project, which, in partnership with the City of New York Department of Health and Mental Hygiene, pays for the installation of medical records systems and training in their use at physician practices in underserved areas, has also received Foundation support.

19. http://www.empireblue.com/wps/portal/ehpmember?content_path=member/noapplication/f3/s0/t0/pw_ad069612.htm&label=Plans%20^%20Benefits, last visited April 10, 2009.

20. School demographic information from www. Greatschools.net, last visited April 8, 2009.

Future Strategy

Empire appears to have approached the immigrant population principally as part of a larger ethnic market. It is just now beginning to do the market studies of different community groups and their leaders that could form the foundation for a focused marketing strategy, and so far it is considering the Hispanic, Asian and African American communities. Although a specific marketing strategy is still in its infancy, Empire's efforts to reduce health disparities and cultural competency barriers are likely to shape whatever strategy ultimately emerges.

Excellus[21]

Overview

Excellus, based in Rochester, is the largest upstate insurer with nearly 2 million members. It perceives its service area to have considerably less immigrant diversity than its downstate counterparts. As a result, the overwhelming focus of its ethnic niche marketing has been to the Hispanic community.[22] It does, however, insure a number of national accounts with employees in areas of considerably greater ethnic diversity and therefore has the ability to target communications in other languages.

Lines of Business

Excellus sells small group, large group and individual insurance. It is an insurer in the State's public FHP, CHP and the Healthy NY programs, as well as providing Medicare Advantage and Medicare drug plans. It also has low cost products for individuals and families earning up to 250 percent of the poverty level who do not have group coverage available to them, do not qualify for Healthy NY, and have been uninsured for 90 days. The products are called ValuMed and ValuMed Plus. ValuMed is limited to inpatient and outpatient hospital care, maternity care, emergency care and well child visits. ValuMed Plus is more comprehensive in some respects, covering regular outpatient visits and diagnostic tests, for example, while its only drug coverage is by a prescription discount plan and it limits coverage for inpatient care to $100,000 in a lifetime.[23]

Marketing and Current Enrollment

Excellus's Hispanic marketing program has been in place for over 10 years and is carried out by a small dedicated staff. Its call center has Spanish capacity and it sends Spanish-speaking representatives to events such as health fairs. Although Excellus has not created special programs for Hispanic-owned small businesses, it does reach out to the community through business associations such as the Latin American Chamber of Commerce.

Excellus, like all the other insurers surveyed, does not identify its enrollees or potential enrollees as immigrant or non-immigrant. It has recognized that culturally distinct communities benefit from services in their own language, have distinct preferences as to how to receive care, and often seek providers of their own ethnicity,

21. Interview Cemette Burdine, Vice President, Brand Management, March 26, 2008.

22. The impression that Hispanic immigrants predominate is inaccurate. The top ten countries of origin of immigrants in upstate New York are, in order of size of population, Canada, , India, Germany, Mexico, Italy, China, Korea, Jamaica, Poland and Bosnia and Herzegovina. Even among undocumented immigrants upstate, only 34% are estimated to be from Central America and Mexico. Kallick, D. "Working for a Better Life: A Profile of Immigrants in the New York State Economy," Fiscal Policy Institute, November 2007, Slides 10 and 12. It may be that Latin American immigrants are more visible as such because there are noticeable concentrations in certain service occupations, while the other immigrant groups comprise smaller numbers or are perceived by marketers as more likely to be in professional or white collar occupations that provide health benefits and not, therefore, as a distinct market segment.

23. https://www.excellusbcbs.com/wps/portal/xl/gst/hpn/hpo/vhpo, last visited April 10, 2009.

making it desirable to have ethnically diverse and linguistically competent panels of providers, which Excellus endeavors to do. In this regard, it has focused not only on Spanish speakers, but also on those who could provide services to small upstate communities of Asians, Lithuanians and Russians.

Excellus has expanded its Hispanic community marketing every year. It does not seek immigration status information as part of the enrollment process and is not aware of any issues having been presented regarding rights to enroll based on that status. (If individual purchasers of coverage have been dissuaded from enrolling because they have been asked to provide social security numbers, it does not seem to have come to the attention of those running the enrollment.) Further, while Excellus has become more rigorous in underwriting – taking steps to verify employment status of its small business group enrollees and auditing current groups to verify members' employment status – it has not to its knowledge encountered a disproportionate share of off-the-books employees among its minority businesses.

Future Strategy

Excellus is trying now to evaluate its targeted enrollment efforts to more formally determine how effective they have been.

UnitedHealthcare[24]

Overview

Perhaps the most mature and highly developed immigrant-oriented marketing program among New York State's major health insurers is the Asian Initiatives program of United Healthcare ("UHC"). Oxford Health Plans, a metropolitan New York-based HMO that has now merged with UHC, started the Asian Initiatives program in the Chinese community in 1994. It expanded the program to the Korean community in 2002 and to the South Asian community in 2005. The program enrolls about 4,000 new members (including dependents) each year; 95 percent of them are in businesses with fewer than ten employees. It manages to retain about 80 percent of its business at renewal time.

Lines of Business

UHC purports to be the largest health care company in the country, with about 70 million enrollees, including about 1.5 million in the New York City metropolitan area insured by Oxford, the regional HMO with which United merged. UHC and Oxford are in all parts of the commercial market and in Medicare supplement and drug plans (through the American Association of Retired Persons) and Medicare Advantage. Through its Americhoice subsidiary, it is a Medicaid managed care insurer in New York, but it does not participate in the CHP or FHP public coverage programs. Oxford now offers sole proprietor coverage in the commercial market through HealthPass, discussed below.

Marketing and Current Enrollment

A significant part of the success of the Asian Initiatives program derives from its combination of rootedness in the community, active outreach with public education and marketing, and a particularly strong social service component. Under the leadership of Chris Law, the program appears to have developed an unusually

24. Based on interview with Carolyn Kerr, Vice President, State Government Affairs, and Chris Law, Vice President of Asian Initiatives, February 18, 2008, and site visit to Chinatown Asian Initiatives office, January 15, 2009, and follow up email communications.

integrated approach to enrollment. The program has not developed any unique products or benefit packages for this market segment. It sells only standard products from UHC's existing lines of business.

Several of the elements of Asian Initiatives can be seen in the programs of the other insurers in the marketplace – culturally and linguistically competent providers and outreach personnel, service offices in the community, public health education, and development of ties with community organizations. What seems unique about UHC's Asian Initiatives is the breadth of activities in each of these areas, the way in which all these elements have been brought together and integrated in pursuit of expanding coverage, and, perhaps most important, the creation of a trusted community institution in which the insurer appears to play the role almost of a small town bank or school. The volume of consumers walking in to the service center for assistance (200 to 300 on a typical day, but observable in a steady stream even on a bitterly cold January day when the streets of Chinatown seemed much more thinly populated than usual) was one indication of the program's success in this regard.

The impetus for Asian Initiatives was the Chinese American Medical Society, a group of providers who initially approached Oxford, acting on the premise that if more Chinatown residents had coverage they would be more likely to receive primary and preventive care. These providers perceived a problem in their community of individuals shying away from care until their symptoms reflected advanced disease. The program started with a core of culturally and linguistically competent providers. Similarly, UHC's efforts in the Korean Community in 2002, came out of the Korean American Physician's Organization. While these initiatives originated in the efforts of community physicians, it is now part of the portfolio of the Asian Initiatives staff to continually recruit culturally and linguistically competent providers to the network. UHC has not become involved in licensing of providers, but it has opened panels to admit culturally competent specialists to its participating provider roster even if the panels were otherwise considered full in a particular geographical area.

The Asian Initiatives office in Manhattan's Chinatown, where 45 of its staff work (the other 15 are in the Queens office) serves as much as a social service agency as it performs a marketing function. From the main reception area, visitors are directed to an appropriate service team member, who will speak with the visitor in his or her own language to resolve issues, provide advice or referrals, or sell products. The majority of visitors come in for help with UHC's Medicare Advantage product forms or claims, and the personnel responsible for assistance with that program have their office on the same floor as the main reception area. But UHC also has a Medicaid managed care plan, AmeriChoice, on one adjacent floor, and a commercial group sales representative (one each for the Chinese, Korean and South Asian communities, plus support staff), on another adjacent floor. If a small business owner comes in to inquire about coverage, he or she sees one of the commercial sales staff from upstairs. The access to help with different products in different markets from a single central reception area gives the consumer the impression that a full range of needs can be met at UHC's offices.

What appears unique about the Asian Initiatives services is the breadth of issues the service staff helps with. Its trained staff of social workers helps not only with Medicare Advantage enrollment and claims, but also with such public entitlement programs as food stamps and rent subsidies, and private disputes involving telephones and utilities. They work closely in referral relationships with social service agencies like the Chinese American Planning Council and Korean Community Services. In September, 2008, the Asian Initiatives program was given a Recognizing Innovation in Multicultural Health Care Award by the National Committee for Quality Assurance (NCQA) for its "In-Language Member and Public Outreach in New York's Asian Community Initiative."

This program was designed to help Chinese Americans enrolled in the company's SecureHorizons Medicare Advantage plans to understand and use social welfare resources.

Despite the strong orientation toward assisting people with public programs in addition to its health insurance products, the staff at Asian Initiatives expressed some reluctance to take on a role as facilitated enrollers for the CHP program or more generally to integrate marketing commercial products with enrollment in public programs. Although CHP could be a useful adjunct to a commercial insurance product, allowing cost conscious customers to enroll employees while referring their dependents to public programs, the staff were concerned that the State would not welcome "dumping" by them into public programs. As a consequence, dependents of UHC's enrollees may remain uninsured although they have been identified as potentially eligible for affordable public coverage, and opportunities to provide assistance and referrals seem to be foregone. This suggests an area where clearer communication between the State and the insurers could help facilitate greater enrollment in public programs that the State wishes to promote, while making it easier for insurers to promote and sell small group coverage.

In other respects, collaboration with the State has reached a very high level. Asian Initiatives has fully involved the State in its efforts to promote Healthy NY, a product which accounts for about 40 percent of Asian Initiative's group insurance business. Joint seminars run by Asian Initiatives sales staff and State Department of Insurance personnel have been, in the view of UHC, highly effective. The imprimatur of the State on UHC's product is seen as a great advantage in the eyes of small business proprietors.

The role of sales staff is indeed expansive in the Asian Initiatives program. They do not simply sell products. They run seminars to educate small business owners about why they should buy insurance at all, even when they are healthy, and about how health insurance works. In a community where surveys shows 60 percent of businesses do not buy insurance, this type of education is a necessity. Asian Initiatives staff does outreach to understand the business owners' priorities and they have a clear sense of price sensitivity among their prospective commercial customers. They have had to confront the dilemma of owners wanting to purchase the insurance for themselves, but not their employees. They have undertaken to educate these employers about the role of health coverage in attracting employees and keeping their loyalty.

The staff of Asian Initiatives, both heads of sales and the service staff, are generally competent in Mandarin, Cantonese, or Korean, as well as English, but the insurer has recruited Chinese and Korean-speaking brokers in the community. (The bulk of commercial sales – over 95 percent – are through community brokers with whom the internal sales staff works closely.) Asian Initiatives' phone lines are staffed by people speaking these languages from 9:00 a.m. to 6:00 p.m. Asian Initiatives believes most South Asians are fluent in English, so that staff ability to speak South Asian languages is viewed as less important.[25] Written summaries of coverage have been translated into Chinese and Korean and there is a Chinese website in operation, although not yet a Korean one. (UHC's national website also has Spanish and Vietnamese portals and the company has made major efforts to make consumer information and interaction of all sorts available in Spanish.)

Finally, Asian Initiatives has not restricted its communications to health insurance sales. It has also brought health information to the community in its own language. This involves not just health promotion through such

25. The assumption of South Asian fluency may apply to some pertinent segments of the market for private coverage, but the Flushing, Queens-based South Asian Council for Social Services, a member of New York Immigration Coalition's Immigrant Health Access and Advocacy Collaborative, has shared numerous cases involving language barriers and has of necessity been advocating for reduction in those barriers. The organization's small staff of six speak seven languages among them, including the more commonly spoken languages of Punjabi, Urdu, Hindi, Bengali, Gujarati, Sindhi and Kannada, as staff language diversity has become a necessity. Recent immigrants among this fast-growing segment of the immigrant population may be less likely to be proficient in English.

efforts as participating in health fairs and producing brochures about specific health issues, but also bridging gaps between physicians and patients through an interactive Asian language provider locator, which has also been given an award by NCQA.

The impressive breadth of services provided by Asian Initiatives, and its apparent success in communities where health insurance has not been a tradition, suggests not only a model for promoting health coverage in immigrant communities, but for connecting health coverage to a broad range of communities, recognizing that information must be accessible and that families have multiple needs beyond securing health coverage.

Future Strategy

UHC has initiated an expansion of its Asian Initiatives model to Asian communities in California. It believes the model is replicable for other communities, and is in the exploratory stages of a pilot program modeled on Asian Initiatives for the Hispanic community in Texas.

Summary observations on commercial initiatives

Other than a broad increase in awareness of the potential of immigrant markets (generally viewed as part of a broader category of underserved markets) and a desire to tap that potential, it would be difficult to discern a single marketing model coalescing out of the health insurance companies we studied. While one insurer perceives that a specialized product will seize the market, others focus on the ability to communicate with the market in its own language, or to recruit providers who are either members of the target groups or at least speak their language. Still another health plan concentrates on public education and on integrating the sale of insurance with other essential, if not necessarily closely related functions, through an intermediary institution in the community.

Despite the wide disparity in method, there are common themes. One theme, which should not be surprising in a commercial environment with sellers attuned to their market, is sensitivity to the price of coverage as a barrier to sales. Virtually all the plans have responded to price sensitivity by emphasizing the sale of products with limited benefits or very tight networks, with the unfortunate effect that those who achieve coverage may find themselves lacking in essential benefits if they actually develop serious illness or disability. The plans have been slower to pursue other measures that might allow them to control costs for the consumer while making more comprehensive benefits available. They could do this, for example, by coordinating enrollment with public programs so that children enroll in the public CHP program while their parents enroll in commercial coverage.

A positive market-wide development is the broad sensitivity to community institutions as means of connecting with potential customers. Virtually all the insurers support community civic organizations, use brokers in the community, and recognize the need to communicate in the customer's language. The most successful one has gone further and created a presence in the community, integrating insurance navigation with other vital needs.

II. ANALYSIS – CONNECTING TO COVERAGE THROUGH INTERMEDIARIES

Insurers and their customers have always dealt more through intermediaries than directly. Brokers and agents are long-standing and essential actors in the marketplace. Brokers who work on commission have, if the commissions are sufficiently high, powerful incentives to solicit business and enroll individuals in coverage. It has been well documented, however, that small groups and individuals are less likely to enroll in health coverage than larger groups. One factor inhibiting that enrollment is that small groups are less attractive to brokers, who can earn far higher commissions enrolling large groups that generate higher premium rolls and hence bigger commissions for the same amount of work. This has led to consideration of whether other strategies might be more effective in enrolling these portions of the market, particularly small businesses, where immigrants are concentrated.

What are connectors?

Connectors, sometimes funded by government or the charitable sector, can fill the gap where the business incentives for selling small group and individual coverage are deficient. In their intermediary role, connectors can also serve other functions that overcome barriers to small group and individual purchasers:

- aggregating large numbers of small purchasers to give them bargaining power with insurers comparable to larger groups, thereby making insurance premiums more affordable;
- performing administrative functions, such as enrollment, disenrollment and premium remittance for small businesses which lack the specialized personnel or expertise to handle such tasks;
- evaluating different coverage options and providing a rational set of choices to purchasers who lack specialized expertise in matters of benefit structure; and
- acting in an ombuds role for enrollees with navigational problems in the system.

Almost all of these functions (other than the ombuds role) can be seen in the Massachusetts Connector, established by that state's major universal coverage initiative.[26] The Connector is a multitasked agency with broad powers:

- to establish standards for types of health insurance benefit plans;
- to certify and de-certify insurance plans offered to individuals and small businesses, which are guaranteed issuance of policies if they purchase through the Connector;
- to create standardized insurance applications;
- to establish criteria for premium assistance;
- to provide subsidies to eligible individuals if they purchase through the Connector; and
- to hear and decide appeals by those who seek exemption from Massachusetts's mandate to buy coverage, on the grounds that they cannot afford it.

In consultation with the state's Medicaid program and safety net providers, the Connector's board is charged with administering the Commonwealth Health Insurance Program, a Medicaid expansion program for people with incomes over 100 percent of the Federal Poverty Level. The Connector also operates a Service Center and is authorized to contract with sub-connectors as further means of interface with the public.

26. Chapter 58 of the Massachusetts Laws of 2006

The Massachusetts Connector has not eradicated the disproportionate lack of coverage among immigrants. As of the fall of 2007, after the program's first year of operation, non-citizens made up 6.5 percent of Massachusetts's insured population, but accounted for 10.9 percent of its uninsured. Naturalized citizens, on the other hand, made up roughly the same proportions of the insured and the uninsured population (9.7 percent and 9.0 percent, respectively).[27] Although no published data have broken down coverage by immigration status for 2008, other data suggest that the coverage gap persists for non-citizens, who, again, comprise lawful permanent residents, individuals with provisional immigration statuses, and unauthorized residents. For example, the 2008 Urban Institute Massachusetts Health Reform Survey found that among nonelderly adults the uninsurance rate for white, non-Hispanic adults was 3.0 percent, non-white, non-Hispanic adults were uninsured at a rate of 4.5 percent; while 13.1 percent of Hispanic adults were uninsured.[28] Those estimates, moreover, have been criticized as overestimating the percentage of insured people overall and underestimating the percentage of immigrants who lack coverage.[29]

New York, which has not yet determined the method by which it will expand coverage, has not developed any similarly comprehensive connector mechanism. It does have several building blocks from which it might develop a comprehensive approach to connecting small groups and individuals to coverage.

New York Statewide Enrollment Center

In October 2008, the New York State Department of Health (DOH) issued a Request for Proposals (RFP) for private bidders to operate a Statewide Enrollment Center, connecting New Yorkers to public health insurance coverage.[30] The principal mission of the Enrollment Center is described in the RFP as to centralize, facilitate and streamline enrollment, renewal of enrollment, and transfers of enrollment in public health insurance programs – Medicaid (including Medicaid for working people with disabilities), FHP, and CHP. The Enrollment Center will also eventually administer premium assistance programs for public program beneficiaries who are eligible for, and may be required to enroll in, employer-provided coverage or COBRA. It will also administer the FHP buy-in program under which employer groups and unions can purchase coverage from health plans that participate in FHP.

The privately operated, publicly funded Enrollment Center is contemplated to operate a call-in center both to provide information and assistance regarding program operations, as is currently offered on various hotlines, and to provide telephone renewals thereby reducing loss of eligible enrollees and streamlining enrollment.

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27. Urban Institute, "Who Gained the Most Under Health Reform in Massachusetts?", Massachusetts Health Reform Survey Policy Brief, based on the 2007 Massachusetts Health Reform Survey at p.8
It is important to note that Census categories such as race cannot be used as a proxy for immigration status. A primary example is the Hispanic or Latino designation, which includes many Americans who were born in Puerto Rico as U.S. citizens; Puerto Ricans are not immigrants.

28. Urban Institute, Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey (published by the Massachusetts Division of Health Care Finance and Policy), December 18, 2008, slide 10 of 37. Available at www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/hh_survey_08.ppt, last visited April 9, 2009. The survey also found that those in fair or poor health and the disabled were less likely to be insured than healthy adults.

29. Nardin, R., Himmelstein, D, and Woolhandler, S., "Massachusetts' Plan: A Failed Model for Health Care Reform," Physicians for a National Health Plan, February 18, 2009, available at www.pnhp.org/mass_report/mass_report_Final.pdf. Last visited April 9, 2009. The authors point out that the Urban Institute survey reached few non-English speaking households, while a U.S. Census survey in March 2008, employing speakers of all major language groups, found an overall uninsured rate of 5.4 percent, similar to what would be anticipated based on the Massachusetts Department of Revenue reports of residents potentially subject to tax penalties for not being insured.

30. http://www.health.state.ny.us/funding/rfp/0808040239/0808040239.pdf

The Enrollment Center will also be required to develop a web-based renewal system. It will develop public education materials and hold enrollment events.

The operator of the Enrollment Center will be required to demonstrate that it has a bilingual or multilingual staff competent to do business in English, Spanish, Russian, Arabic, Haitian Creole, Cantonese and Mandarin. As a government-funded entity, it will be required to provide language services for speakers of other languages as well.

HealthPass[31]

HealthPass is a private, nonprofit connector, founded by New York City and the New York Business Group on Health in 2000, and is operated as an insurance trust. It holds group contracts with several insurers and enrolls businesses in New York City and several downstate suburban counties, as well as sole proprietors in New York City and Long Island. It collects premiums from these businesses and pays them to the insurers.

- Although the premiums are no different from what would be offered by HealthPass's participating insurers directly to the businesses, Health Pass offers several advantages to its participating employers.
- It allows small business owners to fix the level of contribution they wish to make for health coverage, but offers the business's employees the option of deciding which of the insurers, and which of the various plans offered by that insurer, the employee will enroll in. Any difference in cost between the employer's contribution and the employee's elected plan premium is the responsibility of the employee. This range of options is generally not available to employees in small groups in any other context, though it is common to have such flexibility of plan choice for those who work at larger employers.
- It establishes Section 125 Plans (plans allowing employees to pay for certain benefit programs on a pre-tax basis) for participating employers, thus enabling employees who supplement employer contributions for premiums to do so on a tax-advantaged basis.
- It provides other types of insurance along with health coverage.
- It relieves small employers of administrative burdens of enrolling and disenrolling employees, sending COBRA notices and collecting and paying COBRA premiums, and simply requires that the employer pay a single monthly bill; and
- provides Health Advocate – an advocacy, navigational and problem-solving services for individual members for a mandatory $1 per member per month fee.

HealthPass, operating for nearly nine years, has achieved enrollment of approximately 10,000 individuals.[32] It offers more than 30 plan options to employers who could never have given that array of choice to their employees before. It was able to add sole proprietor coverage in 2008, and is working currently to add a Healthy NY option. HealthPass does not, however, have some of the advantages of the Massachusetts Connector, where insurers may be attracted by both the marketing cachet of attaining state endorsement of their products and by a market in which people are legally mandated to buy their products. HealthPass has faced challenges in maintaining a broad selection of insurers, who are reluctant to engage intermediaries between themselves and brokers, when they can sell directly through brokers. Without the breadth of plans which would make it the destination of choice for small business purchasers, HealthPass has not contributed to dramatic increases in small group health coverage. And without the ability to serve its customers in any

31. http://www.healthpass.com

32. Interview with Vince Ashton, Executive Director, and Jerrold Ehrlich, outside counsel, March 11, 2008

language other than English, it would clearly have to make major changes (which to its credit it is willing to contemplate) to serve as a connector for immigrants.

The Freelancer's Union

The Freelancer's Union has long been held up as an example of a new sort of health insurance connector, enabling individuals to get coverage when they do not have the benefit of a traditional employer-employee relationship to acquire health coverage. The independent workers it served to connect to insurance are defined as, "individuals who work as freelancers, independent contractors or consultants, or who are self-employed, employed part-time, temporary workers, or work for multiple companies at the same time. Applicants are not considered to be independent workers if, at the time of application, they are working full-time as W-2 employees and have been for the last 18 months for the same employer."[33]

Freelancer's Union continues to perform that connecting role for the independent worker market, but it is difficult to characterize it as a connector anymore, because in the last year in New York it has formed, and wholly owns, the Freelancer's Insurance Company, a for-profit insurance company, which is the only provider of health coverage for Freelancer's Union members in New York. It is in a sense, then, a connector to itself.

Freelancer's Union does bring individuals together in a natural affinity group of parallel economic experience, and it promotes the concept that its members form a sort of community, of which the insurance coverage is but one aspect of common endeavor and mutual support. It advertises heavily and there is high public awareness of the program. It has in the past emphasized its role as advocate for its members, intermediating with the insurer to resolve problems; however, that function is not prominently discussed now in its promotional materials. When the advocate wholly owns and must operate the insurer as a for-profit enterprise, an inherent conflict of interest may be perceived.

The organization certainly aggregates individuals and offers coverage that is considerably more affordable than that available in the individual insurance market, which is one of the functions of a connector. However, it is difficult to determine the extent to which that price advantage derives from the bargaining power of the group and the extent to which it derives from other unique features of the aggregation, including a concentration of younger members (by virtue of the occupations covered and the relative instability of the employment relationships) and the exclusion of hazardous occupations which might bring higher claim risks.

While child caregivers and home health care providers are eligible for Freelancers' coverage, other occupations with significant concentrations of immigrants, including construction and demolition, restaurant workers, landscape workers, taxicab drivers and domestic workers are not. The Freelancers Union website defines as one of the four eligibility criteria that one be a U.S. resident, without further defining what is meant by that and whether permanent resident status is necessary. Neither the website nor its telephone number suggests any way for LEP speakers to obtain service.

Summary of Existing Connectors

HealthPass, Freelancers Union and the proposed State Enrollment Center each deal by design in very different spheres of coverage and thus reflect the highly chaotic state of the insurance market. For most of HealthPass's customers, other than the recently added sole proprietors, the traditional employment relationship, as defined

33. http://www.freelancersunion.org/insurance/are-you-eligible.html#

by issuance of W-2 wage reporting forms, is what entitles one to buy its private group coverage. Freelancers Union, for which eligibility is conversely defined by the lack of a W-2, offers commercial private group coverage through an entirely different type of employment arrangement. Neither entity connects its patrons to any sort of public coverage. While HealthPass offers a menu of choices from competing companies, Freelancers Union restricts enrollees to a single choice – the health insurance plan it operates.

The New York Statewide Enrollment Center, in contrast, will deal with the full range of New Yorkers: employed, self-employed, freelancing, nonworking poor and disabled people, but to an overwhelming degree will offer them only public programs for which eligibility is defined by their economic means and immigration status. Meanwhile, many of its patrons might also qualify for private health insurance coverage.

In a diverse and confusing marketplace, individuals may not know to which market segment they belong and therefore to which connector they ought to go. Individuals who fit in a particular segment, but contact the wrong connector, may get no assistance at all. On the other hand, some individuals could be eligible for coverage available through each of the three connectors, but would never know the full range of their options if they seek coverage through any particular connector. A marketplace in which consumers were truly empowered to obtain the most appropriate coverage would establish a single intermediary to make available all the types of coverage individuals could qualify for and assist them to determine the best choice.

While breadth of offerings is important, an effective intermediary must also be accessible. A letter to the New York Times this April from Meg Kroeplin, Executive Director of Community Partners in Amherst, Massachusetts, responding to news articles about the Massachusetts reform law, pointed out: "Policies that mandate health care coverage for adults are easy for people to understand and can be effective in encouraging people to obtain insurance. But policies themselves do not get people into insurance programs or find them a doctor. People do.

These people are community-based outreach workers. At food pantries, homeless shelters, schools, hospitals, health centers and on the street, outreach workers find and educate eligible people, helping them to enroll, retain and use coverage."[34]

Different market segments may require different types of outreach. Freelancers Union advertising appears very effectively targeted at informing its intended audience of its availability and drawing them in. A connector which is very broad in its offerings, but fails to reach out to its public, so that it is disconnected from it or even alien to it, will not be effective at fulfilling its mission.

An Immigrant Connector?

If one were to envision a connector mechanism that made sense for the immigrant community, one might be tempted to select some of the characteristics of each of the existing connector mechanisms, while eliminating others:

- The Freelancers Union, much like fraternal benefit societies that were in some sense its forerunners, builds on the cohesion of a group of people with shared experiences and derives strength from that. Its success suggests that a connector based on affinity of national origin or culture may be an approach to channeling individual immigrants to coverage. Its ability to cover temporary and part-time workers and those who

34. Cited in "A Healthy Blog," Healthcare for All Massachusetts, April 6, 2009, http://blog.hcfama.org/?cat=2, last visited April 14, 2009

work for multiple employers speaks to situations faced by many immigrants. Its active advertising and web accessibility mean that people are likely to find their way to the connector.

But the Freelancer's Union's exclusion of occupations that might bring higher claim risk would work to the distinct disadvantage of many immigrants, and its tie to a single insurer, which it owns, raises concerns regarding its ability to play the role of impartial advocate and broker. Its lack of linguistic access effectively excludes millions of New York residents who cannot navigate the insurance enrollment process in English, and Freelancer's vague restriction of eligibility to "U.S. residents" would deter many immigrants, including those who are employment-authorized, and who contribute to the economy and need health insurance, from contacting the connector.

- The flexibility, relief from administrative burden, and convenience of HealthPass make its model very attractive for small business enrollment. Immigrant businesses with limited means or willingness to contribute to employee coverage would find HealthPass particularly attractive because of the way in which it allows businesses to limit their contributions while leaving the employee free to buy better coverage in a tax advantaged way. But the limited range of policies it offers and its relative public invisibility render it unlikely to enroll large numbers of people. It certainly lacks the capacity as currently structured to deal with issues of cultural or linguistic diversity.
- The New York Statewide Enrollment Center, though mandated to provide meaningful access to clients who speak a language other than English, as envisioned in the RFP for contractors to run it, will be accessible to speakers of only certain languages, limiting its ability to serve significant numbers of New Yorkers. It will incorporate some commercial enrollment (employer buy-in to Family Health Plus) with its main function of facilitating enrollment in public programs. But it does not appear from the RFP that the Enrollment Center will have the sort of active marketing and public education effort that may be required to bring immigrant businesses onto the rolls, even when it is dealing with the employer buy-in.

It should not be the role of public policymakers to dictate to private commercial enterprises the most effective ways to market their products. As the illustrations of the individual insurers in the first section of this issue brief show, private enterprise has great creative capacity to experiment with different models and to reach the public in unique ways. Moreover, the commercial imperative of increasing sales, which means channeling enrollment to the products of a particular insurer, will always be in some tension with the public policy goal of connecting as many individuals and businesses as possible with the widest array of choices so that the maximum number of people, including immigrants, enroll in the coverage most appropriate for them.

It would be appropriate and desirable, however, for public policymakers who wish to universalize coverage, be it public, private or a combination, to create connector entities that link the communities, like immigrant communities, most in need of increased enrollment to existing coverage opportunities. The connector entity should make the entire universe of choice available, and should also interface with the community in an accessible, direct and active way.

To offer the full array of health insurance coverage options, a connector should, like the Massachusetts Connector, include links to commercial carriers, public programs, and subsidy programs. This can be done by either compelling commercial carriers to offer their products through that mechanism or, as in Massachusetts, creating inducements for their participation. To ensure that there is appropriate impartiality, the connector should not be operated by or affiliated with any of the commercial insurers, but should either be a government agency or a nonprofit agency on the model of HealthPass.

To reach immigrant communities and others who have been left out of coverage in a significant way, the connector must have an accessible, local face. United HealthCare's highly successful Asian Initiatives may

present a promising model. It functions as a trusted community institution by providing a wide array of social services, in part through trained social workers. It deals with people in their own language and provides significant amounts of public education on topics such as why one would want to buy coverage. Working through brokers rooted in the community both strengthens communal connections and provides a financial incentive to bring enrollees in. If those aspects of Asian Initiatives were coupled with the sorts of flexibility of benefit level and provider choices, and the administrative and tax relief for small businesses that HealthPass offers, it would seem a very powerful combination.

Existing, trusted social service agencies with roots in the community may make excellent homes for such local connectors. They would, presumably, contract with a broad statewide connector entity that, like the one in Massachusetts, would in turn set the conditions for participation by the private insurers and public programs available through the local interface.

CONCLUDING RECOMMENDATIONS

Insurers who wish to market to immigrant communities should intensify their efforts to communicate with immigrants in the languages they speak. Communication in appropriate languages should take place not just in marketing but in all phases of interaction, including insurance policy materials and customer service. Insurers should also improve their efforts to make linguistically and culturally competent providers available in their networks. Public education regarding insurance and assistance with the enrollment process and other consumer concerns should both increase enrollment and earn the trust of immigrants.

To attract significant numbers of immigrant small businesses and individuals, insurers should improve the availability of linguistically and culturally competent health care providers available in their networks.

Insurers should remain acutely sensitive to the price concerns of immigrants. They should avoid, however, reducing benefits or unduly limiting networks in an effort to minimize the cost of coverage. Rather, insurers should recognize the ways in which creative co-marketing with public programs can enhance enrollment and control costs, by enabling immigrants to enroll in affordable public coverage for which they are eligible.

Should the State set up a connector or series of connectors to reach immigrant communities, insurers should participate by authorizing sales through those connectors or through brokers that contract with the connectors. The State, for its part, should form a connecting entity in such a way that it contracts with community-based social service agencies or other nonprofit, neutral organizations to integrate insurance enrollment and navigational assistance into a broader social services and immigrant integration function. These local connectors should be trusted community organizations with full linguistic and cultural competence to serve the immigrant groups likely to constitute the market. The connectors should make available the broadest array of plans possible, should work with community brokers, and should not restrict their role to just one segment of the population according to employment status, sector of the economy, or similar considerations.

Finally, all of the actors involved in promoting and linking health insurance to New Yorkers must recognize the complex and daunting restrictions that the government places on immigrants, both legal and unauthorized, and be aware that significant education needs to be undertaken to help immigrants understand their rights to public and private health insurance, the safety of using such programs, and the benefits of obtaining health coverage.