State of Tennessee
Insurance Exchange Planning Initiative

Best Alternatives to a Federal Insurance Exchange in Tennessee

A Summary of Stakeholder Feedback

October 21, 2011

BEST ALTERNATIVES TO A FEDERALLY-OPERATED INSURANCE EXCHANGE IN TENNESSEE

Introduction

Tennessee has a choice: either the state or the federal government will likely operate an insurance exchange within our borders beginning in late 2013. To help inform this decision, this report summarizes the feedback that we have received from stakeholders over the past year. The report examines each of the key policy questions, explains the relevant options and the advantages/disadvantages afforded by each, and summarizes several preliminary thoughts if the State were to opt for a state-run exchange. This report does **not** recommend whether the State should run an exchange. Rather, the report synthesizes the input of stakeholders to describe the best alternatives to a federally-operated exchange in Tennessee.

As a point of departure, we summarize the requirements of the federal health reforms related to exchanges. To provide some context, we discuss the types of uncertainty (e.g., legal and political challenges to the PPACA) and the impact on our planning effort. We describe the limited amount that is known about a federally-facilitated exchange. We then report the types of feedback that we have received from Tennesseans during a number of presentations and listening sessions across the state. Finally, we present our framework for evaluating various options – and we summarize our results by describing the features of a state-run exchange that appear most appropriate for Tennessee.

Listening to Tennesseans about Alternatives

This document is based on what we have heard from stakeholders in Tennessee. Tennessee is home to many people with expertise and perspective on health insurance, such as small business owners, insurance agents, healthcare providers, consumers, and insurance companies. Over the past year, we have traveled more than 4,000 miles to hold countless meetings all over our state to learn from Tennesseans' expertise. We have written what we learned in this document, and we now ask that stakeholders respond—to tell us what is right and wrong in these pages, what we missed, and what else we should consider. You can send us feedback by emailing insurance.exchange@tn.gov or by attending one of the meetings we have scheduled to discuss the white paper during the month of November 2011. Meeting dates are available at www.tn.gov/exchange or on page 2 of the full white paper document.

Although this white paper does not consider the question of if Tennessee should operate an exchange or cede that responsibility to the federal government, it is worth noting that key Tennessee stakeholders have expressed (in writing) their preference that Tennessee operate the exchange instead of the federal government. These groups include all of the major insurers, both major associations for brokers and agents, Tennessee Medical Association (TMA), Tennessee Nurses Association (TNA), Tennessee Hospital Association (THA), Tennessee Association of Mental Health Organizations (TAMHO), National Federation of Independent Business (NFIB), Tennessee Primary Care Association (TPCA), and American Cancer Society-Tennessee Chapter. Assuming that Tennessee will have an exchange in 2014, no stakeholder group with which we have met has indicated that it prefers a federally-run exchange rather than one operated by the State.

Insurance Exchanges and the PPACA

As currently written, the Patient Protection and Affordable Care Act (PPACA) contemplates insurance exchanges as state-level "market organizers" for health insurance options. Exchanges will primarily serve individuals and small business. Exchanges will also determine eligibility for both (a) premium assistance tax credits for individuals under 400% of the poverty level; and (b) TennCare and CoverKids.

The PPACA encourages states to develop and operate their own insurance exchanges by 2014. For states that elect to run an exchange, the federal government will pay most of the development and implementation costs prior to 2015. For states that do not elect to run an exchange, the federal government will operate a federalized exchange and determine eligibility for state and federal programs in those jurisdictions. The federal government will also set all of the criteria for "qualified health plans" within those states – and will charge user fees or raise other revenue from residents to pay for the costs of the federal exchange in their respective state.

Several PPACA components are particularly relevant to the insurance exchanges:

- **Medicaid Expansion:** TennCare, Tennessee's Medicaid program, presently serves certain categories of low-income individuals (i.e., the aged, blind, disabled, dependent children, pregnant women, and certain low-income parents). The current program does not generally cover "childless adults" – or, more specifically, it does not cover non-disabled adults under age 65 who do not have dependent children. Beginning in 2014, however, federal law expands Medicaid to almost all citizens and qualified aliens who are under 138% of the federal poverty level. Thus, all low-income adults (including childless adults) will be eligible for Medicaid – even if they are not part of the pre-2014 Medicaid eligibility categories.

- **Premium Assistance Tax Credits:** Individuals with incomes between 100-400% of the federal poverty level may be eligible for tax credits and other subsidies to lower their insurance costs, particularly if they do not have access to employer-sponsored health coverage. If an employer-sponsored plan does not cover 60% of the actuarial costs of the "minimum essential coverage," then the employee may be eligible for the tax credits. Likewise, an employee may be eligible for the tax credits if the employer-sponsored plan requires an employee contribution that exceeds 9.5% of the household's modified adjusted gross income. To apply for and make use of the credits, eligible individuals must purchase their health coverage through the insurance exchange.

- **Employer Penalties:** Beginning in 2014, employers with at least 50 full-time equivalents will face penalties if one or more of their full-time employees obtains a premium tax credit through an exchange. The penalty will be $3,000 per full-time employee that qualifies for such credits (though an employer's total liability for all penalties cannot exceed $2,000 multiplied by the total number of full-time employees).

- **Individual Mandate:** Beginning with the 2014 tax year, the Internal Revenue Service will assess a monetary penalty for any months in which a taxpayer or his/her dependents lack minimum essential health coverage. Low-income individuals, those without coverage for only a temporary period, and those with religious objections may apply for exemptions. The PPACA requires the exchanges to process all such exemption

requests. With respect to the constitutional challenges to the individual mandate and other provisions of the PPACA, please see the following section.

These functions illustrate the pivotal role that either a federal- or state-run exchange will likely play within Tennessee.

Planning in the Face of Uncertainty

While the PPACA is currently federal law, it faces several tests. First, federal appellate courts (and likely the U.S. Supreme Court) are considering challenges to the individual mandate and other provisions. Second, the Deficit Reduction Commission established by Congress may recommend changes to the law and/or delays the implementation of various provisions (including but not limited to the premium assistance tax credits and cost-sharing subsidies). Third, the leadership in the U.S. House of Representatives continues to advance arguments for defunding the various programs authorized by the PPACA. Fourth, the presidential and congressional elections in November 2012 may lead to substantial revision to or repeal of the PPACA.

Even if the PPACA remains federal law, the interpretation of the statute continues to evolve. For example, the federal government continues to propose draft text for regulations and subregulatory guidance. The final wording and resulting interpretations will substantially change the context and incentives for various actors in the market. Until these are issued in final form, though, it is difficult to evaluate the likely impact to the market and responses of market actors.

These factors illustrate the substantial uncertainty in which the insurance exchange planning efforts are taking place. For purposes of this white paper, we simply assume that the PPACA as currently written will remain law. However, we continue to plan for contingencies – and the State has structured the sequence of decisions so as to allow for maximum flexibility in the event of any of the eventualities noted above or other, unanticipated developments. In this way, Tennessee can limit the number of decisions to those absolutely necessary and the timing of such decisions to the point at which we have the maximum possible information. It also enables the State to revisit the various policy questions and re-assess options in light of new developments. Thus, Tennessee can keep open as many options as possible – and make course corrections as warranted.

The Federal Exchange

The federal government has not issued substantial guidance regarding the operational details of a federally-facilitated exchange. Federal officials had previously stated that the federal exchange would not be customized for individual states; thus, all states that do not operate an exchange would be served by the same federal portal and exchange structure. As recently as early October 2011, though, federal officials were unable to provide clarity as to how the federal exchange may select qualified health plans, compensate agents, and/or facilitate enrollment in public programs. They were also unable to provide a sense as to whether a federal exchange would ultimately be less expensive – and whether and how they would charge consumers in order to defray the costs of operating the federal exchange in the respective state. One federal official noted recently that it may be “some time” until such operational details are available.

In September 2011, the federal government announced a new "partnership model" in which it hopes to work with states to stand up insurance exchanges. The proposed details of this

approach appear to be structured in a way that such exchanges would still be considered federally-operated and that the federal government rather than the states would conduct the Medicaid eligibility determinations in these exchanges. Based on feedback from a number of states in response to the proposal, the federal government is apparently reconsidering these options, but they have not provided any update or timeframe for decisions in this regard.

Possible Policy Goals and Evaluative Criteria

If the State were to operate the exchange in Tennessee, the broad policy goal might be to provide **meaningful choices** of **high-quality health plans** at the **lowest possible price** to the consumer – as measured over a five-year period. To this end, Tennessee would likely evaluate the options using the criteria that would apply to any health policy issues. Specifically, we may evaluate the extent to which each option would enable the State to:

1. Maintain conservative fiscal management of Tennessee's resources.
    a. Ensure that expenditures for developing an insurance exchange do not exceed federal grant funding;
    b. Maintain control of major cost drivers such as TennCare and CoverKids; and
    c. Minimize Tennessee's exposure to unfunded federal mandates that could grow over time.

2. Encourage long-term economic growth, a business-friendly environment, and Tennessee's global competitiveness.
    a. Minimize employer's health care costs;
    b. Minimize the federal tax burden on Tennessee employers and employees; and
    c. Minimize complexity and red tape.

3. Maintain traditional state control of insurance regulation, and maximize the stability and competitiveness of Tennessee's health care and insurance industry.
    a. Maintain Tennessee Department of Commerce & Insurance regulation of medical insurance in accordance with TCA Chapter 56;
    b. Minimize federal disruption of Tennessee's health insurance industry so that insurance agents, health care providers, and insurance companies continue to provide valuable services in our state; and
    c. Ensure sustainability of exchange-based insurance options over a minimum period of five years.

4. Encourage healthy choices, personal responsibility, and accountability for a healthy lifestyle.
    a. Encourage Tennesseans to take charge of their own health.
    b. Promote health care consumerism.

5. Ensure that all Tennesseans, including rural residents have a range of insurance coverage options.

Features of an Optimal Alternative to a Federal Insurance Exchange

Benefit Comparability

The approach below for the individual exchange balances the need to simplify enrollment for new consumers in the first year of the exchange and also stimulate product innovation in subsequent years. In this sense, the exchange would provide a manageable number of options for consumers, with additional benefit options in the years following the "on-boarding" effort in 2014. In the small group or "SHOP" exchange, by contrast, the central role of insurance agents may mean there is no need to simplify the choice of benefits in the SHOP exchange during the first year.

Accordingly, to provide a manageable number of choices, the individual exchange would focus resources and applicant attention on enrolling in tax credits and public programs in 2014. Learning from the initial Medicare Part D experience, the exchange would avoid overwhelming individual consumers with a high number of benefit design options (particularly if many of the options are substantially similar).

<u>To this end, the individual exchange would either:</u>

- Adopt a "rule of 12" in which the product of (a) the number of issuers in a plan tier and (b) the number of benefit designs each issuer can offer in the respective tier does not exceed 12. This may simplify the consumer experience, but would still provide individuals with 48 standard plans from which to choose (the 4 "metallic" plan tiers x 12); or

- Define a baseline benefit design that all issuers could (but would not be required to) offer and also allow issuers to offer one benefit design of their own.

After the "on-boarding" year of 2014, the exchange could expand the number of choices or options available (e.g., adopt of a "rule of 24" for 2016, etc.) based on what appears manageable both for consumers and carriers. Additional policies proposed by stakeholders, which could complement the above options, include:

- Allow QHPs to provide "standard" network as well as offer consumers access to a broader network with the same QHP and metallic tier for an upcharge (that the QHP sets);

- Establish the two lowest-cost silver tier plans as the alternate defaults in the individual exchange, which individuals could change should they want to pay additional premium amounts for more coverage, broader networks, different benefit designs, different formularies, different issuers (i.e., insurer brands), etc.

<u>In contrast, the SHOP exchange may:</u>

- Allow unlimited benefit design variation in 2014 and subsequent years.

Provider Network Adequacy

Under the law, the exchange must establish minimum provider network adequacy standards for primary care and hospital providers. However, the exchange could elect to set minimum network adequacy standards for primary care providers and hospitals, and then require the QHP to ensure that each member has adequate access to all other categories of medically

necessary services, which would be enforceable through the liquidated damages (LD) provision of the QHP contract. Specifically, the exchange could:

- Set minimum geographic access standards for primary care providers (including women's health providers and pediatricians) and hospitals using the analogous provisions in the third party administration (TPA) contracts for the public employee health plan.

- Establish substantial LD amount for failures for a plan's inability to help a member secure an appointment for medically necessary services with a geographically-accessible, qualified provider (excluding subspecialists) at in-network cost-sharing within a commercially-reasonable timeframe.

- Define the occurrence giving rise to the above LD as a "substantial violation by the plan of a material provision of its contract in relation to the enrollee," thereby triggering a special enrollment event for the enrollee under the proposed federal rules.

Outreach and Navigators

PPACA Section 1311(i)(6) prohibits the use of federal funds for Navigator grants. The requirement to use non-federal (i.e., state) funds for the grant before the exchange is operational may effectively limit the amount of money available for this purpose. Accordingly, the exchange could:

- Prioritize any Navigator grant funding for organizations that (a) have direct interaction with special populations (e.g., those with limited literacy, etc.) but (b) who would **not** otherwise be engaged with health care and the insurance exchange (e.g., adult literacy programs, non-profit tax prep groups, etc.).

- After allocating f funds to priority partners, provide Navigator grants to certain health care providers and advocacy groups that work with vulnerable populations.

- Our agent/broker Technical Advisory Group (TAG) suggested providing a one-time payment for every individual who had been uninsured for the previous 12 months if said individual were to successfully enroll in a qualified health plan via the exchange. Thus, payments would target those who were uninsured rather than those substituting existing coverage for exchange coverage.

Insurance Agent Involvement and Compensation

Tennessee stakeholders believe that the participation of insurance agents is critical to the success of an insurance exchange in Tennessee. The following options related to agents are supported by stakeholders:

- Accredit agents to the SHOP and individual exchanges only if they (a) are currently licensed by and in good standing with TDCI; (b) have current appointments with at least two issuers on the exchange; and (c) demonstrate adequate knowledge of the exchange and qualified health plans by passing a written examination. The agents and brokers would be responsible for the full costs of accreditation (likely in the form of a fee charged by the accrediting entity).

- Require small groups interested in purchasing coverage through the SHOP exchange to work directly through an accredited agent or broker for the first two years of the SHOP exchange.

- In addition to providing a default user portal for the SHOP exchange, allow agents to create or license customized front-end portals with their own branding and features for use with small groups. Such portals would "ping" the SHOP exchange and transmit data in a manner defined by the exchange. As a practical matter, the SHOP exchange could defer approval of the use of such portals until 2015.

- Allow agents to offer additional products (e.g., in the form of a VEBA to small groups, etc.) to individuals and small groups, provided that the agent or broker (a) completes the QHP enrollment before introducing the ancillary products; (b) clarifies to the consumer that such ancillary products are separate from and not endorsed by the insurance exchange; and (c) enrollment in such ancillary products is voluntary and entirely unrelated to QHP enrollment.

- Allow agents to freely negotiate commissions with issuers, provided that the aggregate value of the consideration received by the agent broker (i.e., the commission or compensation structure) from the issuer for the same or similar products is not lower for products sold via the exchange compared to those sold in the parallel market.

- Allow accredited agents to enroll individuals in the individual exchange and collect either or both issuer-paid commissions and/or user-paid assistance fees (to the extent permissible under state law).

- Allow agents to freely negotiate transaction, consulting, and assistance fees (to the extent permissible under state law) with small groups and individuals, provided that all transaction, consulting, or assistance fees are non-discriminatory, prominently displayed, transparent, and fully disclosed to the consumer prior to entering an agreement (i.e., the agent or broker has no "hidden fees").

Premiums in SHOP Exchange

The SHOP exchange would likely focus on expanding the offerings and choices available to employees of small businesses, but do so in a way that makes the costs of such choices (in the form of a higher risk premium) more transparent. To this end, the SHOP exchange could allow issuers (if they choose to do so) to provide two rates in the SHOP exchange: one for those employers that select a single QHP and a separate rate for those employers that allow for more employee choice. (Because these are different products or QHPs, issuers would presumably be able to bid different rates.)

We would make three notes with respect to the employee "full choice" approach:

(i) The SHOP exchange would not require insurers to participate in the full employee choice option; rather, insurers could decide to bid only on the employer choice option;

(ii) If an employer elects full employee choice, the SHOP exchange would require the employer to select a default plan; and

(iii) The SHOP exchange would allow employers to contribute defined dollar amounts to notional accounts (rather than paying a proportion of whichever plan that an employee may choose).

Wellness

The exchange has the opportunity to emphasize the importance of prevention and wellness – and establish expectations about personal responsibility and engagement from the first day of coverage. Given recent evidence about their efficacy, the exchange may want to incorporate some form of market-based incentives for wellness, etc. Accordingly, the exchange may:

- Incentivize enrollees to become more fully engaged with wellness and preventive health care. As is now done among large employer health plans, the exchange could provide incentives for enrollees to:

    (a) Complete a health questionnaire and biometric screening;

    (b) Maintain a normal body mass index (within specified range);

    (c) Maintain a normal cholesterol level (within specified range);

    (d) Maintain a normal blood pressure (within specified range); and/or

    (e) Maintain a normal blood sugar level (within specified range).

In essence, the wellness program could provide some sort of "good driver discount" in the form of a lower premium or other incentives to those enrollees who satisfy these standards.

- Provide reasonable alternatives to qualify for incentives for those enrollees for whom it is unreasonably difficult or medically inadvisable to achieve the standards.

As a practical matter, such a program would want to begin to offer incentives at least 30 days following the completion of enrollment so as to minimize any confusion among new members about enrollment, coverage and the new incentives.

Financial Sustainability

Under the PPACA, the exchange must be self-supporting by 2015, regardless of whether the exchange is operated by the state or federal government. Thus, even a federal exchange will involve some user fees or other revenue provisions in which state residents cover the operating costs of the exchange. If the State were to operate the exchange (and leverage existing administrative infrastructure for various exchange functions), then Tennessee would retain more direct control over the cost structure of the former.

If Tennessee were to operate an exchange, it would presumably structure the sustainability model such that users of the exchange also pay for its operating costs, thereby minimizing the cost burden on state taxpayers. To offset any remaining costs, the exchange could defray costs mainly by fees on those who benefit most from the exchange. It may use standard commercial marketing practices as a possible source of revenue. Accordingly, a state-operated exchange could (in order of priority):

- Allocate costs to Medicaid and other programs (thereby leveraging federal funds) in a manner consistent with federal rules; however, the exchange could provide the local match for the federal funds.

- Incorporate administrative fees into the premiums for QHPs sold in the individual and SHOP exchanges, with the applicable fee reflecting the underlying cost of the respective

exchange. Fees would be higher for family premiums than for individual premiums in order to leverage federal funding.

- Charge recurring administrative fees to employers participating in the SHOP exchange.
- Charge recurring administrative fees to QHPs participating in the individual and SHOP exchanges.
- Charge recurring accreditation fees to agents and brokers to cover costs related to this function.
- Allow online and other advertising, but only to the extent that the exchange could approve content.
- Enter into commercial partnerships for direct marketing, though only to the extent that the exchange retains exclusive possession of all enrollee information and fully complies with HIPAA and Medicaid privacy protections. In other words, the Exchange would never sell or transfer data for marketing purposes, but it could distribute marketing materials in billing notices similar to how some electric service providers currently do with utility bills.
- Charge administrative and reporting fees to reinsurance entity.

Reinsurance and Risk Adjustment

Any approach to reinsurance and risk adjustment would seek to mitigate risks of adverse selection to insurers to the maximum extent possible, thereby inducing a higher number of issuers to submit proposals in response to the QHP RFP. We will be working with our actuarial consultants and the insurer community to understand the level of the uncertainty about (a) average utilization or (b) the risks of outliers. Based on this information, we will be better able to optimize the role for any temporary reinsurance program in Tennessee's individual market. Likewise, we will use this information to help understand the opportunities associated with a longer-term risk adjustment program in both the individual and small group markets.

As a first step, we are reviewing the actuarial experience of past and current state-based reinsurance programs. Several Northeastern states (NY, CT, MA, etc.) have such programs, with the insurer typically responsible for 100% of costs to $5,000; 10% of costs to $55,000 or $75,000; and 0% of costs above $55,000 or $75,000. In contrast to this model, the PPACA envisions a temporary reinsurance program that co-exists or complements traditional reinsurance (often with deductibles or thresholds of $100,000 to $250,000) that issuers already have. We are working to understand whether two or three "layers" of reinsurance would be optimal – and how the layer(s) should be constructed. Likewise, we are reviewing the white paper that the federal government released on risk adjustment in late September 2011. If Tennessee were to move forward with an exchange, then we would likely convene a new technical advisory group of insurance industry actuaries in early 2012 to discuss these issues in greater detail.

Neither the reinsurance nor the risk adjustment programs would require new appropriations by the State. Rather, the PPACA requires that the programs be self-sustaining through industry assessments. Because such assessments apply to self-funded plans, though, the State could face a liability for those state and higher education employees who are covered in the public section health plans. To be clear, these liabilities on a per capita basis are the same for all employers in Tennessee that offer health coverage, whether the employer is public or private.

We anticipate having preliminary recommendations in this regard in early- to mid-2012.

Governance

Under the federal statute and proposed federal rules, states can operate the exchange as a non-profit entity, an independent government agency, or a part of an existing state agency. To the extent that states choose either of the first two options, additional federal rules apply regarding the composition of a governing board, etc. If a state were to choose to create an exchange as an independent government agency, then it would also have to create and define the scope of authority of the new agency in statute – and build the administrative infrastructure to support it. In contrast, an exchange that is part of an existing state agency could provide the State with the ability to react quickly to federal rules – and it leverages existing administrative, legal, and procurement resources. This structure also ensures maximum accountability of the insurance exchange to the Executive and Legislative branches.

Given the uncertainty surrounding the development of insurance exchanges (see the first section of this Executive Summary) and the likelihood for "late-in-the-game" developments, any successful state-operated exchange will require maximum flexibility in the early phases of implementation. Once the exchange completes the first-year "on-boarding" of consumers and qualified health plans and achieves a "steady state" of operations, though, it may be appropriate to revisit the governance structure. Indeed, if Tennessee operates an exchange, the governance structure likely would evolve over time.

An exchange that is operated by an existing state agency may offer the most advantages and also prove the easier to implement. From the inception of the planning efforts, we have engaged all stakeholders including agents and brokers, large and small employers, insurers, health care providers, and consumer advocates. If Tennessee operates an exchange, the State would formalize this process by establishing an official advisory committee comprised of a variety of stakeholders. It may also be advantageous to reserve some appointments for actuaries, accountants, and attorneys who have experience in health care but no pecuniary or other conflicts of interest.

Stakeholders expressed a consistent desire to have a forum or process by which an exchange could elicit public input. Based on our experience with the Technical Advisory Groups, we think that the maximum size of such a committee may be approximately 20 members. So as to maximize public input and inclusiveness, the State may want to create some mechanism to allow all parties to attend and participate in discussions even if they have no formal appointments to or votes on such a committee.

Marketing

Under the proposed federal rules, state-operated exchanges may determine what (if any) marketing restrictions should apply to qualified health plans. In the TennCare program, the State currently prohibits most marketing to consumers by the managed care organizations. This has helped to avoid both marketing abuses and unnecessary regulation – and has ensured the enrollees hear and read and consistent and coordinated set of messages. In contrast, Medicare allows Advantage plans to market to consumers, though such marketing is subject to increasingly detailed prescriptive federal standards.

The issues related to plan marketing are inherently complex. At least theoretically, QHP issuers could target their marketing efforts so as to attract healthier individuals (and, thus, benefit from a "selection" effect). Even with a "marketing prohibition" by an exchange, though, QHP issuers

may still be able to conduct general "brand" marketing or market products that are available outside the exchange.

Several other states have indicated that they may not allow issuers to specifically market QHP products available via the exchange, at least for the first year. Thus, the individual exchange and its partners would be chiefly responsible for building awareness about new coverage options and subsidies for 2014 (e.g., through a public information campaign and Navigator program). That said, a state could still allow insurers to provide unrestricted grants to community partners (perhaps including but not limited to Navigators) to complement the individual exchange's community education effort.

Given the very different contextual factors, it is unclear whether any marketing limitations would be necessary or helpful within the SHOP exchange.

Qualified Health Plan Standards

The federal statute and proposed federal rules establish minimum standards for qualified health plans. Given the extensive nature of these requirements, we believe that it may be appropriate to forego much in the way of additional standards for 2014. In short, we want to avoid injecting more complexity into the insurance markets at a time of such enormous transition.

We note, though, that the exchange may want to address solvency and other factors in much the same way that the State currently does for TennCare MCOs today. Such standards should not complicate matters for insurers as they should involve little if any additional reporting burdens or substantial shift in compliance activity.

Basic Health Program

For reasons outlined in the Appendix A of the full white paper, the Basic Health Program (BHP) may not offer any clear advantages to Tennessee. Stakeholders appeared to concur with the reasoning in this document, and few if any advocated for consideration of the BHP. However, we look forward to reviewing the federal rules regarding the BHP as soon as they are available.

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION: PREPARING FOR FEDERAL HEALTH REFORM IN TENNESSEE

In March of 2010, the federal Patient Protection and Affordable Care Act (PPACA) was enacted by Congress, imposing significant changes on Tennessee employers, insurance agents, healthcare providers, insurance companies, and all Tennesseans. This document reflects the significant input that state staff members have heard from Tennessee stakeholders over the past year on how the state should evaluate available policy options in order to protect and support the interests of the state's citizens and health care community while complying with the legal requirements of federal law.

While this White Paper does not discuss all decision points and design features of the exchange, it highlights critical elements identified during our stakeholder meetings. The paper includes a summary review of 22 separate topics addressing the following areas of interest: benefit plan design options; health plan participation opportunities and certification requirements; consumer outreach and education activities; participation of insurance agents; financial oversight and solvency of participating insurers; employee and employer participation; enrollment activities; and issues related to premium development and pricing. A more detailed list is provided in the Table of Contents. Throughout all of these discussions, the primary goal has been to ensure consumers continue to have a meaningful choice of high quality health plans at the lowest possible price while maintaining and supporting a stable, financially-solvent health insurance industry.

This paper attempts to provide a straightforward discussion of a complicated issue involving many moving pieces. The requirements of PPACA are complex, often confusing, and have widespread implications for all areas of the health care system. The law includes several new provisions that will play key roles in implementation decisions and consumers' participation in the exchange, including:

- The expansion of Medicaid and changes in eligibility requirements that require states to remodel their existing Medicaid programs to meet additional federal requirements;
- The availability of premium assistance tax credits to be used by eligible citizens for purchasing affordable health insurance;
- The imposition of tax penalties on certain large employers that fail to offer insurance; and
- A requirement that all U.S. citizens purchase health insurance or pay tax penalties, with some exceptions.

This white paper also provides an overview of the PPACA requirements and a discussion of some of the key issues that must be resolved regardless of whether the state of Tennessee or the federal government operates the exchange.

Listening to Tennesseans about Alternatives

For the past year months, the insurance exchange planning initiative has gathered the advice and views of Tennessee stakeholders. We released a concept paper and held our first general stakeholder meeting in October 2010. Over the past year, we have traveled more than 4,000 miles to hold countless meetings across our state, from Memphis to Chattanooga, Clarksville to Bristol, and many places in between. We have met with groups of small business owners, insurance agents, healthcare providers, advocates, insurance companies, and general audiences. In addition, we maintain an open door policy, and meet with any individual person or company who requests it.

In terms of communication, we work to keep stakeholders up-to-date by posting online documents we produce, agendas and notes from meetings, and links to useful analyses produced by others. We also send a monthly email update to a list of 500 Tennesseans. Please visit our website (www.tn.gov/exchange) to view documents and to sign up for our email distribution list by sending an email to insurance.exchange@tn.gov.

This present white paper is intended to be a reflection of what we have heard from stakeholders. We are grateful to all the Tennesseans who have lent us their expertise. We are particularly indebted to the insurance agents and actuaries who volunteered to meet with us regularly over the past year in what we call our Technical Advisory Groups, and to the many people who regularly attended our Provider and Advocate Roundtable meetings.

Our commitment to stakeholder consultation and transparency continues. Please comment and provide your feedback by sending an email to insurance.exchange@tn.gov or by attending one of the following community meetings across the state:

Table 1. Insurance Exchange Listening Sessions Fall 2011

DATE	TIME	LOCATION/VENUE	SPONSOR(S)	RSVP CONTACT
October 27	8:30 a.m. CT	**Nashville**: Tennessee Bankers Association Building, 211 Athens Way (Metro Center)	Middle Tennesssee Assoc. of Health Underwriters	Chuck Terry chuck@dunninsinc.com
November 7	6:30 p.m. to 8:30 p.m. CT	**Hendersonville**: Life Church, 120 Indian Lake Blvd	Tennessee Health Care Campaign (THCC), United Chambers of Sumner County, and League of Women Voters	Tony Garr tgarr@thcc2.org
November 8	12:30 p.m. to 2:30 p.m. CT	**Nashville:** Multimedia Room, 3rd floor Tennessee Tower, 312 Rosa L. Parks Ave	Provider and Advocate Roundtable meeting	insurance.exchange@tn.gov

DATE	TIME	LOCATION/VENUE	SPONSOR(S)	RSVP CONTACT
November 8	6:00 p.m. to 8:00 p.m. CT	**Cookeville**: Putnam County Chamber of Commerce, 1 West First St	Putnam County Chamber of Commerce, TN Tech University School of Nursing, TN Tech University School of Business, and Cookeville Regional Medical Center	Tony Garr tgarr@thcc2.org
November 9	12 Noon to 1:30 p.m. CT	**Nashville**: Spruce Street Baptist Church, 504 Spruce Street, Nashville, TN	Interdenominational Ministerial Fellowship (IMF) and THCC	Tony Garr tgarr@thcc2.org
November 10	7:00 p.m. ET	**Blountville**: Wellmont Performing Arts Center, Northeast State Community College	TriCities Citizens for Improved Health Care, THCC, Wellmont Health System, Kingsport Chamber of Commerce, Johnson City-Jonesborough-Washington County Chamber of Commerce, Integrated Health Solutions Network, Northeast State Community College Division of Nursing, Mountain States Health Alliance, and Bristol Chamber of Commerce	Zellie Earnest zellie@chartertn.net
November 10	3:00 p.m. ET	**Bristol:** Bristol Chamber of Commerce, 20 Volunteer Parkway	Bristol Chamber of Commerce, Johnson City Chamber of Commerce, and Kingsport Chamber of Commerce	Tiffany Goforth TGoforth@bristolchamber.org
November 14	11:00 a.m. ET	**Knoxville:** Summit Medical Group (contact sponsor for details)	Summit Medical Group	Kay Hannah khannah@summithealthcare.com
November 14	7:00 p.m. ET	**Knoxville:** East Tennessee Historical Society, 601 South Gay Street	University of Tennessee Center for Health Policy and Services Research.	Carole Myers cmyers9@utk.edu

DATE	TIME	LOCATION/VENUE	SPONSOR(S)	RSVP CONTACT
November 15	8:00 a.m. ET	**Knoxville:** Calhoun's On The River, 400 Neyland Dr.	Knoxville Health Underwriters Association	Cliff Horne cliff@wyattinsurance.com
November 17	11:30 a.m. CT	**Jackson:** DoubleTree Hotel, 1770 Highway 45 Bypass	Jackson/West Tennessee Association of Health Underwriters	Darlene Tucker j.darlene.tucker@mwarep.org
November 17	6:00 p.m. CT	**Memphis:** Fogelman Executive Center, University of Memphis, 330 Innovation Drive	Health Choice (Methodist & Metro Care Physicians), Memphis Memphis Medical Society, Memphis Business Group on Health, Univ. of Memphis School of Public Health, and Healthy Memphis Common Table	Register at www.MyHealthChoice.com (click calendar icon at bottom of home page to access seminar listing)
November 18	8:00 a.m. CT	**Memphis:** Crescent Club, 9th floor, 6075 Poplar Ave.	Mid-South Health Underwriters	Philip Johnson pjohnson@argylebenefits.com

Insurance Exchanges and the PPACA

As currently written, the PPACA requires that every state must have an insurance exchange through which individuals owners can purchase insurance coverage, and an insurance exchange for small businesses. The individual exchange also must coordinate with eligibility and enrollment functions performed by the state through TennCare, the state's Medicaid program, and CoverKids, the state's CHIP program.

If a state decides not to create an exchange, or if the federal government does not grant conditional approval of a states exchange by January 1, 2013, the federal government will create and operate an exchange for the state. Building an exchange is an ambitious process that requires a significant effort by a diverse group of stakeholders and policymakers. The law gives states very little time to decide how to proceed as they must demonstrate by January 1, 2013 that they are making progress on establishing an exchange.

Planning in the Face of Uncertainty

While the PPACA is currently federal law, it faces several tests. First, federal appellate courts (and likely the U.S. Supreme Court) are considering challenges to the individual mandate and other provisions. Second, the Deficit Reduction Commission established by Congress may recommend changes to the law and/or delays the implementation of various provisions (including but not limited to the premium assistance tax credits and cost-sharing subsidies).

Third, the leadership in the U.S. House of Representatives continues to advance arguments for defunding the various programs authorized by the PPACA. Fourth, the presidential and congressional elections in November 2012 may lead to substantial revision to or repeal of the PPACA.

Even if the PPACA remains federal law, the interpretation of the statute continues to evolve. For example, the federal government continues to propose draft text for regulations and subregulatory guidance. The final wording and resulting interpretations will substantially change the context and incentives for various actors in the market. Until these are issued in final form, though, it is difficult to evaluate the likely impact to the market and responses of market actors.

These factors illustrate the substantial uncertainty in which the insurance exchange planning efforts are taking place. For purposes of this white paper, we simply assume that the PPACA as currently written will remain law. However, we continue to plan for contingencies – and the State has structured the sequence of decisions so as to allow for maximum flexibility in the event of any of the eventualities noted above or other, unanticipated developments. In this way, Tennessee can limit the number of decisions to those absolutely necessary and the timing of such decisions to the point at which we have the maximum possible information. It also enables the State to revisit the various policy questions and re-assess options in light of new developments. Thus, Tennessee can keep open as many options as possible – and make course corrections as warranted.

The Federal Exchange

The federal government has not issued substantial guidance regarding the operational details of a federally-operated exchange. Federal officials had previously stated that the federal exchange would not be customized for individual states; thus, all states that do not operate an exchange would be served by the same federal portal and exchange structure. As recently as early October 2011, though, federal officials were unable to provide clarity as to how the federal exchange may select qualified health plans, compensate agents, and/or facilitate enrollment in public programs. They were also unable to provide a sense as to whether a federal exchange would ultimately be less expensive – and whether and how they would charge consumers in order to defray the costs of operating the federal exchange in the respective state. One federal official noted recently that it may be “some time” until such operational details are available.

In September 2011, the federal government announced a new "partnership model" in which it hopes to work with states to stand up insurance exchanges. Disappointment characterized the response of most states after learning of the proposed details, largely because the announcement fell substantially short of previously communicated expectations. Specifically, the “partnerships” explicitly require such exchanges to be federally-operated; moreover, the federal government rather than the states would conduct the Medicaid eligibility determinations in these exchanges. Responding to the objections voiced by a number of diverse states, the federal government is apparently reconsidering these options, but they have not provided any update or timeframe for decisions in this regard.

Possible Policy Goals and Evaluative Criteria

If the State were to operate the exchange in Tennessee, the broad policy goal might be to provide **meaningful choices** of **high-quality health plans** at the **lowest possible price** to the consumer – as measured over a five-year period. To this end, Tennessee would likely evaluate

the options using the criteria that would apply to any health policy issues. Specifically, we may evaluate the extent to which each option would enable the State to:

1. Maintain conservative fiscal management of Tennessee's resources.
    a. Ensure that expenditures for developing an insurance exchange do not exceed federal grant funding;
    b. Ensure that no state appropriations are required for ongoing support of an insurance exchange;
    c. Maintain control of major cost drivers such as TennCare and CoverKids; and
    d. Minimize Tennessee's exposure to unfunded federal mandates that could grow over time.

2. Encourage long-term economic growth, a business-friendly environment, and Tennessee's global competitiveness.
    a. Minimize employer's health care costs;
    b. Minimize the federal tax burden on Tennessee employers and employees; and
    c. Minimize complexity and red tape.

3. Maintain traditional state control of insurance regulation, and maximize the stability and competitiveness of Tennessee's health care and insurance industry.
    a. Maintain Tennessee Department of Commerce & Insurance regulation of medical insurance in accordance with TCA Chapter 56;
    b. Minimize federal disruption of Tennessee's health insurance industry so that insurance agents, health care providers, and insurance companies continue to provide valuable services in our state; and
    c. Ensure sustainability of exchange-based insurance options over a minimum period of five years.

4. Encourage healthy choices, personal responsibility, and accountability for a healthy lifestyle.
    a. Encourage Tennesseans to take charge of their own health.
    b. Promote health care consumerism.

5. Guarantee geographic equity by ensuring that rural residents of Tennessee have access to coverage options.

Additional Sources of Information

This white paper assumes a basic understanding of the individual/non-group and small group insurance markets in Tennessee. Likewise, it assumes a working familiarity with the federal Patient Protection and Affordable Care Act (PPACA). We include a summary of the current insurance market rules in Tennessee as Appendix A; the appendix also summarizes the substantial changes in insurance regulations required by the PPACA. To the extent that you would like background information on the insurance markets or the PPACA, please see the following publications:

> *Summary of New Health Reform Law*, published by Kaiser Family Foundation, available at: http://www.kff.org/healthreform/upload/8061.pdf

Everything You Wanted to Know About Health Reform But Were Afraid to Ask, published by the Urban Institute. Available at: http://www.urban.org/health_policy/health_care_reform/Everything-You-Wanted-to-Know.cfm

CHAPTER TWO

HEALTH INSURANCE EXCHANGE REQUIREMENTS: OVERVIEW OF FEDERAL HEALTH REFORM PROVISIONS

While the PPACA establishes the outline for many exchange requirements and restrictions, Congress delegated to several federal agencies the authority to establish rules that describe many of the important details states need to make key decisions. A number of rules and guidance related to exchanges have been published, including two draft regulations released this summer (**Table 2**). However, many of the important details states need to proceed with exchange planning were not included, and the draft rules that have been released are expected to be revised based in part on comments submitted to the federal agencies, so states will not have the benefit of final regulations until sometime later this year or early next year. Unfortunately, due to the aggressive timeline of federal requirements, Tennessee and other states may not be able to postpone the decision on whether to implement an insurance exchange until final rules for exchange provisions are available. States that wait for all the necessary information to make their decisions may be unable to meet the January 2013 deadline for condition approval and will thereby insure a federally operated exchange will operate within their borders.

Table 2 – Exchange-Related Federal Regulations and Guidance Publications to Date

Federal Regulatory Document	Date Published	Status
Exchange and Medicaid Information Technology (IT) Systems. Version 1.0. Available at: http://cciio.cms.gov/resources/files/joint_cms_ociio_guidance.pdf	November 3, 2010	Interim Guidance
Initial Guidance to States on Exchanges. Available at: http://cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html	November 18, 2010	Interim Guidance
Guidance for Exchanges and Medicaid Information Technology (IT) Systems. Version 2.0. Available at: http://cciio.cms.gov/resources/files/exchange_medicaid_it_guidance_05312011.pdf	May 31, 2011	Interim Guidance
Health Care Reform Insurance Web portal Requirements; 45 CFR Part 159. Available at: http://cciio.cms.gov/resources/files/webportal.html	October 1, 2010	Interim Guidance
Establishment of Exchanges and Qualified Health Plans (CMS-9989-P); 45 CFR parts 155 and 156. Available at: http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf	July 15, 2011	Interim Final Rule
Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment (CMS-9975-P); 45 CFR Part 153. Available at: http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf	July 15, 2011	Proposed Rule
Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers (CMS-9974-P); 45 CFR Parts 155 and 157. Available at: http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20776.pdf	August 17, 2011	Proposed Rule
Health Insurance Premium Tax Credits (REG-131491-10); 26 CFR Part 1. Available at: http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf	August 17, 2011	Proposed Rule
Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 (CMS-2349-P); 42 CFR Parts 431,433,435, and 457. Available at: http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf	August 17, 2011	Proposed Rule
Summary of Benefits and Coverage and the Uniform Glossary (CMS-9982-P); 26 CFR Parts 54 and 602. Available at: http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf	August 22, 2011	Proposed Rule

Insurance Exchange Requirements

The following are some of the key federal requirements of an exchange.

Selection of Health Insurance Companies for Exchange Participation

The exchange must establish a process by which insurance companies will be "qualified" or authorized to participate in the exchange. A plan that is certified for exchange participation is referred to as a qualified health plan (QHP). The exchange may decide to allow all insurers that meet the minimum participation requirements to offer health plans, or the state may decide to limit the number of insurers through a competitive procurement process. Participating insurers must be licensed and in good standing with the state.[1] The exchange must offer plans with different benefit levels--platinum, gold, bronze, and silver—with platinum providing more coverage of the cost of benefits than gold, and so on. Participating insurers must offer at least one "silver" and one "gold" health plan; must charge the same premium for a plan offered both within and outside the exchange; and must comply with any other applicable requirements established by the State or federal government.[2]

Exchange Health Plan Requirements

In addition to complying with the broad PPACA health insurance reforms applicable to most plans both within and outside the exchange, health plans sold through the exchange must meet additional requirements. One of the primary functions of the exchange is to certify plans for participation. Though federal regulations on specific plan benefits have not been issued, at a minimum QHPs must comply with the following broad requirements:

- meet marketing requirements that prohibit marketing practices and benefit design that discourage high-risk enrollees;
- ensure a sufficient number of network providers and supply information about the availability of providers in and out-of-network;
- include in-network essential community providers that serve low-income, medically underserved individuals;
- implement and report on a quality improvement strategy, including pediatric quality;
- implement activities to reduce disparities in health and health care;
- use a uniform enrollment form;
- comply with premium rating and reporting requirements;
- submit justifications for premium increases;
- use a standard format for presenting benefit options;
- offer at least one "gold" and one "silver" benefit plan that meets the federal PPACA design requirements;
- submit information in plain language on claims payment, financial disclosures, enrollment, cost sharing, enrollee rights, and other information as directed; and
- provide information to enrollees on cost sharing with respect to specific items.

[1] PPACA Section 1301(a)(1)(C)(i) and the proposed rules at 45 CFR § 156.200(b)(4) require all qualified health plan issuers to "[b]e licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage." See Establishment of Exchanges and Qualified Health Plans 76 Fed. Reg. 41866-927, 41923 (July 15, 2011).

[2] Congressional Research Service, "Private Health Insurance Provisions in PPACA (P.L.111-148), April 15, 2010. Available at http://assets.opencrs.com/rpts/11-148_20100415.pdf

Financing of the Exchange

Federal funds, in the form of Exchange Establishment Grants, are available through 2014 for development and operation of the exchange. Beginning January 1, 2015, exchanges must be self-sustaining through funding mechanisms designed and implemented by the State.[3] Examples of some options the state may consider for financing the exchange include (1) allocating certain costs to Medicaid and other programs in order to leverage federal funds; (2) charging administrative fees to employers participating in the SHOP exchange; (3) charging recurring administrative fees to qualified health plans (QHPs) participating in the exchange; or (4) allowing online advertising and/or direct marketing through the exchange.

Additional Exchange Requirements

In addition to the above requirements, the PPACA also requires the insurance exchange to:

- determine eligibility for and enroll applicants in public programs such as Medicaid and SCHIP (i.e.,TennCare and CoverKids);
- administer advance premium assistance tax credit payments by the Department of Treasury to insurers (i.e., the exchange must oversee distribution of federal tax credit payments for qualified individuals that are paid directly to the QHP selected by the enrollee);
- determine eligibility for new tax credits and cost-sharing reductions for persons who meet financial eligibility requirements
- provide health plan ratings based on relative quality and price to individuals "shopping" on the Exchange;
- design an enrollee satisfaction survey system for Exchange plans to execute;
- provide web resources (e.g., cost calculator) and toll-free call center support to users;
- administer the exemption process for the federal individual mandate requirement (explained in further detail later in this paper);
- determine whether employer-sponsored insurance meets the PPACA threshold standard for affordable coverage, and which employees with access to employer-sponsored coverage are eligible for exchange coverage because the employer plan does not meet the affordability requirements;
- develop and operate an exchange or state-funded consumer assistance program using "navigators" who will help consumers make purchasing decisions; and
- report user and employer data to the Department of Treasury to prevent the imposition of tax penalties and protect Tennesseans.

Structure and Design of the Exchange

States have the option to establish the exchange using an existing state agency, through creation of an independent public entity sometimes referred to as "quasi-governmental" agency, or as a nonprofit entity. It must operate in a transparent manner and have technically competent leadership to oversee and manage the exchange functions.[4] The exchange must also ensure public accountability and provide objective information on the performance of plans, treat

[3] Regarding the requirement that the exchange be financially self-supporting by 2015, PPACA Section 1311(d) notes that exchanges may charge users fees, etc. to ensure financial support for continued operations. See also the proposed rules at 45 CFR § 155.160, Establishment of Exchanges and Qualified Health Plans 76 Fed. Reg. 41866-927 (July 15, 2011).

[4] National Association of Insurance Commissioners, "Health Insurance Exchanges Under the Affordable Care Act: Governance Options and Issues," May 9, 2011.

consumers, health plans and other partners fair and impartially, and must prohibit conflicts of interest.[5]

Exchange Integration with Public Programs

The PPACA requires that states integrate eligibility determinations for Medicaid, CHIP and exchange subsidies using a streamlined process that meets federal regulatory requirements. Whether a state establishes a state-based exchange or chooses to defer to federal operation, these operational requirements will require significant changes to current eligibility and enrollment rules, new functionality for information technology systems, and close coordination with the exchange.

Individual Insurance Mandate Requirement and Penalties

One of the most controversial requirements of the federal PPACA is the individual mandate to require all U.S. citizens and legal residents to obtain insurance that complies with minimum federal standards defined by law and regulations. Beginning January 1, 2014, individuals will be required to provide proof of insurance when filing their annual federal tax return. Exceptions are provided for:

- financial hardship, which includes those for whom the lowest cost benefit plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold;
- religious objections;
- American Indians;
- non-legal residents who are not eligible for exchange coverage;
- incarcerated individuals;
- those without coverage for less than three months; and
- any individual who the Secretary of HHS determines to have suffered a hardship with respect to the capability to obtain coverage.[6]

Individuals (including both adults and dependent children) who do not have coverage will be required to pay a penalty for each month of noncompliance. The penalty is calculated as the greater of either: (1) a percentage of the amount by which household income exceeds the personal exemption of the tax year, or (2) a flat dollar amount assessed on each taxpayer and any dependents.[7] The penalty will be phased in over a three year period beginning in 2014 as follows:

- $95 in 2014,
- $325 in 2015,
- and $695 in 2016 for the flat fee,

[5] Ibid.
[6] PPACA Section 1501 (which adds a new Chapter 48 to the Internal Revenue Code) requires individuals to maintain "minimum essential coverage." The statute defines these terms and the relevant exceptions and exemptions. For more information, please see Congressional Research Service Report R41331, "Individual Mandate and Related Information Requirements under PPACA" (August 16, 2010), available online at http://www.nahu.org/legislative/resources/Individual%20Mandate%20and%20Related.pdf.
[7] National Association of Insurance Commissioners, "Health Insurance Exchanges Under the Affordable Care Act: Governance Options and Issues," May 9, 2011.

or

- 1% of taxable income in 2014,
- 2% of taxable income in 2015,
- and 2.5% of taxable income in 2016.

After 2016, the penalty will be adjusted for inflation. The flat fee is assessed for each taxpayer and any dependents, up to the family cap. The dollar amount will be reduced by one-half for dependent children under age 18.

Tax Credits and Subsidies to Help Reduce the Cost of Insurance

Beginning in 2014, some individuals and families will qualify for premium tax credits to assist with the cost of their health insurance. In addition, some will also qualify for cost-sharing subsidies that will help pay the insurance deductible and copayments required when a person obtains health care services. This financial assistance is only available for plans purchased through the exchange.[8] Subsidy calculations are a fairly complex process, and will vary based on several factors. Following is a general description of how tax credits and cost sharing subsidies will be calculated.

Premium Credit Calculations: Generally, individuals living in households with incomes up to 400% of the federal poverty level (FPL) will qualify for some level of premium credit that will be paid directly to the insurer to cover part of the cost of the insurance plan. Individuals with incomes between 300% and 400% of the FPL would pay no more than 9.5% of their income to purchase the second lowest cost "silver" plan available in the exchange. (Note: individuals may choose more expensive plans, but will be responsible for additional premiums.) For individuals with incomes above 133% and up to 300% of FPL, the percent of income they will pay ranges from 3% up to 8.05%. Families with incomes up to 133% of FPL will pay no more than 2% of their income.

Table 3 below illustrates the maximum annual premium payment a single family of one and a family of four would have to pay towards the cost of insurance under the PPACA requirements. The calculations are based on payments that would be required under the current 2011 FPL guidelines, which are the most recent guidelines available. Actual premium contributions for 2014 cannot be calculated until the 2014 FPL guidelines are issued. In the illustration below, a family of one (i.e., a single individual with no other family members) with an annual income of no more than $16,335 (150% of the FPL) would pay a maximum of $653 a year for health insurance. A family of four with an annual income of $33,525 would pay a maximum of $1,341 a year for health insurance.

[8] Under the federal proposed rules, tax credits may not be used towards the purchase of catastrophic plans, even though eligible individuals may purchase these plans to satisfy the individual mandate requirement.

Table 3 – Annual Premium Cost after Tax Credit for 2nd Lowest Cost Silver Level Plan

Income as a Percentage of FPL	Premium Cost after Tax Credit for 2nd Lowest Cost Silver Level Plan as a Percentage of Income	Premium Cost after Tax Credit for 2nd Lowest Cost Silver Level Plan by Family Based on Current FPL Levels (2011)*			
		Family of 1 Income	Premium Cost after Tax Credit	Family of 4 Income	Premium Cost after Tax Credit
150%	4.0%	$16,335	$653	$33,525	$1,341
200%	6.3%	$21,780	$1,372	$44,700	$2,816
250%	8.05%	$27.225	$2,192	$55,875	$4,498
300%	9.5%	$32,670	$3,104	$67,050	$6,370
350%	9.5%	$38,115	$3,621	$78,225	$7,431
400%	9.5%	$43,560	$4,138	$89,400	$8,493

*Table uses FPL for 2011; maximum annual premium requirements for 2014 will be calculated based on FPL limits for 2014 when those numbers are released.

Tax credits may only be used to purchase qualified health plans offered in the exchange. Individuals who are eligible for Medicare, Medicaid, CHIP, military health benefits, an employer sponsored plan, a grandfathered plan or other coverage will generally not be eligible for tax credits. However, an individual who is eligible for but not enrolled in an employer-sponsored plan may be eligible for subsidies if the employee's cost of the coverage exceeds 9.5% of household income, or if the employer's plan covers less than 60% of total allowed costs of minimum essential benefits.

Cost-Sharing Subsidies: People who qualify for premium credits and are enrolled in a silver-level exchange plan will be eligible for cost-sharing subsidies to help pay their out-of-pocket costs for health care. Exchange plans must limit out-of-pocket costs, and subsidies will further lower those costs based on the individual's/family's income. These individuals will have lower costs (including deductibles, coinsurance, and copayments) as a result of the cost-sharing subsidies; they will also pay lower net premiums due to tax credits.

For example, the maximum out-of-pocket amount that any QHP enrollee would pay in cost-sharing (e.g., deductibles, coinsurance, etc.) would likely be about $6,000 in 2011 dollars. However, the additional cost-sharing subsidy will reduce the out-of-pocket maximum to about $2,000 for persons under 200% FPL.[9] Stated more technically, the actuarial value for a silver plan is, by definition, 70%. With the cost-sharing subsidy, though, the actuarial value for a silver plan would increase to 94% for persons under 150% FPL and 87% for persons between 150-200% FPL.

[9] As explained by the Congressional Research Service, "[E]xchange plans will be required to limit out-of-pocket costs based on high deductible health plans (HDHPs) that qualify individuals for health savings accounts (HSAs). For 2010, the out-of-pocket maximum for HSA-qualified HDHPs is $5,950 for single coverage and $11,900 for family coverage.... [The cost-sharing] subsidies will further reduce those out-of-pocket maximums by two-thirds for qualifying individuals between 100% and 200% FPL, by one-half for qualifying individuals between 201% and 300% FPL, and by one-third for qualifying individuals between 301% and 400% FPL." Congressional Research Service Report R40942, "Private Health Insurance Provisions in PPACA (P.L. 111-148)" (April 15, 2010), available online at http://healthreform.kff.org/~/media/Files/KHS/docfinder/crsprivateinsurance.pdf.

Employer Requirement and Penalties

While the PPACA does not require an employer to provide employee health insurance benefits, large employers (i.e., those with 50 or more full-time equivalent employees) that fail to offer coverage may be charged penalties beginning in January 2014. An employer with at least 50 full-time equivalents (FTEs)[10] that does not provide coverage, or provides coverage that does not pay for at least 60% of covered health care expenses, may be charged a penalty if one or more of its full-time employees receives a premium credit through the Exchange.[11] Certain employees, including full-time seasonal employees who work for less than 120 days a year are not counted as FTEs. Penalties are assesses differently for firms that do and do not offer health insurance, as follows:

- **Penalties for a Large Employer Not Offering Health Insurance:** Employers not offering insurance will be subject to a penalty for any month in which any full-time employee receives premium credits in an exchange plan. Penalties assessed on a monthly basis are equal to the number of full-time employees, minus 30, and multiplied by one-twelfth of $2,000. After 2014, the penalty is indexed by a premium adjustment percentage for the calendar year.[12] Employers are also required to file a tax return stating they do not offer coverage and must provide additional information required by HHS and the Internal Revenue Service (IRS).

- **Penalties for a Large Employer Offering Insurance:** A large employer that offers insurance will still be subject to penalties if at least one full-time employee receives premium credits in an exchange plan because the employee's required premium contribution exceeds 9.5% of their household income, or if the employer's plan pays for less than 60% of covered health care expenses. In 2014, the monthly penalty is first calculated by multiplying the number of full-time employees who receive a premium credit by one-twelfth of $3,000. However, the total penalty is limited to the total number of the firm's full-time employees minus 30, multiplied by one-twelfth of $2,000 for any applicable month. Beginning in 2015, the penalty amounts will be indexed by an annual premium adjustment percentage.[13]

Existing Exchanges and Insurance Purchasing Cooperatives

The concept of an insurance exchange is not new, and several successful exchanges operate today. The insurance exchange concept was originally developed in the form of "purchasing cooperatives" in the early 1990s by states working to improve small groups' health insurance options.[14] The cooperatives were designed to provide small employers with the advantages larger employers enjoy by combining numerous small groups to achieve administrative simplicity, choice of more health insurance options, and leverage in negotiating lower premiums. By combining many small groups together, the cooperative sought to consolidate and reduce

[10] The calculation of FTEs for any month includes (1) the number of full-time employees working an average of at least 30 hours per week, and (2) the total number of hours worked by employees who are not full-time, divided by 120.
[11] Congressional Research Service, "Summary of Potential Employer Penalties Under PPACA," April 5, 2010. Available online at http://healthreform.kff.org/document-finder/crs-report-on-employer-penalties.aspx.
[12] Congressional Research Service, "Private Health Insurance Provisions in PPACA (P.L.111-148), April 15, 2010. Available at http://assets.opencrs.com/rpts/11-148_20100415.pdf
[13] Ibid.
[14] United States General Accounting Office, "Private Health Insurance – Cooperatives Offer Small Employers Plan Choice and Market Prices," March 2000.

costs of marketing, enrollment, premium billing and account administration that result in higher premiums for small groups compared to larger groups. By 2009, at least 28 states had created or authorized the formation of purchasing cooperatives.[15] While many cooperatives share common features, the operational and organizational features as well as participation requirements vary widely among states.

Cooperatives have met with varying success. Many were discontinued because they failed to achieve the level of enrollment needed to support the program, or were unable to attract and retain health insurers' participation.[16] However, several cooperatives have achieved long term success and still operate today.

Under Republican governors and administrations, both Utah and Massachusetts created different exchange programs. In 2009, Utah established a statewide health insurance exchange for the small group market that provides employees of small businesses access to an exchange website where they can compare and enroll in a commercial health insurance plan.[17] The employer determines the amount of premium that will be paid by the company on behalf of each employee, and employees are responsible for paying the balance of the premium cost. Employees who work for more than one employer or who have a spouse or other family member working for another employer can combine premium contributions from multiple employers. While Utah's program does not meet all of the requirements of the PPACA and currently has no individual exchange, the state is working to identify and implement the necessary changes for operating an exchange that satisfies the federal requirements.

In 2006, Massachusetts enacted legislation creating the Commonwealth Health Insurance Connector Authority, an independent, quasi-governmental agency that provides assistance to small businesses and individuals shopping for insurance.[18] The Connector is a comprehensive exchange that provides access to commercial insurance plans for small employers and individuals who do not qualify for financial assistance. The Connector also enrolls individuals in Commonwealth Care, a program which provides subsidized insurance for eligible adults who do not have access to employer-sponsored insurance. Similar to the requirements of the federal PPACA, the Connector offers varying levels of insurance plans identified as bronze, silver and gold. The Connector performs a comprehensive level of administrative services, including plan enrollment, regulatory oversight, outreach and marketing, and financial management.

In addition to the Utah and Massachusetts exchange plans, several private exchange-type programs with similar design features have also been created. One of the earliest programs, eHealthInsurance, offers a range of insurance products including individual and small group health, short term health insurance, disability, dental and life insurance. Consumers complete a short questionnaire and are then directed to a selection of plans that meet their preliminary criteria. According to the company's website,[19] eHealthInsurance is licensed in all 50 states and the District of Columbia, and works with more than 180 insurance companies to offer more than 10,000 health insurance products online.

[15] National Conference of State Legislatures, "State Health Purchasing Alliances and Cooperatives," May, 2011. Available at http://www.ncsl.org/default.aspx?tabid=18905
[16] Ibid.
[17] http://www.exchange.utah.gov/
[18] National Conference of State Legislatures, "American Health Benefit Exchanges," November 2010. Available at http://www.ncsl.org/documents/health/HRExchanges.pdf.
[19] http://www.ehealthinsurance.com/about-ehealth-index

Timeline

Whether or not a state chooses to operate an insurance exchange, there are significant deadlines set by the PPACA and federal requirements. **Table 4** below provides a summary of some of the key activities the state will need to complete during the next two years to meet federal deadlines. This table is not a comprehensive overview of all activities that will be required, but is intended to convey a general sense of the type of planning and implementation activities and extensive coordination that will be required. If Tennessee decides not to implement an exchange and the federal government creates the exchange, there will still be requirements on the state. Items that appear in **bold** print and include an asterisk indicate activities that the state will likely need to complete or participate whether the federal government or the state implements the exchange. Other items are only necessary if the state implements the exchange.

The PPACA provides federal funds states may use to assist in the evaluation and planning stages. Tennessee received an initial planning grant in late 2010, and has submitted for additional "Level One" funding to continue planning this year. The funding Tennessee has applied for so far does not obligate the state to establish or operate an exchange. If Tennessee chooses to implement an exchange rather than defer to a federally-operated exchange, the state will need to apply for a "Level Two" planning grant no later than March 2012 in order to allow sufficient time for completing the competitive procurement process for selecting private contractors necessary for implementing the exchange. Contractors will need to begin building the technology structure for the exchange as early as possible for the state to meet the federal deadline of January 1, 2013 for conditional approval of the state's exchange.

Table 4 - Key Implementation Requirements and Target Deadlines for Exchange Implementation*

2011
Identify state changes necessary to support exchange operational requirements.*
Conduct GAP analysis of Information Technology infrastructure necessary to support exchange operational requirements (include changes to Medicaid enrollment and eligibility systems.)
Begin preliminary design requirements for IT system development, including web portal for exchange activities.
Develop governance model.
Develop budget draft and identify state resources required to implement an exchange, or support related state functions if the state defers to a federally-operated exchange.*
Submit Level One Establishment planning grant.
2012
Determine whether state will implement the exchange.*
Identify Tennessee statutes and regulations that will require revision as a result of the state or federal exchange. Take action as determined appropriate by the Tennessee Legislature.*
Begin process of developing IT system changes necessary to support the exchange; develop, and publish RFPs to procure contract services. Award contracts to vendors.
Develop certification plan requirements and quality rating criteria for QHPs. (Note: if the

state defers to a federally-operated exchange, it is likely but not certain the TN DOCI will be required to oversee QHP certification and quality rating activities.)*
Develop health plan issuer participation requirements and approval process for exchange.
Establish protocols for appeals and coverage determination processes
Hire key staff for exchange support and operations.
Submit Level Two Establishment grant application by March 30.
Evaluate call center requirements and begin process of establishing call center (whether state-operated or contracted).
Develop consumer outreach and communication strategy; develop and publish RFPs to procure outreach and marketing services. Award contracts to vendors.
Develop appeals system and processes.
Identify federal reporting requirements; develop plan for compliance.*
2013
Complete all IT systems development necessary for exchange operations. Begin and complete all systems testing to ensure all operations are successfully integrated and operational.
Complete procurement process for all health plan issuers participating in the exchange.
Complete approval of all QHPs.*
Load all health plan information into IT system.
Identify Navigator organizations; begin training.
Launch consumer education and information campaign. Note: if the state defers to a federally-operated exchange, the state will need to revise existing consumer education materials and develop new information to ensure consumers fully understand how the non-exchange market functions, and what their options are. While this process may be coordinated with the federal exchange, the state will need to participate in these activities and may incur some costs.*
Provide training to insurance agents and brokers.*
Hire additional staff to support program operations.*
Initiate processes to comply with all federal and state reporting.*
Begin initial enrollment activities.
2014
Exchange health insurance coverage begins January 1, 2014.*

***The state will likely be required to complete or assist with these activities even if the federal government operates a Tennessee exchange instead of the State of Tennessee.**

CHAPTER THREE

KEY INSURANCE EXCHANGE ISSUES, OPTIONS, AND IDEAS FOR TENNESSEE'S CONSIDERATION

Implementation of an exchange is a complex process that involves many critical decisions which will have long term implications for consumers, businesses, health care providers, and all aspects of the health insurance industry, both inside and outside the exchange. Over the past year, Tennessee staff members have worked with stakeholders to evaluate the implications of the exchange program for Tennessee. This chapter is designed to provide an overview of some of the key issues the state is considering as part of this deliberative process. While this section includes a variety of policy options based on significant analysis and input from a broad array of stakeholders, no final decisions have been made and stakeholders are encouraged to provide comments. In addition, please note that many of the options discussed in this document are not mutually exclusive, Tennessee may select several options for a "mix and match" approach. Each of these choices must be considered in relation to other decisions so no one single approach is recommended.

Due to the complexity of this project, we have limited this white paper to a discussion of what we consider to be key design issues. This white paper is not intended to address every decision or operational issue, but instead focuses on the features and decisions that will have the most impact on the exchange program. The fact that some issues are not discussed in this paper should not be viewed as an indication that the state is not considering or evaluating those issues.

Finally, there is significant uncertainty regarding many of the federal requirements affecting operational and design features of the exchange. The dynamics of the health insurance market are extremely complex, and it is impossible for the state to anticipate or predict the impact of each and every program decision. Additionally, federal requirements that will be released in the next two years will require the state to continually re-evaluate key decisions to determine if newly available information will impact the analysis and decisions made to date. While ideally the state would have all federal regulations and guidance available immediately, we must proceed with the planning process and make decisions based on the best information available at this time. The state will continue to re-evaluate all decisions and options as new information becomes available, and will work closely with stakeholders to identify the options that ensure a financially stable, competitive insurance market the provides Tennessee consumers with meaningful choice of high quality health plans at the lowest possible price.

Topic 1: Benefit Comparability

Overview

The federal PPACA and related federal rules require health insurance exchanges to certify, recertify and decertify health plans as "Qualified Health Plans" (QHP) for participation in the

exchange. Federally approved multi-state plans are deemed to be QHPs unless specifically provided for otherwise in statute or regulation. In order to be certified as a QHP, plans are required to be licensed and in good standing in each state in which they offer health insurance coverage.[20] A QHP must offer at least one product in the silver coverage level and at least one product in the gold coverage level. Each of these products must be offered at the same premium rate as plans offered outside the exchange and must include "essential benefits" that will be defined by the federal government.

Within the exchange, issuers may offer individual and small group plans at four levels of actuarial value (AV). AV is determined by calculating the percentage of health care costs that a plan is likely to pay for health care services used by a typical population. For example, a plan with a 90 percent AV would pay approximately 90 percent of the typical consumer's health care costs. The four AV levels of coverage in an exchange are as follows:

- **Bronze**: with an actuarial value of 60 percent;
- **Silver**: with an actuarial value of 70 percent;
- **Gold**: with an actuarial value of 80 percent; and
- **Platinum**: with an actuarial value of 90 percent.

While all issuers participating in the exchange must offer at least one silver plan and one gold plan, carriers may be allowed to offer different benefit designs for an actuarial value level. The possible benefit design variations are practically infinite, even between plans that share the same actuarial value and that cover the same health care benefits. As the Kaiser Family Foundation noted in its April 2011 issue brief on actuarial value:

> Because the coverage tiers are defined based on actuarial value - which measures the generosity of a plan for a standard population - the cost-sharing structure could vary from one plan to another. For example, one plan may have a higher deductible than another, compensating by having a lower coinsurance percentage once the deductible is met in order to achieve the same actuarial value. Or, a plan may cover some physician visits before a person meets the deductible, compensating by having a higher deductible or coinsurance percentage. While enrollees in the aggregate would be expected to pay the same out-of-pocket costs in two plans that have the same actuarial value, any given enrollee could have different costs in the two plans depending on how much and what type of health services he or she uses.

The brief then describes several different benefit designs that might yield the same actuarial value.[21] In some cases, small differences between benefit designs are not meaningful, in others cases a small difference can mean the consumer pays a great deal more. Evaluating the impact of differences in benefit design is often difficult for a non-expert.

In addition to the four plans described above, two other types of coverage may be available in the exchange for individual purchasers:

- **Catastrophic:** Catastrophic policies are only available in the individual market for (1) persons under age 30, or (2) people who can demonstrate they cannot find affordable

[20] PPACA Section 1301(a)(1)(C)(i). *See also* the proposed rules at 45 CFR § 156.200 (Establishment of Exchanges and Qualified Health Plans 76 Fed. Reg. 41866-927 (July 15, 2011)). We have not received or seen any explicit federal guidance on this point.

[21] Kaiser Family Foundation, "What the Actuarial Values in the Affordable Care Act Mean" (April 2011), available online at http://www.kff.org/healthreform/upload/8177.pdf.

coverage or would suffer a hardship if required to buy other coverage. A catastrophic plan will include coverage for essential health benefits and have deductibles equal to the amounts specified as out-of-pocket limits for Health Savings Account (HSA) qualified high deductible health plans (HDHPs). The deductibles will not apply to at least three primary care visits.[22]

- **Child-only:** If a QHP product is offered through the Exchange at any level of coverage, the issuer shall also offer that same level of coverage in a plan specifically designed for individuals under age 21.

If the different levels of actuarial value, and the benefit design variations within those levels, become too complex for consumers, it could actually discourage individuals from purchasing a plan.[23] In fact, consumer confusion was a significant problem for individuals selecting a prescription drug benefit plan when Medicare Part D was initially implemented. While most consumers reported they were satisfied with their plan selection, they frequently reported problems selecting a plan and enrolling in the program.[24] The array of choices and benefit options was significant. An actuary with Milliman described the initial implementation as follows: "Rarely has a government-sponsored program caused such confusion among its participants and generated as much negative publicity as the new prescription drug benefit provided under Medicare Part D."[25]

Options Available to Tennessee

Individual Exchange:

If Tennessee chooses to operate an exchange, the state has a range of options to consider, and several possibilities were proposed during stakeholder meetings. There are many variations, but the possibilities are generally related to one of the following four options:

A. Standardize all benefit designs, so that plans offered through the exchange would all conform to one of a few sets of identical benefits and features. The Medicare Supplement Market uses a similar approach that allows enrollees to select from a limited number of standard plans;

B. Allow unlimited numbers of plans to be offered in the insurance exchange, similar to the policy of Medicare Part D;

C. Adopt a "rule of 12" in which the product of (a) the number of issuers in a plan tier and (b) the number of benefit designs each issuer can offer in the respective tier does not exceed 12. This may simplify the consumer experience, but would still provide individuals with 48 standard plans from which to choose (the 4 "metallic" plan tiers x 12)

[22] Hinda Chaikind, Bernandette Fernandez, Mark Newsom, Chris L. Peterson, *Private Health Insurance Provisions in PPACA (P.L. 111-148)*, Congressional research Service April 15, 2010.
[23] Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues,"* July 2010, The Commonwealth Fund.
[24] J.D. Power and Associates, 2006 Medicare Part D Beneficiary Satisfaction Survey";
http://businesscenter.jdpower.com/news/pressrelease.aspx?ID=2006200
[25] Steve Kaczmarek, "Sizing up the hurdles of Medicare Part D." May 2006.
http://insight.milliman.com/article.php?cntid=6141&utm_campaign=Milliman%20Redirect&utm_source=milliman&utm_medium=web&utm_content=articles/sizing-up-hurdles-medicare-insight05-01-06.php

plus catastrophic and child-only plans. Note that this option could be altered to be a rule of 8, 14 or some other number.

D. Define a baseline benefit design that issuers could (but would not be required to) offer and also allow issuers to offer one additional benefit design of their own.

Additional policies proposed by stakeholders, which could complement the above four options, include:

- Limit the number of QHP issuers in each tier to a total six.
- Allow QHPs to provide plans with a "standard network" of health benefit providers as well as offer consumers access to the same benefit plans with a broader network (i.e., more choice of providers), at an increased cost determined by the issuer.
- In 2014, to the extent an issuer wishes to offer either (a) a Preferred Provider Organization (PPO) design with a Health Savings Account (HSA), or (b) a PPO without an HSA but with an individual deductible of less than $1,200 or family deductible of less than $2,400, the exchange could require that the issuer use standardized PPO benefit designs provided by the exchange to avoid further confusion among individual enrollees.
- Establish the two lowest-cost silver tier plans as the default alternative in the individual exchange; individuals could select any other plan, but would pay additional premium amounts for more coverage, broader health care provider networks, different benefit designs, different prescription drug formularies, or other benefit features.
- If allowed by federal rules, auto-assign renewing enrollees in 2015 (and subsequent years) to one of the two lowest-cost silver tier plans if they do not affirmatively make a QHP selection. In order to maximize the incentive for plans to participate in 2014, auto assignment would be limited to only those plans that participated in 2014. Auto-assignment may help contain total costs and limit premium rate increases by providing an incentive to issuers to minimize rate increases and provide more innovative plan designs in order to compete for enrollees. The prospect of default enrollment may also encourage consumers to compare plans and make a selection rather than defer to the exchange's assignment to a plan.

The concepts listed above are not necessarily mutually exclusive, but could be combined to provide the optimum market solution. Regardless of which option, or combination of options, may be selected, the state would annually evaluate plan design options and consumer preferences to determine whether a change is needed.

<u>SHOP Exchange:</u>

The SHOP exchange could allow for customized products for each individual employer. While there is benefit to having a select number of benefit designs in the individual exchange because of the potential for consumer confusion, the SHOP exchange is primarily focused on allowing small employers to obtain the same market benefit, negotiation and leverage afforded to large employers. Currently, many small employers purchase coverage for their employees and design a coverage benefit that best reflects their employee needs. Because employers have more experience with insurance purchasing and usually work with agents who assist in the selection process, the SHOP exchange does not need to standardize the benefit designs to reduce consumer confusion. Design options to consider for the SHOP exchange include:

A. Allow unlimited benefit design variation in 2014 and subsequent years.

B. Allow a pre-determined number of benefit designs during the initial year, and expand to unlimited variations in 2015 or subsequent years based on health plan and consumer preferences.

Integral to any decision the state makes will be continued efforts to work closely with employers and health plans to identify "best practices" for providing the optimal number of plan selections and reducing enrollment complexities.

Ensuring a Stable and Competitive Market

While stakeholders were not unanimous on this point, most rejected the idea that the state should prescribe the detailed benefit designs for **all** the insurance sold through the exchange. At the same time, stakeholders agreed that allowing infinite benefit design variation in the individual exchange would lead to serious customer confusion, especially in the initial "onboarding" years of the exchange. Therefore, there may be an optimal number of benefit design options will allow consumers in the individual exchange to make a simplified apples-to-apples comparison when shopping for health coverage, and allow insurance carriers to offer innovative products in a fair and competitive market using price, network, quality and cost-sharing to attract and retain consumers. An exchange that establishes a maximum number of standardized benefit designs will also ensure that the administrative functions associated with the internet portal, call center and other consumer services will not be overwhelmed in the first years. A select number of benefit designs will also require less review and administrative oversight, which should result in lower costs to the consumers, plan issuers and the exchange.

For the SHOP exchange, stakeholders felt that allowing more, or even an unlimited number of benefit designs could be appropriate. While many of the people enrolling in the individual exchange will likely never been insured or shopped for health insurance, small employers are more likely to have familiarity with health insurance, and many will have an established relationship with an insurance agent or broker as a result of purchasing other types of business-related insurance. Of the small employers to whom we spoke, the vast majority expressed the need to continue to work with a knowledgeable professional to help them reach decisions about employer sponsored coverage. Given the central role of agents and brokers in the small group or "SHOP" exchange (and the lack of tax credit eligibility determinations), SHOP exchange shopping is likely to be much easier for small employers compared to the challenges faced by individual consumers. (In addition, the exchange may require small businesses to use agents to purchase insurance coverage through the SHOP exchange in at least the first two years. See Topic 4 for more information.)

Topic 2: Provider Network Adequacy

Overview

PPACA requires the exchange to establish minimum standards for health care provider networks that provide services to enrollees in QHPs. Network adequacy requirements are necessary to ensure consumers have access to all health care providers within a reasonable timeframe appropriate for the level of urgency associated with a specific medical condition. Network adequacy requirements typically have separate standards for primary and specialty physicians.

Tennessee law currently requires health plans with closed networks (such as HMOs) to demonstrate to the Commissioner of Commerce & Insurance that their provider networks meets

minimum standards, including: all covered benefits are accessible to enrollees without unreasonable delay; enrollees have access to emergency care at all times and within a reasonable distance; the network includes a sufficient number of primary care providers to ensure enrollees can select a PCP within close proximity to their home or business location; and enrollees have options if they must see an out-of network provider because a network provider is not available. Health plans are also required to review their networks on a regular basis and must annually demonstrate to the Commissioner that they meet all requirements. However, if an insurance plans offers any coverage for out-of-network coverage (such as in a PPO), then the provider network requirements in Tennessee law do not apply.[26]

Options Available to Tennessee

If Tennessee chooses to operate an insurance exchange, there are three general options available:

A. Allow issuers to provide evidence of network adequacy on an individual plan basis, with no standardized requirements.
B. Adopt detailed network adequacy requirements that specify consumer to provider ratio requirements for both primary care and specialty care, with adjustments for regional variations (i.e., rural vs. urban areas).
C. Focus on member's ability to get medically necessary care:
    - Set minimum geographic access standards for primary care providers (including women's health providers and pediatricians), hospitals, and certain other providers. These standards could be similar to Tennessee's contracts with third party administrators for the public employee health plan[27] or other commercial plans.
    - Establish substantial Liquidated Damages (LD, i.e., financial penalties) amounts for a plan's inability to help a member secure an appointment for medically necessary services with a geographically-accessible, qualified provider at in-network cost-sharing within a reasonable timeframe.
    - Define the occurrence giving rise to the LD as a "substantial violation by the plan of a material provision of its contract in relation to the enrollee," thereby triggering a special enrollment event for the enrollee under the proposed federal rules.

Ensuring a Stable and Competitive Market

Stakeholders have not reached a consensus on what the standard for provider network adequacy should be, although many thought that the provider network adequacy standard in Tennessee's public employee plan—where some services have a specific geographic standard while others services are measured by the member's ability to access medically necessary services within a reasonable period of time—could serve as an appropriate point of departure.[28] At the same time, insurers could offer broader networks with more choices, but consumer would likely pay higher premiums.

[26] Tennessee Code Annotated 56-7-2356.
[27] See appendix E for more information on Tennessee's public employee health plan geographic access standards.
[28] Stan Dorn, *State Implementation of National health Reform: Harnessing Federal Resources to meet State Policy Goals*, July 2010, prepared for State Coverage Initiatives by the Urban Institute.

Topic 3: Outreach and Navigators

Overview

Section 1311(i) of PPACA requires an exchange to establish a Navigator program that provides grants to entities that assist consumers as they seek services from an exchange. However, **PPACA Section 1311(i)(6) prohibits the use of federal funds for Navigator grants.** For this reason, the state has previously communicated to stakeholders that if Tennessee has a navigator program, it may be an extremely limited program. In addition, the federal government has indicated that they are considering requiring exchanges to establish Navigator grant programs on the first day of the initial open enrollment period in order to provide consumers assistance during the transition to 2014, despite the fact that states are not likely to have self-sufficient funding structures by this time frame.

The law defines the duty of Navigators to:

- Conduct public education activities that raise awareness of the availability of qualified health plans through the Exchange;
- Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions;
- Facilitate enrollment in qualified health plans;
- Provide referrals to appropriate entities for enrollees with grievances, complaints or questions regarding their health plan, coverage, or a determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by an exchange.

Entities eligible to be Navigators must be able to demonstrate that they have or could develop relationships with the exchange target population, including employers and employees, uninsured and underinsured consumers or self-employed individuals likely to be eligible to enroll. PPACA further prescribes potential entities who can serve as Navigators, including trade industry and professional associations; community and consumer-focused non-profit groups; commercial fishing industry organizations, ranching, and farming organizations; chambers of commerce; unions; Small Business Administration resource partners; other licensed insurance agents & brokers, and other entities that can perform Navigator duties and meet federal standards[29]. If Navigators "negotiate" with insurers, they are likely to require licensure under state law.

It is unclear at this time whether additional federal regulations related to requirements for Navigators will be issued, so it is unknown how much flexibility states will have in establishing Navigator program requirements. However, the law requires that a Navigator cannot be a health insurance issuer or receive any consideration (including payment) directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

Also worth noting is that if the federal government operates the Tennessee exchange, the federal government will oversee the Navigator program and is expected to recoup the costs of the navigator grants through some type of user fee collected from either enrollees or QHPs, or both. If the federal government creates a more extensive program than would be created under

[29] The July 2011 proposed regulations entitled "Establishment of Exchanges and Qualified Health Plans." indicate that the exchange must utilize entities from at least two but not all of the identified categories.

a state-operated exchange, higher costs will be passed on to users than would have otherwise been imposed under a state-operated exchange.

Options Available to Tennessee

If Tennessee chooses to operate an exchange, then federal limitations on Navigator program funding may limit the options for a Navigator program. Thus, the state must either:

A. Appropriate state funding for a Navigator Program; or
B. Manage stakeholder expectations toward a small and/or volunteer Navigator program, supplemented by Navigator-like functions supported by non-state sources of funding.

Additional policies to improve the effectiveness of a modest Navigator program include:

- Create a Navigator program for organizations that have a connection to populations that would likely enroll in an exchange, but otherwise would not be involved in promoting health insurance, such as tax preparation services.
- Use a pay-for-performance compensation structure.
- Focus the Navigator program on enrolling people who are not currently insured, rather than those who are substituting one type of coverage for another.

Ensuring a Stable and Competitive Market

The state has worked closely with stakeholders on exploring various options to "repurpose" existing assets that would encourage individual enrollment in an exchange. One idea that merits specific mention is development of a process by which health care providers could voluntarily "forgive" medical debt if a previously uninsured person obtaining insurance and remaining insured during 2014. Programmatically, the provider could forgive the debt after the individual proved enrollment for a specified period. To enable this program to work, the IRS must expressly exclude this type of medical debt forgiveness from the definition of personal income. In this way, the individual would not incur an income tax liability for the forgiveness of medical debt. Likewise CMS may also need to make changes in various policies so that providers would not be penalized in some unintended way. While this option would require cooperation of several federal agencies, it is an opportunity that may be worth consideration. The state would appreciate comments on this and other ideas described above.

The requirement to use non-federal (i.e., state) funds for Navigator grants before the exchange is operational limits the amount of money available to support the Navigator program. With this in mind, stakeholders have supported the concept of a Navigator program that prioritizes grants for entities that might not otherwise provide this sort of assistance, do not have access to funding for outreach activities, and are able to meet certain performance standards. Entities such as adult literacy programs and non-profit tax preparation groups that may be well-connected to exchange target populations and are not typically involved in health insurance outreach activities could be given preference during the selection process, although other entities could also be selected as Navigators.

Another policy that may promote effective use of limited resources is that Navigators could be compensated for each individual or family successfully enrolled with a QHP on the exchange or another subsidized health insurance program like Medicaid or CHIP, if the applicant had been previously uninsured for a certain time period such as the last six or twelve months. This approach would target eligibility and enrollment assistance for the uninsured rather than those substituting existing coverage for exchange coverage. In addition, by providing an incentive

related to enrollment for not only the exchange but also other subsidized health insurance programs, this would help ensure that the Navigators would provide application assistance to all potentially eligible individuals.

Topic 4: Agent Involvement and Compensation

Overview

Other states may chosen to exclude insurance agents from their exchange design, and it remains unclear how a federal exchange in Tennessee would treat agents, However, if Tennessee chooses to implement an exchange, Tennessee's agents would be valuable resources. Tennessee insurance agents have a long established role in helping consumers understand the complex health insurance market to determine which health plans and benefit options are best suited for their personal needs and fit within their budget. Federal health reform changes and the introduction of QHPs will create more confusion for consumers, who will be required to complete eligibility applications that include financial details, compare numerous health plan options to select a plan that is best for them, enroll in the plan and make arrangements for premium payments. Once enrolled, consumers will continue to need professional assistance to understand their benefits and financial obligations when seeking health care. See Topic 3 for a discussion of why the navigator role will be limited and why navigators will not displace agents if Tennessee implements an exchange.

Options Available to Tennessee

If Tennessee implements an insurance exchange, there are three general options related to the participation of agents in the individual and SHOP exchange:

A. Do not include agents in the insurance exchange, so that all insurance is purchased directly on the exchange.
B. Allow all licenses agents – regardless of their experience, training or knowledge of the exchange operations – to enroll individuals.
C. Allow agents to participate in the exchange if they meet specific requirements, such as: they are currently licensed by and in good standing with Tennessee Department of Commerce and Insurance (TDCI); have current appointments with at least two issuers on the exchange; and demonstrate adequate knowledge of the exchange and QHPs by passing a written examination. The agents and brokers would be responsible for the full costs of accreditation (likely in the form of a fee charged by the accrediting entity).

The state would also have multiple options for the compensation of agents:

A. Authorize the exchange to establish commission payments either as a set amount or percentage of premium.
B. Allow agents to freely negotiate commissions with issuers, provided that the aggregate value of the consideration received by the agent (i.e., the commission or compensation structure) from the issuer for the same or similar products is not lower for products sold through the exchange compared to those sold in the market outside the exchange.
C. Allow agents to freely negotiate transactions, consulting and assistance fees with small groups and individuals (to the extent permitted by state law), provided that all transaction, consulting, or assistance fees are non-discriminatory, prominently

displayed, transparent, and fully disclosed to the consumer prior to entering an agreement (i.e., the agent or broker has no hidden fees).

D. Allow accredited agents and brokers to enroll individuals in the individual exchange and collect either/or both issuer-paid commissions and/or user-paid assistance fees (to the extent permitted under state law).

Additional policies proposed by stakeholders, which could complement the above options, include:

- Require small groups interested in purchasing coverage through the SHOP exchange to work directly through a licensed/accredited agent or broker for the first two years of the SHOP exchange, after which the exchange would assess the experience to date to determine whether state policy changes should be revised based on market performance and experience. [30]
- Provide an online and telephone "matching" service which individuals and employers can use to quickly and easily access an agent/broker for assistance, without causing significant delays for the employer.
- In addition to providing a default user portal for the SHOP exchange, allow agents and brokers to create or license customized front-end portals with their own branding and features for use with small groups. Such portals would "ping" the SHOP exchange and transmit data in a manner defined by the exchange. As a practical matter, the SHOP exchange could defer approval of the use of such portals until 2015.
- Allow agents and brokers to offer additional products (such as a VEBA to small groups, etc.) to individuals and small groups, provided that the agent or broker (a) completes the QHP enrollment before introducing the ancillary products; (b) clarifies to the consumer that such ancillary products are separate from and not endorsed by the insurance exchange; and (c) enrollment in such ancillary products is voluntary and entirely unrelated to QHP enrollment.

Ensuring a Stable and Competitive Market

Stakeholders (including agents and others) have argued that the participation of agents is critical to the success of an insurance exchange in Tennessee. The long-established client relationships and expertise developed by agents over years of experience makes them a valuable partner to an exchange. Agents may be especially well-positioned to reach consumers in rural areas, including many people who do not have access to or do not use the internet for purchases. Stakeholders also agree that agents will need some specific training in order to understand exchange-specific areas such as the premium tax credits, and that this type of training would be a reasonable requirement for agents seeking to sell insurance through an exchange.

Tennessee's Agent and Broker Technical Advisory Group argued that the state should utilize the current method of agent compensation in which insurance companies directly compensate agents for enrolling members. There is a possibility that this traditional compensation could be combined with other forms of compensation from the consumer directly to the agent, but stakeholders have not agreed on how that type of compensation might function. The State has

[30] While it is unlikely federal regulators will allow the exchange to require the use of agents in the individual exchange, we believe the state could successfully argue that the use of agents be made mandatory at least for an initial period to minimize confusion in small group health insurance purchases.

noted throughout the TAG and other meetings that the amounts of payments should be market-based rather than artificially set by an exchange.

Topic 5: SHOP Exchange QHPs Offered to Employers and Workers

Overview

Proposed federal rules indicate that the SHOP can allow a small employer to choose one QHP as the only group plan available to its workers, which is how small employer coverage is traditionally arranged. However, the SHOP is also required to allow small employers to offer a multiple plan options to their employees. Such choices could be broadened, structured or constrained in a variety of ways.

Federal guidelines also require that a SHOP allow a small employer to select a level of coverage, and allow its workers to choose from among all QHPs at that level.[31] In addition, the SHOP could allow the employer to define its contribution level (for example, to set its employer contribution based on a low-cost plan), and give its workers the option to make a cost-conscious choice of another plan.

Some insurance industry stakeholders expressed concerns that individual worker choice among competing issuers would exacerbate adverse selection problems and therefore raise the cost of insurance in the small-employer market. To the degree permissible, they argue the costs of such adverse selection should be made as transparent as possible, and should not unnecessarily increase the costs of traditional single employer plan arrangements. Tennessee included such recommendations in the comments to the proposed federal rules.

Options Available to Tennessee

If Tennessee chooses to operate an insurance exchange, the state will have the following options for employer and worker choice in the SHOP exchange:

A. Consistent with the PPACA requirements, allow worker choice of all SHOP-participating QHPs at the metallic tier If the employer were to choose the “employee choice” model. Under the proposed rules, the employer would also retain the option to select a single QHP for employees.

B. Offer other employer options for worker choice designed to mitigate adverse selection problems. This might be in addition to the first approach or, with federal permission, adopted in lieu of that approach. For example, the exchange might allow issuers to join one or more alternative employer “suites” of QHPs. An employer could choose one “’suite,” which might in an urban area offer worker choice of two or three different narrow-network plans at the same benefit level, or might include one or two tightly managed plans with low cost-sharing together with an alternative broad-provider-network plan(s) with higher cost-sharing.

Tennessee’s comments on the proposed federal rules argued that state exchanges should have the flexibility to allow issuers (if they choose to do so) to provide two rates in the SHOP exchange: one for those employers that select a single QHP and a separate rate for those employers that allow their employees to select from more than one plan choice. (Because these will appear on the exchange as different products or QHPs, issuers would be able to charge

[31] 45 CFR 155.705(b)(2)

different premium rates without violating federal rating restrictions.) We would note three issues in this regard:

- The SHOP exchange may not require insurers to participate in the employee choice option that allows employees to select among multiple QHPs; rather, insurers could decide to offer only QHPs that limit the employees' choice to a single plan selected by the employer;
- If an employer elects to allow employees to any QHP within a metallic tier, the SHOP exchange could require the employer to identify a default plan for employees who fail to select a plan; and
- The SHOP exchange could allow employers to contribute defined dollar amounts on behalf of each employee rather than paying a proportion or percentage of whichever plan that an employee may choose.

Ensuring a Stable and Competitive Market

Stakeholders have recommended that a state shop exchange work with issuers and employers to arrange an employer option that provides workers a choice among competing QHPs at a benefit level chosen by that employer. To the extent permissible under federal guidelines, the SHOP exchange would give issuers the opportunity to offer separate QHPs distinctly for this purpose. Issuers would design and set premiums for these QHPs specifically for individual worker choice among competing QHPs. An issuer could therefore adjust premium price for QHP products available for this worker-choice option. (Note that this price could not vary based on an individual's health status and that all QHPs offered through the SHOP exchange would participate in the market-wide risk-adjustment and reinsurance systems.)

Under the latter approach, the SHOP would solicit separate QHPs for its worker-choice option, and SHOP policies regarding QHP offerings would be substantially different from those in the individual exchange. Therefore, participation in the SHOP exchange and the individual exchange would not be linked, and an issuer could choose to participate in only the worker-choice SHOP option, only the single-employer-plan SHOP option, only the individual exchange, or in any combination of the three.

While the state has submitted comments to proposed regulations advocating for state flexibility to establish employer and employee plan choice in a way that best supports the state's insurance market, final federal law and regulations may ultimately restrict the state's options. Though final decisions cannot be made until final regulations are published, the state will continue to work with stakeholders to identify options that best support the small employer market both within and outside the exchange.

Topic 6: Wellness

Overview

Stakeholders have emphasized that wellness is a significant concern and the "on-boarding" of newly-insured enrollees offers an opportunity to set expectations in this regard. The PPACA requires plans to implement wellness programs and provide services that will encourage and enable enrollees to improve their health status. PPACA also removes the ability of issuers to consider the health status of people enrolling in health plans when establishing premium rates. The law requires issuers to accept all eligible applicants regardless of an individual's health status. Wellness incentives and rewards must comply with other federal rules related to nondiscrimination.

Options Available to Tennessee

If Tennessee operates the exchange, the state would have the opportunity to emphasize the importance of prevention and wellness by harnessing the power of market-based solutions. Accordingly, the exchange may create incentives designed to support and coach enrollees to maintain healthy lifestyles and take responsibility for their medical conditions.

The State of Tennessee recently implemented a large, program-wide wellness incentive for the 200,000+ adults in its public employee health plans. Beginning in 2011, the State offers a "Partnership PPO" with a lower premium and low member cost-sharing -- but eligibility is predicated on the member's completion of a health questionnaire, biometric screening, etc. Members who do not agree to the terms of this "Partnership Promise" must enroll in the Standard PPO, which has a higher premium and higher member cost-sharing.

In developing in the Partnership Promise, the State conducted an exhaustive review of the scientific literature, government reports, available unpublished manuscripts, and materials from the National Business Group on Health and others. Though this process, we were able to tailor an approach that we felt would be most likely to succeed in our market.

Tennessee's approach was inspired in part by approaches akin to that described by Ian Ayres of Yale Law School in his book, "Carrots and Sticks." He cites on example of BeniComp, an Arkansas-based company, that has achieved renown for its wellness efforts:

> BeniComp Advantage has caused a stir in the group insurance industry by providing companies with plans that lower an employee's deductible by hundreds of dollars each year if the employee meets certain National Institutes of Health wellness goals. 'It's like a good-driver discount for health insurance,' [BeniComp President Doug] Short said. For example, in Benton County, Arkansas, the BeniComp plan came in and raised health-care deductibles for county employees from $750 in 2004 to a whopping $2,750 in 2005. But the employees can reduce their deductibles to as low as $500 if they don't smoke, are not overweight (with a BMI of less than 24.9), and have low cholesterol (LDL under 160), low blood pressure (lower than 140/90), and low glucose (under 126).

In essence, the wellness program could provide some sort of "good driver discount" in the form of a lower premium or other incentives to reward enrollees who meet specific health measurement criteria that are within their control. To comply with federal non-discrimination requirements, though, there would need to be reasonable alternatives to qualify for incentives for those enrollees for whom it is unreasonably difficult or medically inadvisable to achieve the standards.

Specific options available to the state to increase the utilization of wellness programs in exchange plans include:

- Provide incentives for health plan issuers who develop innovative wellness programs; and/or
- Require QHPs to include in their consumer publications and on-line plan materials detailed information describing wellness program services and how the company protects the privacy and personal health information of all program participants.

With respect to risk assessment or questionnaires, stakeholders noted that consumers could confuse these with medical underwriting practices (which the PPACA prohibits beginning in

2014).[32] Stakeholders suggest that any health risk assessment process occur only after an individual has enrolled in a plan. As a practical matter, such questionnaires should be at least 30 days following the completion of enrollment in order to reduce confusion among new members about enrollment, coverage and the new incentives.

Ensuring a Stable and Competitive Market

Wellness programs provide a valuable opportunity for health plans to identify enrollees at risk for health problems and work with enrollees to develop a patient-specific program for achieving maximum health care results. A successful, market-based program will not only improve the health of enrollees and prevent future complications among those with chronic conditions, but will also encourage personal responsibility and provide enrollees with the information they need to take control of their personal health care.

The state will continue to work with health care experts and behavioral economists to identify additional program options that are compliant with federal requirements, and invites stakeholder input to on wellness incentives in exchange plans.

Topic 7: Financial Sustainability

Overview

Under the PPACA, the exchange must be self-supporting by 2015, regardless of whether the exchange is operated by the state or federal government. Thus, even a federal exchange will involve some user fees or other revenue provisions in which state residents cover the operating costs of the exchange. If the State were to operate the exchange (and leverage existing administrative infrastructure for various exchange functions), then Tennessee would retain more direct control over the cost structure of the former.

Options Available to Tennessee

If Tennessee were to operate an exchange, it would presumably structure the sustainability model such that users of the exchange also pay for its operating costs, thereby minimizing the cost burden on state taxpayers. To offset any remaining costs, the exchange would defray costs mainly by fees on those who benefit most from the exchange. It may use standard commercial marketing practices as a possible source of revenue. Accordingly, a state-operated exchange could:

- Allocate costs to Medicaid and other programs (thereby leveraging federal funds) in a manner consistent with federal rules; however, the exchange could provide the local match for the federal funds.
- Incorporate administrative fees into the premiums for QHPs sold in the individual and SHOP exchanges, with the applicable fee reflecting the underlying cost of the respective exchange. Fees would be higher for family premiums than for individual premiums in order to leverage federal funding.
- Charge recurring administrative fees to employers participating in the SHOP exchange.

[32] Medical underwriting is the insurance industry practice of evaluating an individual's health status and health history as a part of the application process. Depending on state law and an applicant's health history and currently status, insurers can currently deny health insurance or impose exclusions or riders.

- Charge recurring administrative fees to QHPs participating in the individual and SHOP exchanges.
- Charge recurring accreditation fees to agents and brokers to cover costs related to this function.
- Allow online and other advertising, but only to the extent that the exchange could approve content.
- Enter into commercial partnerships for direct marketing, though only to the extent that the exchange retains exclusive possession of all enrollee information and fully complies with HIPAA and Medicaid privacy protections. In other words, the Exchange would never sell or transfer data for marketing purposes, but it could distribute marketing materials in billing notices similar to how some electric service providers currently do with utility bills.
- Charge administrative and reporting fees to reinsurance entity.

Ensuring a Stable and Competitive Market

To make choices about sustainability, an exchange may want to prioritize options in a way that would minimize the costs that the insurance industry and consumers pay. However, the exchange must also balance important privacy and free speech concerns (particularly related to content regulation of advertising). We would appreciate stakeholder feedback and suggestions in this regard.

Topic 8: Reinsurance and Risk Adjustment

Overview

One of the primary concerns voiced by Tennessee insurers considering participation in the exchange is the risk that an issuer may receive a disproportionate number of sick, high-cost enrollees, referred to as "adverse selection". Because issuers are required to accept all applicants regardless of their health status, and because enrollees may apply for coverage at any time with no penalty, the risk of adverse selection is significant. To minimize the risk of adverse selection, the PPACA establishes a temporary reinsurance program under which payments will be made to non-grandfathered individual market plans (inside and outside the exchange) that cover a disproportionate share of high-risk individuals. Under federal law, the reinsurance payments will be funded by mandatory assessments collected from all individual and group plans, including grandfathered plans and self-funded plans.[33]

The goal of the reinsurance program is to stabilize premiums and encourage plans to participate in the exchange. Plans that end up with a high number of expensive enrollees risk significant financial losses, which reinsurance is intended to mitigate. While insurers have access to private reinsurance, the reinsurance program will reduce the amount of money issuers would have spent on private reinsurance, generating insurer savings which may be passed on to consumers in the form of lower premiums.[34]

[33] American Academy of Actuaries, *Risk Adjustment and Other Risk-Sharing Provisions in the Affordable Care Act*, June 2011.
[34] Ibid.

Options Available to Tennessee

In proposed rules published July 15, 2011, HHS indicates that states that operate insurance exchanges will be able to make a number of decisions regarding the design and operation of a reinsurance system.[35] HHS will publish a federal "template," which states may modify based on their specific requirements. Tennessee agrees that states should have maximum flexibility in order to design a plan and has suggested to HHS an approach that would allow varied reinsurance and risk adjustment payments to QHPs based on whether they participate in the individual or SHOP exchange. In order to mitigate the risks of adverse selection (and thereby attract insurers), states could be allowed to make higher reinsurance and risk adjustment payments to plans inside the exchange.

While stakeholders did not recommend specific options that Tennessee should consider, we are working closely with our actuaries to identify the best approach for the state. As a first step, we are reviewing the actuarial experience of past and current state-based reinsurance programs. Several states currently sponsor reinsurance programs, with the insurer typically responsible for 100 percent of costs to $5,000; 10 percent of costs to $75,000; and 0 percent of costs above $75,000. In contrast to this model, the PPACA envisions a temporary reinsurance program that co-exists or complements traditional reinsurance (often with deductibles or thresholds of $100,000 to $250,000) that issuers already have. We are working to understand whether two or three "layers" of reinsurance would be optimal, and how the layer(s) could be constructed. Likewise, we are reviewing the white paper that the federal government released on risk adjustment in late September 2011. If Tennessee were to move forward with an exchange, then we would likely convene new technical advisory group of insurance industry actuaries in early 2012 to discuss these issues in greater detail. We welcome input from stakeholders as we continue to evaluate our options.

Ensuring a Stable and Competitive Market

If Tennessee operates an exchange, the reinsurance program would be a tool to minimize adverse selection and protect insurers from extreme financial risk, thus enhancing the financial solvency and sustainability of issuers and the exchange. Specific design features of the reinsurance program will ensure the risk of high cost enrollees is offset by the reinsurance funding, providing issuers with protection from unexpected and excessive losses. Additional policy recommendations will be issued following the conclusion of our continued analysis and evaluation, and pending the release of additional federal requirements.

Topic 9: Governance

Overview

Under PPACA and proposed federal rules, states have options for the structure of governing their exchange. Due to the ongoing evolution of exchange regulations and the uncertainty surrounding the development of exchanges, a state-operated exchange must remain flexible during the initial phases of planning and implementation. Once the initial enrollment period is completed and the exchange achieves a stable population, state-operated exchanges may wish to revisit the exchange governance structure to evaluate whether changes are appropriate.

[35] Preamble text of 76 FR 41933

Options Available to Tennessee

If Tennessee chooses to operate an insurance exchange, there are three options for governance under PPACA:

A. A non-profit entity,
B. An independent government agency, or
C. A part of an existing state agency.

Ensuring a Stable and Competitive Market

Of the options identified above, the third option to include the exchange as part of an existing agency may offer the most advantages. To the extent that states choose to govern an exchange through a non-profit entity or independent government agency, additional federal rules apply regarding the composition of a governing board, etc. If a state were to choose to create an exchange as an independent government agency, then it would also have to create and define the scope of authority of the new agency in statute – and build the administrative infrastructure to support it. In contrast, an exchange that is part of an existing state agency provides the State with the ability to react quickly to federal rules – and it leverages existing administrative, legal, and procurement resources. This structure also ensures maximum accountability of the insurance exchange to the Executive and Legislative branches.

From the beginning of the planning activities, stakeholder engagement has remained a priority of the planning initiative, and the State has included agents and brokers, large and small employers, insurers, health care providers, and consumer advocates in the planning process. Given the maturing nature of these consultations, the State could formalize this process by establishing an official advisory committee with representation from all the various stakeholder groups. It may also be advantageous to reserve appointments for actuaries, accountants and attorneys who have experience in health care but no pecuniary or other conflicts of interest. The State may also want to allow all parties to attend and participate in discussions even if they have no formal appointments to or votes on such a committee.

Topic 10: Marketing

Overview

Under the proposed federal rules, state-operated exchanges may determine what (if any) marketing restrictions apply to qualified health plans. One concern with exchange plan marketing is that there are many ways plans can market specifically to healthy people and therefore attract people with less risk of high cost claims. It is important to note that any rules that an exchange adopts regarding marketing exchange plans would not apply to non-exchange plans. Therefore insurance carriers are likely to continue to promote their overall brand as they do today regardless of whether there are restrictions on marketing exchange plans. Also, the TDCI regulates the marketing practices of insurance carriers generally.

In the TennCare program, the State currently prohibits most marketing to consumers by the managed care organizations. This has helped to avoid both marketing abuses and unnecessary regulation – and has ensured the enrollees hear and read and consistent and coordinated set of messages. In contrast, Medicare allows Advantage plans to market to consumers, though such marketing is subject to increasingly detailed prescriptive federal standards.

Options Available to Tennessee

If Tennessee operates an insurance exchange, there are three basic options available for how carriers market exchange plans:

A. Carriers could market their exchange plans using all methods available under TDCI regulation.
B. Carriers would be restricted to marketing insurance plans in some specific ways, as is the case with Medicare Advantage plans.
C. Carriers could be banned from marketing their exchange plans, similar to the prohibition on most marketing to consumers by the managed care organizations in the TennCare program.

Ensuring a Stable and Competitive Market

Stakeholders suggest that partial restrictions on marketing insurance plans can lead to a large and burdensome "rulebook" as the State responds to specific instances of plan marketing. Medicare Advantage plans are governed by increasingly prescriptive marketing standards, for example. If Tennessee operates an exchange, therefore, the simplest approach to avoiding any marketing abuses may be to adopt the TennCare approach of not allowing exchange plan marketing, at least for the first year. Thus, the exchange and its partners would be chiefly responsible for building awareness about new coverage options and subsidies for 2014 (e.g., through a public information campaign and Navigator program). That said, the State could still allow insurers to provide unrestricted grants to community partners (perhaps including but not limited to Navigators) to complement the exchange's community education effort.

Given the very different contextual factors, it is unclear whether any marketing limitations would be necessary or helpful within the SHOP exchange.

Topic 11: Qualified Health Plan Standards

Overview

The federal statute and proposed federal rules establish minimum standards for qualified health plans. The PPACA and related federal rules require an exchange to develop procedures for certifying eligible QHPs and ensuring they are compliant with all requirements. Draft federal rules propose to require QHPs to:

- comply with federal regulations on an ongoing basis;
- comply with all exchange processes, procedures, and requirements;
- ensure compliance with benefit design standards;
- be licensed and in good standing with the each state in which the QHP offers coverage;
- implement and report a quality improvement strategy;
- implement appropriate enrollee satisfaction surveys;
- pay any applicable fees assessed by the exchange; and
- comply with the standards of the risk adjustment program.

States that operate their exchanges may add additional requirements.

Options Available to Tennessee

If Tennessee chooses to operate an exchange, there are at least two general options for how the state sets standards for qualified health plans in the exchange:

A. Set significant additional state standards for qualified health plans, with the understanding that such an approach may limit the number of plans that are able to meet the requirements to sell insurance in the exchange.

B. Set minimal additional standards so that any insurance carrier that has ample financial reserves and experience operating as a health plan can sell insurance on the exchange if chooses to apply.

Ensuring a Stable and Competitive Market

Given the extensive nature of federal requirements on QHPs, Tennessee stakeholders have not advocated for many additional standards for QHPs if the state operates its exchange. Stakeholders note that additional new standards imposed by a state would reduce the number of insurers that may be willing to participate in an exchange.

Therefore state standards for QHPs could be limited to requirements for solvency and operational history in much the same way that the State currently does for TennCare MCOs today. As Tennessee has an interest in ensuring that TennCare service is continuous and high quality, only insurance carriers with strong finances and experience operating insurance are able to apply to be TennCare MCOs. Such standards may be advantageous for the exchange market as well, and should not complicate matters for insurers as they do not increase regulatory burdens or create substantial shift in compliance activity.

A state health exchange that allows for a number of different, high-quality QHPs to participate will ensure a robust and competitive environment. Limiting the additional state requirements for QHPs will allow issuers to focus financial and administrative resources on enhanced benefits and plan design features that provide consumers with more choices.

Topic 12: Benefit Mandates

Overview

The PPACA requires that health plans offered through a health insurance exchange, as well as new individual and small group health plans sold outside of an exchange, meet minimum standard coverage requirements as of January 1, 2014. The PPACA directs the Secretary of the U.S. Department of Health and Human Services (HHS) to define “Essential Health Benefits” (EHB) for such plans. The law further requires that states bear the additional cost for any state-level benefit requirements for exchange plans where the state-level mandated benefit is beyond the scope of the federal definition of EHB by making a payment to either the individual purchasing coverage, or the qualified health plan in which such individual is enrolled. The law applies no matter if Tennessee chooses to operate its own exchange or defaults to a federally administered program.

The federal government has not released a proposed definition of EHB, and we do not know when the rule will be released. The PPACA directs the Secretary to include certain general categories of services and requires that the scope of EHB must be equal to benefits provided under a “typical employer plan”. The law further requires the Secretary to choose services that

do not discriminate based on age, disability, or expected length of life, and take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. The PPACA also adds coverage of certain preventive health services to existing federal health benefit mandates which already include 1) mental health and substance abuse benefits services for companies with 50 or more employees, 2) hospital coverage for mothers and newborns following delivery, and 3) breast reconstruction for health plans that provide mastectomy coverage.

It is important to note that the law does not define the term "state-level mandated benefit", and HHS has issued no guidance to date as to how, or if, future regulations may define mandated benefit. That decision is likely to impact Tennessee's actions regarding the state's mandated benefits, a summary of which is included in Appendix D. It is conceivable that the definition could include not only those mandates that require coverage of a specific illness or medical condition, but also "any willing provider laws" that require coverage of a wide range of providers. Until the relevant federal rule is published, it will not be possible to identify which of Tennessee's existing state-level benefit mandates will exceed the federal EHB definition, making it impossible for Tennessee to truly evaluate the options.

Options Available to Tennessee

Once the Secretary of HHS finalizes the definition of EHB, Tennessee will be able to identify which state-level mandates exceed the federal definition. Given the breadth of the EHB requirements, many, if not most, state-level mandates will likely be covered. However, to address the benefit mandates beyond the EHB definition, Tennessee may consider one of the following three types of approaches:

A. Appropriate money to pay for actuarial costs of mandates in QHPs offered through the exchange;
B. Consider removing mandated benefits from all health plans, whether sold on the exchange market or not. This option would avoid additional state costs created by the PPACA for state-level mandated benefits beyond the scope of EHB; or
C. Take a more "middle ground" approach and amend state law so the mandated benefit requirements do not apply to QHPs sold on the exchange market. This option would avoid additional state costs created by the PPACA for state-level mandated benefits beyond the scope of EHB. However, it would also have the effect of creating a lower set of coverage mandates for individuals who purchase insurance through an exchange.

Until HHS issues EHB regulations, it is not clear what methodology and process will be followed to determine the value of the state-level mandated benefits beyond EHB. The fiscal impact on the state also cannot be estimated until final federal rules are published.

Ensuring a Stable and Competitive Market

Once the federal government has released the EHB regulations, Tennessee will be able to identify and evaluate the cost of all state-level benefit mandates beyond the scope of the final EHB definition for all individual and small group plans, and the impact on plan costs whether offered inside or outside of the exchange market. Any of the options described above would require legislation.

Topic 13: Enrollment Policies

Overview

Proposed federal regulations require the exchange to provide an initial open enrollment period and annual open enrollment periods during which qualified individuals may enroll in a QHP or enrollees may change QHPs. In addition, the exchange must provide special enrollment periods when certain triggering events occur, including loss of minimum essential coverage such as employer coverage or Medicaid, gaining a dependent, becoming newly eligible or newly ineligible for advance payment of premium tax credits.

The proposed federal regulations include specific calendar dates for open enrollment periods and deadlines for when plan enrollment must be effective, and include other detailed requirements. The state has developed comments in response to the proposed regulations, which may be accessed at the following website link: www.tn.gov/exchange

Options Available to Tennessee

If Tennessee chooses to operate an exchange, and depending on federal rules, the following options for open enrollment may be available:

A. Offer an open enrollment period from October 1, 2013 through February 28, 2014 followed by annual open enrollment period of October 15 through December 7 in subsequent years. In accordance with the proposed federal rule.
B. If the federal government allows states flexibility in open enrollment policy, the exchange could move the open enrollment period so that it included April 15 tax day, to take advantage of the association between tax credits and exchange coverage.
C. If the federal government allows states flexibility on open enrollment policy, the exchange could spread its enrollment workload throughout the year by tying open enrollment in the years after 2014 to the birthday of the oldest member of the household or the annual redetermination of premium tax credit eligibility.

Ensuring a Stable and Competitive Market

Limiting general open enrollment to a specific period each year promotes stability of coverage and helps to avoid adverse selection. The timeframes in the proposed federal regulations, however, are highly prescriptive and may not be operationally feasible (e.g., requiring plan enrollment by the 1st of the following month if a plan selection is made by the 22nd of a given month). As Tennessee explained in comments to the proposed federal rule, allowing a longer initial open enrollment period, e.g., through April 15, 2014, could encourage more people to enroll during the initial year. Tennessee stakeholders have encouraged state officials to press the federal government for greater state flexibility in this area.

Stakeholders have also stated that states should be given opportunities to establish requirements that are consistent with state policies and allow small businesses to coordinate SHOP enrollment with Section 125 plan enrollment. Section 125 plans allow, among other things, employees and employers to pay insurance premiums using pre-tax dollars (with some limitations), but must comply with strict federal requirements which allow little flexibility.

Stakeholders noted that requiring that open enrollment for the individual market always occur in the last quarter of the calendar year (as in the proposed regulations) could be inefficient. Insurers process more than 70% of their commercial business enrollments during this same

period. Exchanges may find that they can offer improved customer service by spacing the open enrollment/eligibility redeterminations over the course of the year.

Topic 14: Grace Periods

The federal law includes a "grace period" that requires health benefit plan issuers to follow specific procedures when cancelling an individual's QHP coverage. Proposed federal rules issued in July 2011 recommend individuals who are eligible for tax credits but fail to pay premiums would be granted a three month mandatory grace period prior to any termination of a policy by an insurer.[36] During the three month grace period, the issuer must continue to pay all eligible claims. The enrollee's QHP issuer also continues to receive the tax credit payment during the grace period. The rules require the issuer to provide a termination notice that complies with standard notice requirements that will be issued at a later date. Any premium payments that are made during the grace period time frame must be applied to the oldest premium billing cycle for which payments are late.

The federal proposed rule regarding grace periods differs from Tennessee state law. Tennessee law requires insurers to provide policyholders with a grace period that ranges from 7 to 31 days (depending on whether the enrollee pays premiums weekly, monthly or according to some other schedule), after which time the insurer may cancel the plan if the enrollee fails to pay the late premiums. Insurers must comply with state requirements to ensure consumers are aware their policy is pending cancellation for non-payment. The state's existing notification requirements have been successful in providing consumers with sufficient notice to make payments before their health coverage is cancelled while not imposing unreasonable burdens on health insurers.[37] The federal grace period requirements for plans offered within the exchange will be more expensive and more difficult to administer than plans outside the exchange. The extended grace period also imposes financial burdens on health plan issuers who are responsible for continuing coverage for which they have not been paid.

The following quotation from Tennessee's response to a federal notice of proposed rulemaking summarizes stakeholder feedback to date on this issue: [38]

> **We believe that the federal approach to the 90-day grace period may help relatively few while potentially disadvantaging many.** We question the federal government's implicit assumption that premium nonpayment is the result of temporary liquidity problems; consequently, we are skeptical that such a generous grace period would likely result in substantially greater continuity of coverage. While the benefits are unclear, the costs are not: issuers will have to compensate for their estimate of delinquent or foregone premiums from such enrollees during these grace periods by increasing the base premium rates for all enrollees. Individuals who receive advance payments of tax credits will be insensitive to these increases – but those who do not will have to pay higher premiums either (a) in the exchange or (b) in the parallel market if they purchase QHPs from issuers that also sell on the exchange. Thus, the proposed rule may increase premiums and reduce access to coverage for those households with incomes above 400% of the federal poverty level. Given the size of this group (and the fact that it is disproportionately comprised of chronically-ill persons age 50-64), this remains a substantial concern – particularly given the uncertainty about any offsetting benefit.

[36] 45CFR Section 156.270
[37] Tennessee Code Annotated 56-26-110
[38] For more information on this issue and the state's comments in response to proposed federal regulations, please see "TN Response Federal Request for Comments on QHPs and Exchanges (27Sept11)," available at www.tn.gov/exchange.

Topic 15: Establishing Geographic Rating Areas

Overview

The PPACA requires the state to establish geographical rating areas for all health plan issuers offering exchange QHPs, unless preempted by the secretary of HHS.[39] Rating areas are used by insurers to develop premiums that reflect differences in health care costs that vary by region. Individuals who live in an area of a state that has higher health care costs may, therefore, pay higher insurance premiums. Typically health plans use counties or zip codes to establish premium rating areas.

Currently, Tennessee insurers are allowed to determine their own geographic areas for purposes of determining premium rates and areas of the state where they will offer their plans. The state does not regulate or oversee the geographic territories or the premium rates charged within various regions. In general, health insurers establish these premium rating areas in order to define geographic areas that are similar in health care costs and utilization, and thus premiums, to manage cross-subsidization across geographies.

Options Available to Tennessee

If Tennessee decides to implement an exchange, the state must choose geographic rating areas for both the individual and SHOP exchange market. The state has several options to consider:

A. A single state rating area
B. Three rating areas for the State's three grand divisions.
C. Rating areas for individual counties.
D. Rating areas based on Health Service Areas (HSAs) originally defined by the National Center for Health Statistics (part of the Centers for Disease Control and Prevention) to be a single county or cluster of contiguous counties which are relatively self-contained with respect to hospital care. According to the NCI modified definitions, Tennessee has 17 HSAs that include all 95 counties.[40]
E. Rating areas based on Hospital Referral Regions (HRRs) representing regional health care markets for tertiary medical care that generally requires the services of a major referral center. The regions are defined based on a review of patient utilization data. Each HRR has at least one city where both major cardiovascular surgical procedures and neurosurgery are performed. Tennessee is served by nine HRRs, two of which are centered in Alabama.[41]

The state will also need to decide whether to require issuers to use identical rating areas within and outside of the exchange.

Ensuring a Stable and Competitive Market

Larger rating areas require lower-cost areas to subsidize higher-cost areas, which could result in individuals/groups in those lower cost areas to look for other alternatives or go without coverage. Smaller areas allow a more area-specific view of the cost of medical care. If a rating

[39] States are responsible for determining the geographic rating areas in their state, but the Department of Health and Human Services (HHS) can review the state determinations to ensure they're "adequate." If they're not found adequate, the Department can establish the rating area (§ 2701(a)(2)(B)).
[40] http://seer.cancer.gov/seerstat/variables/countyattribs/hsa.html
[41] http://www.darthmouthatlas.org/data/region/

area becomes too small, however, analyzing the relative cost of medical care within that area becomes difficult due to insufficiently credible data.[42]

Tennessee stakeholders, especially members of our agent and actuarial advisory group suggested that county-level rating areas would be complex to implement, and that there may not be meaningful differences between adjacent counties. These stakeholders were also opposed to a state rating area or a grand division rating area because they believed the cross-subsidies that resulted would lead to adverse selection and gaming. Stakeholders believed that fewer than 12-15 rating areas across the state that reflected patterns of health care cost and utilization, such as hospital referral regions, may be an appropriate middle ground option for geographic rating areas. Stakeholders did not reach a clear consensus about the optimal number of rating areas in mind, however. Stakeholders also found that rating areas based on hospital referral regions, or similar geographic boundaries, would be consistent with the goal of rural-urban equity.

To simplify administration, Tennessee may want to use parallel definitions for rating areas and required coverage areas. As an added benefit, Hospital Referral Region rating areas and required coverage areas may lower barriers for new insurance carriers to enter Tennessee's market one part of the state at a time, increasing competition.

Topic 16: Minimum Premium Floors

Overview

The creation of an exchange at the same time that rating rules are being rewritten for Tennessee by the federal government creates the possibility of instability in Tennessee's health insurance market. In the individual market especially, insurers are attempting to price insurance policies for a population with an unknown risk profile. If an insurance company offers a price that is too low, then the insurer may not be able to cover its costs and there is the possibility that the insurer will exit the market in the middle of member's coverage year, which would lead to operational chaos for the exchange. At the same time, the value of Tennessean's premium assistance tax credits could be lowered by insurers offering prices that are too low to cover costs.

Options Available to Tennessee

If Tennessee chooses to operate an insurance exchange, there:

A. The state may establish an actuarially-based minimum premium "price floor" and prohibit plans from offering a product below this price floor in the individual market.[43]
B. If the state does not establish a minimum premium price floor, then the state is open to other suggestions from stakeholders on how to mitigate the risk of instability posed by excessively low premium bids in the exchange.

[42] American Academy of Actuaries, Comments on Health Insurance Exchanges, October 4, 2010. Available at http://www.actuary.org/issues/pdf/AAA%20Exchanges%20RFI%20response%20100410.pdf

[43] Because health plan issuers use a different rating process for establishing group premiums and because the small group market has more experience data that allows them to more accurately predict the financial risk of future enrollees, SHOP QHPs would not be subject to premium floor requirements, but would be subject to financial solvency standards that ensure issuers will be able to meet their financial obligations to enrollees and providers while offering consumers a range of competitive health plans.

Ensuring a Stable and Competitive Market

In order to reduce the risk of instability from insurers setting premiums that will not cover costs, as well as to guard against the possibility that plans and issuers that may attempt to enter the market with a “loss-leader” strategy, only to significantly increase their rates after obtaining market share or suffer financial instability, some stakeholders have suggested that the state establish premium floors to ensure plans are appropriately capitalized and can pay all health care claims. The state has successfully used a “premium floor” concept since returning to a full-risk TennCare model in 2008.

Topic 17: Definition of Small Group Size

Overview

Only employers that qualify as "small employers" may purchase insurance in the small group insurance market. The PPACA §1304(b)(2) defines "small employer" as having … fewer than 101 employees.[44] But the PPACA §1304(b)(3) also allows individual states to define "small employer" as businesses with fewer than 51 employees until January 1, 2016. Beginning in 2016, the federal definition will apply. Tennessee needs to decide whether or not to define small employers as businesses with fewer than 51 employees for this temporary, two year period.

The PPACA also provides requirements on the minimum size of small groups, and whether “groups of one” would be eligible for coverage as a small employer. Tennessee does not currently require insurers to include “groups of one” in their small-group insurance risk pools. Under PPACA §1304(b)(2), a "small employer" includes a business that has only one employee. Proposed federal regulations at 45 CFR 155.20 clarify that, to be considered an "employer," a business must have one or more employees. A sole proprietor, certain owners of S corporations, and certain relatives are not considered "employees" under this definition.

Options Available to Tennessee

Whether or not Tennessee chooses to operate an insurance exchange, the state must decide whether to:

A. Define "small employer" as having fewer than 101 employees
B. Define "small employer" as having fewer than 51 employees

Tennessee also has options available regarding whether groups of one employee are allowed to participate in the small group market. These options include:

- Advocating for changes to the relevant federal proposed rule, or state flexibility on this point
- Investigate ways to comply with the letter of the federal rule, while in practice eliminating groups of one.

Ensuring a Stable and Competitive Market

Tennessee stakeholders have said that defining small businesses as fewer than 51 employees is preferable because it is a cautious approach, and that there is no apparent reason to use the fewer than 101 definition. In Tennessee, the number of employees who work for groups of less

[44] Employer size is measured as the average number of employees on business days during the preceding calendar year.

51 employees is about 225,000, while an additional 75,000 eligible employees work for businesses with 51 to 100 employees.[45] It seems unlikely that this additional potential enrollment would be needed to maintain the stability of the small-group market, even if some small employers currently offering insurance decide to stop offering coverage in response to federal health reform. Additionally, the higher definition of the small group would also require employers with 51 to 100 employees to comply with adjusted community rating rules that apply to small groups and individual plans. This requirement could encourage at least some employers to move to self-funding or terminate their plan entirely.[46]

Federal regulations issued to date do not address whether a state's definition would affect the ability of the state to make risk adjustment payments to group of 51-100. This issue is critical to ensure the stability of the insurance market and is viewed by the state as a priority issue that requires immediate federal clarification.

If the proposed federal regulations are adopted without change, Tennessee would be required to open its small-group insurance market to businesses that have only one employee. However, sole proprietors with no other (unrelated) employees would not be permitted to purchase in the small-group market and would have to purchase insurance in the individual market (as they must now).

The Agent Technical Advisory Group has pointed out that distinguishing sole proprietors and self-employed individuals from small groups consisting of only one employee is likely to prove extremely challenging in actual practice. Such one-employee groups are said to be rare. Further, most such employees would qualify for premium assistance tax credits and cost-sharing subsidies in the absence of employer coverage, and therefore would often be better off purchasing coverage through the individual exchange.[47] In response to proposed regulations, Tennessee submitted comments requesting that the federal government permit states to exclude all "groups of one", arguing that an employer group with one employee would virtually always have two or more participants. If the rule is not changed, and Tennessee operates its exchange, the state will likely want to investigate if there are administrative or policy options that would comply with federal rules, but eliminate the impact of groups of one employee on an exchange.

Topic 18: Merged or Separate Risk Pools for Small and Individual Market

Overview

The PPACA allows states to decide whether to combine or keep separate risk pools for the small group and individual market. Currently, Tennessee insurers treat individual and small group risk pools separately. If the state elects to keep separate risk pools, the premium rate offered by a carrier would be different for the same person applying for individual coverage versus coverage through a small business. If the state merges the risk pools, then the rates offered by an insurance carrier to the same person in the individual and small group market would be the same.

When the myriad of health reform changes become effective January 1, 2014, the revisions to rating rules will occur in conjunction with many other significant changes including the introduction of standardized benefit plans, minimum benefit requirements, and an individual

[45] Based on analysis of data from the employer-survey component of the Medical Expenditure Panel Survey (MEPS).
[46] Ibid.
[47] See comments on Tennessee Health Reform website at http://www.tn.gov/nationalhealthreform/exchange.html

mandate to purchase insurance, and significant premium assistance for low income enrollees. The introduction of so many new variables at one time will undoubtedly create an environment that is impossible to fully understand or predict. Changes in premiums will be a reflection of the interaction of many factors, and will vary for individuals based on his or her health plan selection and age. Some individuals may see premium rate increases while others experience rate reductions. Likewise, the impact of premium changes on small groups will also vary, with some seeing little or no change while others may experience higher or lower premiums.

While combining the individual and small group markets into a single actuarial pool would create a larger insurance market for rate setting purposes over time, the long term effects of such a decision are difficult to predict in the absence of other known factors. Merging the markets may affect not only premiums, but could also impact health benefit costs, enrollment decisions, carrier participation, and the ability of carriers to respond to market changes and consumer needs.[48] Combining risk pools could also destabilize the existing market by encouraging insurers to withdraw from the non-exchange market or preventing them from participating in the exchange. In addition, once the risk pools are merged, it could be extremely difficult to reverse the decision at a later date. Actuarial studies in other jurisdictions suggest that merging of the two markets would most likely result in higher premium rates for small group members and lower rates for enrollees in the individual exchange. In some cases, the increased premiums could result in some small businesses dropping coverage if other, more affordable options are not available.

Options Available to Tennessee

Whether or not Tennessee chooses to operate an insurance exchange, the state must decide whether to:

A. Preserve the separate risk pools for individual and small group markets.

   Based on extensive feedback from stakeholders, if the state preserves separate risk pools, the state may wish to develop the best possible "early warning" system that could detect problems in the small group market that may signal an unwinding and should have in place a stabilization plan to implement quickly. Specifically Tennessee's Technical Advisory Groups encouraged the State to work with the larger insurers to:

   a. Determine the approximate number of small groups whose existing coverage does not satisfy the minimum essential coverage standard, which may be a leading indicator; and
   b. Monitor the level of non-renewals in the small group market. The State should also consider working with the agent and broker community (perhaps through informal, quick-response surveys) to gauge the state of the small group market.

B. Combine the individual and small group risk pools. If so, then the state may also wish to:
   a. Combine the risk pools both inside the exchange and in the parallel market; and
   b. In lieu of a one-time combination, consider other policy interventions (e.g., reinsurance and cross subsidization of risk pools) that would allow it to transition more smoothly over a multi-year period to a combined risk pool.[49]

[48] Palmer, Herbold, and Houchens, "*Assist with the first year of planning for design and implementation of a federally mandated American health Benefit Exchange*."
[49] See Elliot K. Wicks, "Merging the Individual, Small Group, and Association Markets in Vermont," prepared for Vermont health Care Reform Commission, January 2009, page 23.

Ensuring a Stable and Competitive

While the merging of markets might make more sense in states that already require some form of community rating or guarantee issue, or in states where the overall market is relatively small, neither of these circumstances apply to Tennessee. Absent a strong argument for imposing additional regulatory changes on the insurance market, Tennessee's actuary and underwriter Technical Advisory Group and Agent Technical Advisory Group advised that the state should maintain separate individual and small group risk pools.

Topic 19: Ensuring Continuity of Coverage

Overview

The prototypical exchange under the PPACA would increase financial access to health insurance. However, given the structure of the federal programs, low-income families with children may have to select different insurers for various members of the family. To minimize the complexities and challenges of managing multiple health plans and to ease transition between plans, Tennessee is interested in the possibility of allowing Medicaid managed care organizations (MCOs) to offer a product in the insurance exchange. Goals of such an approach may include:

- Ensure a common insurer for families regardless of differences in the eligibility categories of various family members;
- Ensure continuity of coverage by insurer over time, regardless of an individual's eligibility category.

Either because of their own business strategy or agreements with health care providers, the MCOs may wish to limit the availability of the product only to persons who have a dependent in their immediate family that is enrolled in Medicaid or CHIP or has been enrolled in either program within the last six or twelve months. Thus the product may be available only to a subset of individuals of a particular age in a given rating area (depending on the issuer's preference).

Options Available to Tennessee

We are working with stakeholders to explored options that allow all members of a nuclear family to have coverage under the same insurer. We evaluated the Basic Health Program (BHP) options, the "zero-dollar" bronze options, the regular silver-level qualified health plan (QHP) options, and a unique "MCO only" silver-level plan option. Under each scenario, we also compared the federal payments to the exchange, the likely member premiums and cost-sharing, and the operational considerations.

A. The exchange could permit TennCare MCOs to offer a special silver-level product to families with dependents in TennCare/CoverKids. This approach minimizes the State's financial risk and may also lower premiums for eligible families. Health care providers may initially have a negative reaction to the role of the TennCare MCOs, but they may fare considerably worse under the likely alternative of a zero-dollar bronze plan.

Caveats: This recommendation assumes that:
- CoverKids enrollees would receive services from a TennCare MCO by 2014;
- CoverKids would eliminate the "buy in" category by 2014;
- The MCOs would meet any federally-defined provider network adequacy requirements;

• TennCare's covered services would satisfy the essential health benefits standard;
• The federal government will not be able to block or disqualify for subsidies a special plan offered to a subset of individual exchange customers; and
• The implementation of a BHP would not exempt employers from "free rider" penalties.

Note: These recommendations are made in the absence of important federal regulations and will be reviewed and amended subject to the issuance of federal requirements. Tennessee has provided comments to CMS urging the federal government to support Tennessee's goal of "one family, one card" through the adoption of regulations that allow the states to determine the benchmark plan for each metallic tier, for each age group in each rating area.

Ensuring a Stable and Competitive Market

If the State decides to implement the Tennessee exchange, a primary goal will be to maximize enrollment and reduce the number of uninsured residents. The "one family, one card" philosophy supports the goal of coverage expansion by:

- Consolidating families under one insurance carrier;
- Creating a market that allows families to get coverage through a common provider network using a single insurance card;
- Reducing the "hassle factor" for families by allowing people to stay in the same provider network and continue using the same card even when their eligibility category changes (subject to some conditions) and they obtain different coverage;
- Increasing financial access to insurance; and
- Reducing administrative costs by eliminating premium collection for premiums under a specific threshold (e.g., $50 per month).

Maximizing enrollment opportunities and creating a process that minimizes "red tape" further supports the State by reducing financial risk to the State and mitigating potential adverse selection.

For reasons outlined in the Appendix B, the Basic Health Program (BHP) may not offer any clear advantages to Tennessee. Stakeholders appeared to concur with the reasoning in this document, and few if any advocated for consideration of the BHP. However, we look forward to reviewing the federal rules regarding the BHP as soon as they are available.

APPENDIX A:
TENNESSEE INSURANCE MARKETS
AND PPACA RELATED CHANGES

While the focus of this White Paper is on policy options related to insurance exchanges, this appendix provides a brief overview of the key health insurance market segments most affected by PPACA. It also includes a summary of some of the key PPACA requirements affecting each of those markets in order to demonstrate the importance of carefully considering each exchange decision and how each of those decisions will have broader implications not just for the exchange, but for the entire health insurance market and the consumers who purchase those plans. Regardless of whether Tennessee operates an exchange or the federal government establishes an exchange in the state, the entire health insurance market will be affected.

Tennessee Insurance Market Today

The majority of Tennessee consumers with private health insurance coverage are insured under an employer-sponsored health plan or an individual health plan. Many businesses sponsor "group health plan" coverage for their employees and the employees' families. Individual plans, referred to as "direct purchase plans," are obtained directly from an insurer by the individual and are most often purchased by people who do not have access to an employer-sponsored plan. Group health plans and direct purchase plans and the insurance companies that offer them must be licensed or approved by the Tennessee Department of Commerce and Insurance (TDCI). However, if an employer is self-funded, then the insurance plan does not have TDCI oversight, as described later in this appendix.

Not all insurers offer all types of plans. Some insurers only offer individual products, or may offer only individual and small group plans. Others may offer only large employer plans. Companies decide which markets are best suited to the nature and financial aspects of the company, and must regularly demonstrate to the TDCI that they are financially sound and able to pay all claims. The TDCI has a comprehensive, ongoing oversight process to ensure companies meet financial solvency requirements and are able to meet all obligations to their policyholders.

Individual Health Plans

People shopping for individual health insurance usually work with an insurance agent who helps the consumer select an affordable plan that best meets the needs of the individual and his or her family. Individuals can choose from a wide variety of policies that range from "major medical" plans that provide comprehensive coverage for hospital stays, physician services and prescription drugs to more limited plans that may cover only specific services or illnesses, or may provide coverage only for a short period of time. Comprehensive policies are more expensive because they cover more costs while more limited plans have lower premiums and less coverage. While all policies must be approved by the TDCI to ensure the plan meets minimum requirements and provides consumers with certain protections, under Tennessee law, insurers have significant discretion to design innovative insurance plans that respond to the needs and requests of consumers.

Consumers applying for individual plans are subject to "underwriting", which means the company will evaluate the applicant's medical history and other relevant factors that allow them to determine whether the person's expected medical needs are comparable to other people of their age and gender, or may be higher or lower. Based on this review, the company may approve or deny the application. If approved, the company will calculate the premium based on the enrollees' anticipated expenses using a variety of personal characteristics and premium rating criteria that are based on sound actuarial data that estimates the cost of insuring people with different characteristics. While insurers have their own underwriting and rating processes and use their own data for calculating premiums, criteria that a company typically uses to determine individual premium rates include:

- Age and gender of the enrollee;
- Geographic area where the individual lives (health care utilization and costs vary based on where a person lives);
- Health history and the individual's current health status;
- Current and previous use of tobacco;
- Whether the individual participates in certain sports or activities that increase the likelihood of injuries; and
- The benefits and coverage included in the policy being purchased.

Based on these and any other factors the insurer uses, the applicant may be offered a standard rate, or may receive a lower or higher rate. Insurers may also offer policies that "exclude" certain pre-existing conditions, which allow individuals with medical conditions to obtain insurance for all other medical needs not related to the pre-existing condition.

Because insurers are able to compete on the basis of their benefit plans, underwriting practices and premium rates, consumers are encouraged to shop and compare their options when buying an individual policy. Persons who are denied coverage or quoted a higher than average premium rate at one company may find a competing company that will offer coverage or charge a more affordable premium.

Group Health Plans

State and federal laws and regulations for group plans are different from individual plans and vary depending on the size and nature of the group. The most common types of group plans are those offered by employers. Employers in Tennessee are not required to offer insurance, but often do so as part of an employee benefits package. Employer-sponsored group health plans generally fall into the following three categories:

Small Employer Plans are provided by businesses with two to 50 eligible employees. Insurers who sell small employer plans must comply with "guarantee issue" laws that prohibit an insurer from refusing to sell a policy to a small employer solely because of their employee's health status. Employees and dependents of the small employer who are applying for coverage may be asked to complete applications that request health history information similar to that required of individual insurance applicants. However, the health insurer uses that information to develop premium rates for the entire group as a whole. For groups of 3 to 25, Tennessee restricts how much premiums can increase due to the health status of the group. However, no limit applies to groups of 2 or more than 25.

Insurers may require that a minimum percentage of eligible workers participate in the group plan and can deny the application if enough employees do not enroll. Insurers also may require the

employer to contribute a minimum percentage of each worker's premiums (such as 50 percent of the employee-only cost, not including additional costs for dependents).

Like individual insurers, small group insurers use a variety of factors to determine a small group's premium rate. Factors that may be considered include:

- Age and gender of the enrollees;
- Health status and health history of each enrollee;
- Number of participants in the health plan (group plans are usually less expensive than individual plans. As group size increases, administrative costs and claims costs can be spread across a larger population.);
- Claims history of the group if previously insured;
- Industry of the group (some types of occupations have a history of having higher than normal health care claims due to the hazards of the job); and
- Geography (health costs vary by region of the state).
- Coverage included in the health plan (more comprehensive benefits will result in higher premiums).

Large Employer Plans may be offered by businesses that do not meet the small employer requirements and don't self-fund. Large employers are generally defined as those with more than 50 or 100 employees. Unlike small group plans, large employer groups may be turned down by an insurer. Insurers offering large employer plans may require group applicants to complete a health history application, but often do not do so for larger groups. This decision is entirely up to the insurer and may vary by company. Premiums are generally based on factors similar to those used for small groups, but again will vary significantly by group size and insurer. For larger groups, insurers use fewer rating factors since larger groups have more people to spread the risk, reducing the potential impact of a few less-healthy individuals.

Large employers are not required to offer insurance and may offer coverage to a specific class of employees – such as executives – and not offer coverage to everyone else. However, if employers offer coverage to a certain class, they must offer it to all employees in the class equally. They are also prohibited from using health status as a reason for not offering coverage to a particular group or excluding any particular employee from enrolling in the plan.

Self-Funded Plans are governed by the federal Employee Retirement Income Security Act (ERISA) and are exempt from state regulation. They are often called ERISA or self-insured plans. Employers who self-fund their health plans pay the costs of their employee's health care themselves. These plans are generally offered only by large employers with the financial resources necessary to cover the risk of unknown health care costs. They may contract with an insurer to provide administrative services (such as enrollment, claims processing, contracting with providers, and enrollee customer services) but they do not pay premiums and do not purchase insurance from the company. The self-funded employer pays all claims using their own company funds; because no "insurance" is purchased, these plans are, for the most part, not subject to any state insurance requirements. The benefits offered by self-funded plans vary by employer, but generally provide comprehensive coverage. Federal law prohibits discrimination against individual employees based on health status, so all eligible employees may participate in a self-funded plan. Self-funded plans are regulated by the U.S. Department of Labor Employee Benefits Security Administration.

PPACA Insurance Market Requirements

In addition to creation of the exchange, the federal PPACA includes many additional, significant changes to the private health insurance market. While implementing the exchange is a challenge in and of itself, the complexities are exacerbated by short implementation deadlines and these additional insurance market reforms, many of which will take effect at the same time the exchange is launched. Some of the PPACA mandated insurance market changes the state and Tennessee insurers must address include[50]:

- Creation of a process for the annual review of premium increases;
- Restrictions and limitations on premium rating activities;
- Coverage of pre-existing conditions with no restrictions;
- Prohibition against lifetime benefit limits;
- Restrictions against annual benefit limits;
- Prohibition against rescissions of health insurance policies;
- Coverage of preventive health care services and immunizations with no co-payments;
- Extension of dependent coverage up to age 26;
- Limits on insurance company administrative expenditures;
- Compliance with uniform summary of benefits documents; and
- New federal reporting requirements.

These provisions are not limited to plans sold in the exchange, but also apply to plans offered outside the exchange. Self-funded plans are generally exempt from state regulatory requirements but are required to comply with many of the federal PPACA provisions. In addition, it is important to note that the implementation dates of these requirements vary. Some provisions have already taken effect and others will be implemented in stages during the next few years. Some of the most significant reforms coincide with the implementation of the exchange, affecting plans sold beginning January 1, 2014.

While several of these requirements on their own have significant implications for both consumers and insurers, the combination of all of these provisions in conjunction with the introduction of exchange plans will have long-term consequences, many of which are unknown. Further complicating this situation are the following facts:

- Not all provisions apply to all market segments (individual, small group, large group and self-funded), and each market will respond differently to these changes depending on unique market conditions.

- Some plans are eligible for “grandfathered status” under separate PPACA provisions, which means those plans will be exempt from some – but not all – of these and other requirements that otherwise apply to all other plans within that market segment. Grandfathered plans are plans that existed at the time PPACA was enacted (March 23, 2010) and that made none of the changes identified in PPACA as disallowed for grandfathered status. The state has no way of tracking or identifying grandfathered plans and will have to create an additional process for overseeing those policies and addressing consumer complaints related to those plans.

[50] Congressional Research Service, *“Private health Insurance Provisions in PPACA* (P.L. 111-148), April 15, 2010.

- Most importantly, unless overturned by the U.S. Supreme Court or Congress, the PPACA mandate requiring individuals to purchase insurance beginning January 1, 2014 adds an additional "unknown" factor that further complicates the ability of insurers and the state to plan for the exchange and predict the implications for the non-exchange market.

One thing is certain – the combination of these requirements makes it imperative that the state carefully and thoughtfully evaluate the range of options and use the best resources available to understand what actions the state can take to preserve and maintain a competitive and stable insurance market that continues to provide consumers with the choices and opportunities they currently enjoy in Tennessee. The table on the following page provides a summary of some of the more significant changes and how those provisions apply to each of the market segments. Please note that this is not an inclusive list of all insurance market changes, but only a highlight of some of the more challenging requirements that will directly impact the individual, small group and large group insurance market.

Selected Federal PPACA Insurance Market Changes

Summary Description of PPACA Insurance Market Requirement	Effective Date	Potential Impact on Tennessee Insurance Market*	Market Segment Affected**					
			Individual		Small Group		Large Group	
			Grandfathered Plans	New Policies	Grandfathered Plans	New Plans	Grandfathered Plans	New Plans
No Lifetime Dollar Limits on Benefits	9/23/2010	Likely to increase premiums	X	X	X	X	X	X
Restrictions on Annual Dollar Limits on Benefits	9/23/2010	Likely to increase premiums		X	X	X	X	X
Prohibition on Annual Dollar Limits on Benefits	1/1/2014	Likely to increase premiums		X	X	X	X	X
No Pre-existing Exclusion for Children under Age 19	9/23/2010	Likely to increase premiums		X	X	X	X	X
Coverage of Preventive Services with No Co-Pay	9/23/2010	Likely to increase premiums						
Extension of Dependent Coverage to Age 26	9/23/2010	Likely to Increase premiums	X	X	X[51]	X	X[51]	X
Plans Must Meet Minimum Medical Loss Ratio Requirements	1/1/2011	Will vary by insurer; may decrease premiums in some cases; likely to reduce agent/broker commission payments	X	X	X	X[2]		X[2]
Plans Subject to Rate Review	Varies by State	Unknown at this time; will increase administrative costs for insurers		X		X[2]		X[2]
Coverage is Guaranteed Issue	1/1/2014	Likely to increase premiums for individual plans and small groups, particularly if healthy people fail to enroll		X	X	X		X
Plans Must Comply with New Premium Rating Restrictions That Limit Insurers' Ability to Price Premiums Based on Enrollee's Age, Gender, or Health Status, or Whether Policy of for a Family or	1/1/2014	Will vary by plan and enrollee; likely to increase premiums for small groups and younger/healthier individual enrollees; may lower premiums for older/sicker individual enrollees		X[2]		X[2]		

Individual								
No Pre-Existing Exclusion Period Allowed	1/1/2014	Likely to increase premiums for all groups		X	X	X	X	X

[1] Before 2014, grandfathered plans are required to offer dependent coverage only if dependent is not eligible for other employer group coverage. Source: Congressional Research Service, *Grandfathered Health Plans Under PPACA*, April 7, 2010.

[2] Applies to Fully-Insured Plans Only; does not apply to Self-Funded plans.

*__Actual__ impact on the TN insurance market is impossible to predict and will vary based on the combination of market changes, onsumer and employer response, and the impact of the exchange in 2014. The __Potential Impact__ described in this table is based on reasonable assumptions and expectations, but is only an estimate.

** Grandfathered plans are plans in which a person was enrolled on the date of PPACA's enactment (i.e., March 23, 2010). Grandfathered plans may lose their status if they make certain changes after March 23, 2010.

APPENDIX B:

ONE FAMILY ONE CARD OPTION

Many stakeholders expressed concern that families may be "split" across different insurers due to the eligibility status of individual family members. For example, a pregnant mother, her husband, and their six-year-old child have an income equivalent to 150% of the federal poverty level. Under the rules that will be in effect in 2014:

- The mother would qualify for TennCare/Medicaid, at least until two months after her delivery – at which point she would qualify for premium tax credits to lower the cost of a qualified health plan via the exchange;
- The father would qualify for premium tax credits to lower the cost of a qualified health plan via the exchange;
- The child would qualify for CoverKids/CHIP; and
- The newborn would qualify for TennCare/Medicaid until its first birthday, at which point it would qualify for CoverKids/CHIP.

This family could conceivably have three of four different insurance cards from different insurers with very different benefits. The family's situation would become even more complicated if their income changed in the course of the year (which is highly likely, given the birth of the new child); in such cases, one or more members of the family may have to change insurers.

Stakeholders suggested that we consider options that might allow a family to enroll in and retain insurance coverage through a single insurer. They noted that Tennessee may be uniquely positioned to accomplish these goals because all Medicaid and CHIP enrollees are in managed care organizations (MCOs). They felt that we may be able to work with MCOs and QHPs to design a structure that would achieve this level of simplicity and coordination for all exchange consumers.

Working with stakeholders, we identified a "one family, one card" policy option that would:

(a) enable members of a nuclear family to hold coverage through a common insurer/provider network, regardless of their eligibility status (e.g., Medicaid, CHIP, and premium tax credits); and

(b) facilitate continuity of coverage by allowing individuals to retain coverage through the same insurer/provider network if their eligibility status were to change (e.g., from Medicaid to premium tax credits or vice-versa).

Under one approach, TennCare MCOs would provide a single card for use by the entire family while a dependent was enrolled in the Medicaid/CHIP programs and for a defined period thereafter. In this way, the system would reduce discontinuities/ disruptions in insurance coverage owing to different eligibility groups and periodic income changes. For your reference, I am attaching an analysis that we wrote back in June that describes this in greater detail. In the attached memo, we refer to the option described above as the "special silver level product"; elsewhere, this has also been called a Medicaid "bridge" product.

Either because of their own business strategy or agreements with health care providers, the MCOs may wish to limit the availability of the product only to persons who have a dependent in their immediate family that is enrolled in Medicaid or CHIP or has been enrolled in either program within the last six or 12 months. Thus, the product may be available only to a subset of individuals of a particular age in a given rating area (depending on the issuer's preference).

This approach would be consistent with the potential policy goals described above

To be clear, this is not a proposal, nor is it Tennessee's position that we should or even would allow such a program in our market. Rather, we would simply like to have this as an option. Accordingly, we are discussing this and related policy options with federal officials.

Several stakeholders also asked us to evaluate the potential use of the Basic Health Program (BHP) as a potential option that may achieve the same policy goals. The attached memorandum summarizes our analysis of this option. Stakeholders appeared to concur with the reasoning in this document, and few if any advocated for consideration of the BHP. However, we look forward to reviewing the federal rules regarding the BHP as soon as they are available.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE
INSURANCE EXCHANGE PLANNING INITIATIVE
312 Rosa L. Parks Avenue, Suite 2600
William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-4517
FAX (615) 253-8556

Mark A. Emkes
COMMISSIONER

Darin J. Gordon
DEPUTY COMMISSIONER

To: Scott Pierce
From: Brian Haile
Date: June 10, 2011
Subj: Exchange, BHP and MCOs

Regardless of whether Tennessee elects to operate an insurance exchange, the State must still develop policies to address a variety of issues. These include a policy addressing the relationships among the Basic Health Program (BHP), TennCare managed care organizations (MCOs), and a state- or federally-administered exchange.

We summarize below our assessment to date regarding the exchange, BHP, and MCO issues. If and when you think it appropriate, we could distribute this memo for stakeholder comment.

Executive Summary

Background: The prototypical exchange under the PPACA would increase financial access to health insurance. Given the structure of the federal programs, though, low-income families with children may have to select different insurers for various members of the family.

Analysis: We explored options that allow all members of a nuclear family to have coverage under the same insurer. We evaluated the Basic Health Program (BHP) options, the "zero-dollar" bronze options, the regular silver-level qualified health plan (QHP) options, and a unique "MCO only" silver-level plan option. We compared the federal payments to the exchange under each, the likely member premiums and cost-sharing, and the operational considerations.

Preliminary Recommendation: The exchange should permit TennCare MCOs to offer a special silver-level product to families with dependents in TennCare/CoverKids. This approach minimizes the State's financial risk and may also lower premiums for eligible families. Health care providers may initially have a negative reaction to the role of the TennCare MCOs, but they may fare considerably worse under the likely alternative of a zero-dollar bronze plan.

Caveats: This recommendation assumes that:

- CoverKids enrollees would receive services from a TennCare MCO by 2014;
- CoverKids would eliminate the "buy in" category by 2014;
- The MCOs would meet any federally-defined provider network adequacy requirements;
- TennCare's covered services would satisfy the essential health benefits standard;
- The federal government will not be able to block or disqualify for subsidies a special plan offered to a subset of individual exchange customers; and
- The implementation of a BHP would not exempt employers from "free rider" penalties.

We may need to update this recommendation after reviewing forthcoming federal rules.

Detailed Explanation

Goals (in order of priority)

- Consolidate families under one insurance carrier;
- Increase financial access to insurance; and
- Reduce administrative costs by eliminating premium collection for premiums under a specific threshold (e.g., $50 per month).

Parameters (in order of importance)

- Avoid any financial risk to the State; and
- Mitigate potential adverse selection.

Analysis of Alternatives

The **Basic Health Program** (BHP) has generated the most attention. We note the following:

- The BHP is limited to persons under 200% FPL, which inhibits the State's ability to consolidate family coverage under a single insurer for the TennCare and CoverKids eligible families above 200% FPL.

- While the BHP may offer more programmatic flexibility, it generates less federal revenue (i.e., 95% of tax credit and cost-sharing subsidies) and may require higher member cost-sharing. The latter is likely to be a concern among providers, who may have to write off the amounts as bad debt.

- It is unlikely the State could limit the BHP to parents/caretakers with spouse and child dependents in TennCare/CoverKids; likewise, it is unclear how segregating BHP and non-BHP risk pools may affect the viability of an exchange.

- The creation of a BHP would mitigate adverse selection to zero-dollar bronze plans because all individuals under 200% FPL must enroll in the BHP. On a related point, the BHP could possibly have its own risk pool and reinsurance, risk adjustment and risk corridor programs; it is unclear whether doing so may be advantageous.

- While we think we could reduce/eliminate any financial risk to the State, this remains at least a theoretical possibility.

- The BHP option reduces the buying power of the exchange.

- It is unclear whether the implementation of the BHP would exempt Tennessee employers from the "free rider assessments" or penalties under PPACA Section 1513.

In contrast, the **zero-dollar bronze option** generates substantially less federal revenue because members cannot use cost-sharing subsidies for bronze, gold, platinum plans, or catastrophic plans. The zero-dollar bronze option also leaves members (and, thus, providers) exposed to much higher levels of member cost-sharing (and bad debt). It also does not further the State's policy goals of consolidating families under a single insurer.

The **silver-level option** maximizes federal revenue, but it also maximizes member premiums. As with the bronze-level option, the silver-level option does not further the State's policy goals of consolidating families under a single insurer.

As an alternative to the regular silver-level option, the exchange could allow (but may not necessarily require) TennCare MCOs to offer a **special silver-level product** to families with spouse or child

dependents in TennCare/CoverKids. This would satisfy the key policy goal of unifying families under a common insurer, but it would also preserve consumer choice and maximize the size of the exchange's market share (and hence its viability). It would maximize the federal payments on behalf of each family (while holding constant the State share), which would presumably result in higher provider reimbursement rates. By relying on the TennCare delivery system, the MCOs may be able to achieve sufficient efficiencies to allow them to offer lower premiums for eligible families.

This approach has at least one drawback in the sense that the MCOs must (presumably) use the reinsurance, risk adjustment, and risk corridors for the commercial, non-Medicaid market rather than the risk adjustment system defined in the TennCare MCO contracts.

To the extent that we believe that zero-dollar bronze plans may be destabilizing to the risk pool, we can explore alternative policies to address this issue (e.g., minimum premiums, etc.). We do not necessarily need to address the adverse selection issue in this context.

Attachment A describes two case examples (the first for an individual and the second for a family of four) under each of the scenarios above. These may better illustrate the issues described above.

Details of Preliminary Recommendation

Notwithstanding the drawback described above, we recommend that the exchange allow TennCare MCOs to offer (at their option) a special silver-level product to families with spouse or child dependents in TennCare/CoverKids. Under this approach:

- This product would be available **only** to eligible parents/caretakers and dependent children to age 26 (who "aged out" of TennCare/CoverKids) who have other members of their nuclear family in TennCare/CoverKids. However, it is unclear whether this would extend to families that would qualify only by virtue of a family member's eligibility for Medicaid via Spenddown, long-term care, etc.).

- Parents/caretakers and other eligible individuals would retain the right to select any other plan on the exchange. However, the plan selection mechanism might use this MCO/plan option as the default for eligible individuals.

- The exchange could automatically qualify MCOs to offer this product to the eligible population. MCOs would not be required to meet any Tennessee-specific, nonfederal qualified health plans requirements for such products offered to eligible individuals. However, the MCOs would have to meet all QHP requirements for all other products offered via the exchange to all other persons

- MCOs could but are not required to use the same provider networks that they currently use to serve the Medicaid population. Likewise, they could but are not required to use the same payment rates.

- MCOs could set their premium levels at any level.

Providers may initially react negatively to the reliance on the TennCare delivery system. However, the alternative of a zero-dollar bronze plan will leave them considerably more exposed to financial risks.

Please note the caveats included in the Executive Summary.

Attachment

cc: Darin Gordon
Brooks Daverman
Bo Irvin

Attachment A
Comparison of Options for Low-Income Exchange Alternatives
(All figures expressed as monthly amounts)

Household of 1 100% of FPL = $908 AV= $645	Federal Funding		Member Premium		Average Member Cost Sharing (risk to providers and members)*		Total Federal and Member Funds		Risks to State
Options	Low (138% FPL)	High (200% FPL)	Low (138% FPL)	High (200% FPL)	Low (138% FPL)	High (200% FPL)	Low (138% FPL)	High (200% FPL)	
Silver Level	PATC+CSS		3% of Income	6.3% of Income	6% of AV	13% of AV	Federal Funding + Member Premium + Cost Sharing		
Regular Silver	$569	$447	$38	$114	$39	$84	$645	$645	None
MCO Silver	$569	$447	$38	$114	$39	$84	$645	$645	May affect TennCare MCO procurement
MCO Silver (MA/CHIP only)	$569	$447	$38	$114	$39	$84	$645	$645	May affect TennCare MCO procurement
Basic Health Program	95% of PATC+CSS		≤ 3% of Income or less	≤ 6.3% of Income or less	≤ 10% of AV	≤ 20% of AV	Federal Funding + Member Premium + Cost Sharing		
Basic Health Program	$540	$424	$0	$114	$65	$129	$605	$668	Financial risk, smaller exchange pool
$0 Premium Bronze	PATC		None		40% of AV		Federal Funding + Member Premium + Cost Sharing		
$0 Premium Bronze	$414	$337	$0	$0	$258	$258	$672	$595	None

Household of 4 100% of FPL = $1,863 AV= $1,678	Federal Funding		Member Premium		Average Member Cost Sharing (risk to providers and members)*		Total Federal and Member Funds		Risks to State
Options	Low (138% FPL)	High (200% FPL)	Low (138% FPL)	High (200% FPL)	Low (138% FPL)	High (200% FPL)	Low (138% FPL)	High (200% FPL)	
Silver Level	PATC+CSS		3% of Income	6.3% of Income	6% of AV	13% of AV	Federal Funding + Member		
Regular Silver	$1,500	$1,225	$77	$235	$101	$218	$1,678	$1,678	None
MCO Silver	$1,500	$1,225	$77	$235	$101	$218	$1,678	$1,678	May affect TennCare MCO procurement
MCO Silver (MA/CHIP only)	$1,500	$1,225	$77	$235	$101	$218	$1,678	$1,678	May affect TennCare MCO procurement
Basic Health Program	95% of PATC+CSS		≤ 3% of Income or less	≤ 6.3% of Income or less	≤ 10% of AV	≤ 20% of AV	Federal Funding + Member Premium + Cost Sharing		
Basic Health Program	$1,425	$1,164	$0	$235	$168	$336	$1,593	$1,734	Financial risk, smaller exchange pool
$0 Premium Bronze	PATC		None		40% of AV		Federal Funding + Member		
$0 Premium Bronze	$1,097	$940	$0	$0	$671	$671	$1,769	$1,611	None

*Member cost sharing is a risk to providers who will have difficulty collecting from low-income patients, and a risk to members who may be hit with unexpected high medical expenses.
FPL=Federal Poverty Level (set to FPL for 2011)
PATC= Premium Assistance Tax Credit
CSS= Cost Sharing Subsidy
AV= Actuarial Value of Plan (set to approximate actuarial value of state employee health plan)

APPENDIX C:

POTENTIAL TENNESSEE INSURANCE EXCHANGE MARKET

***Tennesseans who may enter an individual or SHOP exchange market*[52]**

- Uninsured: 947,200[53]
- Individual Market: 307,500[54]
- Self-employed Tennesseans: 284,884[55]
  Note that some of these people will be uninsured, covered through Medicare, or covered through TennCare.
- Small group firms with 2-50 employee offered health insurance: 505,106[56]
- Small group firms with 51-100 employees offered health insurance: 97,353[57]
- Access TN: 3,800[58]
- Federal Pre-Existing Condition Insurance Program in Tennessee: 170[59]
- Currently insured but "dumped" by employer: Unknown, conflicting analysis are available from The Lewin Group, Mercer, McKinsey & Company, RAND, The Urban Institute, Booz & Co, and others.

[52] Note that any of the above people who go to the exchange portal but are eligible for newly expanded TennCare will contribute to the internet and call center load but not to the size of the exchange insurance market.
[53] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements). http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=44&ind=125&sub=39
[54] Ibid.
[55] American Community Survey 2007-2009 3-year estimate.
[56] Medical Expenditure Panel Survey—Insurance Component, 2009.
[57] Ibid.
[58] As of February 2011.
[59] As of February 2011.

APPENDIX D:

CURRENT TENNESSEE MANDATED INSURANCE BENEFITS

ACCIDENT & HEALTH COVERAGE REQUIREMENTS

56-7-2302(e) Requires coverage of **adopted children** at the time of placement with no denial.

56-7-2367 Requires coverage of **autism spectrum disorders** for children under age 12.

56-7-2312 Requires group insurers to offer **continuation and conversion**.

56-7-2314 Sets forth the exemptions when an insurer does not have to offer **conversion**.

56-7-2315 Sets forth the allowable reasons an insurer does not have to renew a **conversion** policy.

56-7-2353 Requires BC/BS and insurance companies to provide coverage for hospital confinements for children for **dental procedures** if age 8 or under. Having dental coverage is not a requirement.

56-7-2302(a) Sets the limiting age for **dependents** at 24 years.

56-7-2302(b) Requires continuation of **dependent coverage** for children who are handicapped.

56-7-2302(d)(1) Prohibits denial of coverage of a **dependent** because they are not claimed on income tax, born out of wedlock or not residing with the parent.

56-7-2302(d)(2) Requires coverage of **dependent** child who is otherwise eligible when there is a court order.

56-7-2605 Requires HMOs, BC/BS, Fraternal, and insurance companies to provide coverage for **diabetic supplies, treatment, and counseling.** The supplies include monitors, test strips, insulin, injection aids, syringes, pumps oral medication pediatric appliances, and emergency strips. This must be at the same coverage as any other treatment.

56-8-304 Does not allow an insurer or HMO to deny a claim because it was caused by **domestic abuse**.

56-7-2352 Requires HMOs, BC/BS, Fraternal, and insurance companies to provide coverage to the same extent as any other **drug coverage** for **off label drug** use as long as it has not been banned by the FDA.

56-7-2355 Requires HMOs, BC/BS, Fraternal, and insurance companies to provide coverage for **emergency medical treatment** where a prudent layperson believes a serious impairment/dysfunction might occur if such treatment is not

received. Coverage is subject to applicable co-payments/deductibles which are not necessarily the same as other treatment.

56-7-2304 Authorizes the commissioner to develop rules regarding **extension of benefits**.

56-7-2502(a) Requires coverage for **mammography** when recommended by a physician.

56-7-2507 Requires HMOs, BC/BS, Fraternal, and insurance companies to provide for **reconstructive** breast surgery within 5 years of a **mastectomy** for both the diseased and healthy breast. Note: there is no requirement that the initial surgery be covered by the current insurer.

56-7-2364 Requires coverage for payment of **medication counseling** for people with 6 or more medications.

56-7-2360 Requires a minimum of 20 inpatient and 25 outpatient visits for **mental health** disorders. Also requires that the out of pocket for mental illness be no greater than any other illness.

56-7-2503 Prohibits the exclusion of coverage in a **mental hospital** based solely on the fact the hospital does not have organized operating facilities.

56-7-2301 Requires any insurer to offer **newborns automatic coverage** as long as application and premium are furnished within 31 days of birth.

56-7-2302(c) Requires coverage for **non-charitable hospitalization claims.**

56-7-2505 Requires coverage for medical and nutritional treatment of **PKU**

56-7-117 Requires group contracts not to discriminate against **pharmacies** by requiring equal treatment with mail order pharmacy coverage.

56-7-1701 Requires the offering of a non **pre-paid dental plan** when a prepaid dental plan is offered.

56-7-1702 Requires a **prepaid dental plan** permit and provide coverage for a second opinion.

56-7-118 Requires 30 day notice of **premium rate increases** for bank draft or pre-authorized checks.

56-7-2354 Requires HMOs, BC/BS, Fraternal, and insurance companies to provide coverage for testing for **prostate cancer** in men over 50 and under 50 if the tests are medically necessary and recommended by a physician.

56-7-2604 Requires the coverage of newborns for **routine nursery care**.

56-7-2365 Requires coverage for **routine patient care costs** in approved **clinical trials**.

56-7-2323 Does not permit the coordination of group insurance with **school accident insurance**.

56-7-2324 Does not permit **school accident coverage** to reduce benefits because of other insurance unless the policyholder pays 100% of the premium.

56-7-2301(b) Requires BC/BS and insurance companies to provide coverage for newborns and pregnant women for prevention of Perinatal Group B **Streptococcal Disease.**

56-26-133 Requires an insurance company not to exclude coverage that should be provided under **workers compensation** if the employer is not required by law to provide such coverage.

ACCIDENT & HEALTH REQUIRED COVERAGE OFFERINGS

56-7-2602 Requires the offering to a group policyholder of coverage for **alcohol and drug abuse treatment** the same as any other illness. If coverage is rejected, then the policyholder can request different levels of coverage. Applies to HMOs and non-profit hospital organizations.

56-7-2505 Requires an offering of coverage for **bone density** testing if recommended by a physician.

56-7-2504 Requires an offering of coverage for **bone marrow transplants** by insurance companies HMOS and non-profit hospital associations if Tenncare provides coverage.

56-7-2606 Requires BC/BS, HMO and insurance companies to offer provide coverage for **chlamydia** testing on an annual basis to women under age 29.

56-7-2363 Requires an offering for coverage for **colorectal cancer early detection** testing.

56-7-2601(a) Sets forth that unless specifically excluded, **mental illness** is covered like any other illness.

56-7-2601(b) Requires the offering to a group policyholder of coverage of **mental illness,** including alcohol and drug abuse, when treatment is rendered in a community mental health center. Coverage is not required for more than 30 visits.

56-7-2603 Requires the offering to each resident of the State of Tennessee of coverage for **speech, voice and hearing disorders** when treatment is received from a licensed audiologist or speech pathologist. Applies to HMOS and non-profit hospital organizations.

ACCIDENT & HEALTH REQUIRED PROVIDER COVERAGE

56-7-2404 Requires non-discriminatory coverage of **chiropractic care** if the services would have been covered if provided by a physician.

56-7-2405 Requires coverage of care provided by a duly licensed **dentist** or **podiatrist** if the care would have been covered if provided by a physician.

56-7-2407 Requires coverage of care provided by a duly licensed and certified **midwife** if the care would have been covered if provided by a physician.

56-7-2408 Requires coverage of care provided by a duly licensed **nurse practitioner** (ie. Nurse anesthetist, clinical specialist) if the care would have been covered if provided by a physician.

56-7-2401 Requires coverage for an **optometrist**, licensed **psychologist** designated as a health service provider(ie.; clinical school and counseling), a licensed **psychological examiner**, a licensed practitioner of **social work** and a **podiatrist**, if the services would have been covered if provided by a physician.

56-7-2406 Requires managed care organizations to allow **St. Jude** to participate in their networks.

56-7-2501 Does not permit an insurer to discriminate in covering **sterilization** procedures.

DEFINITIONS

56-2-201(1) Definition of **accident and health insurance**.

56-7-105 Defines a **bad faith action** as refusal to pay a claim after 60 days after all information has been received and states the penalty for a bad faith claim against an insurer.

56-32-202(1) Defines **basic health care services** as relating to HMO coverage.

56-26-101(1) Defines **blanket accident and sickness insurance**.

56-26-101(2) Defines **cancelable** as a renewal provision.

56-7-101 Defines what constitutes a **contract of insurance**.

56-26-201(a) Defines **employees** as officers, managers, owners, or partners as well as those who are employed.

56-26-119 Defines **false statements** in the application and the fact that they can't be used if the agent knew of the untruth.

56-26-101(3) Defines **franchise accident and sickness insurance.**

56-26-201(b) Defines **group accident & health insurance** and eligible groups.

56-42-103(5) Sets forth the definition of **Long term care insurance** as being for a benefit period of at least one year and provide medically necessary coverage.

56-7-103 Defines what a **material breech** for voidance of an insurance contract constitutes.

56-26-101(4) Defines **non-cancelable** and **guaranteed renewable**.

56-7-2101 Defines **pet insurance** and the state requirements.

HMO REQUIREMENTS

56-32-202(1) Defines **basic health care** services as relating to HMO coverage.

56-32-223 Requires an **employer** to offer their employees HMO coverage if an HMO so wishes to offer this coverage to the group of 25 or more employees.

56-32-219 Requires an HMO to pay a $50 **filing fee** when amended any group contracts, subscriber agreements, provider contracts, service area adjustments, etc.

56-32-207(a)(2) Requires the **filing of an evidence of coverage** and amendment to such document prior to use in this state.

56-32-207(b)(1) Requires the **filing of all schedules of enrollees charges** prior to use in this state.

56-32-202(6) Defines **Health Maintenance Organization** and allows a PHO to contract with an HMO and not be a risk bearing entity.

56-32-202(10) Defines **Physician-Hospital organization** as formed to allow physicians and hospitals to contract jointly with an HMO.

INSURANCE COMPANY OPERATION REQUIREMENTS

56-3-201 Requirement that insurers whose major market is **direct response** have in state claims offices.

JURISDICTION

56-2-106(4) **Exempts** an insurance company from having a **certificate of authority** when a group or blanket insurance policy is lawfully delivered outside the state.

56-7-1010 Defines which insurance **contracts** fall under the **jurisdiction** of the state of Tennessee.

LONG TERM CARE INSURANCE ACT

56-42-103(5) Sets forth the **definition of Long term care insurance** as being for a benefit period of at least one year and provide medically necessary coverage.

56-42-104 Requires the filing of **out of state group** contracts for informational purposes prior to issuance in Tennessee. The situs state must have similar laws.

56-42-105(d) Prohibits a company from requiring **prior hospital confinement** in order for a benefit payment for nursing home or home health care.

56-42-105(b)(4) Prohibits a company from requiring the receipt of **skilled care** before benefits are paid for lower levels of care.

POLICY FILING AND FORMAT REQUIREMENTS

56-26-125 Requires notice of the companies right to **cancel coverage** be prominently displayed on the face page.

56-26-106(1) Requires the **consideration** and money be expressed in the policy.

56-7-102 Requires that a policy contain the **entire contract** between entity providing coverage and the policyholder.

56-26-102(a) Sets forth the **filing requirement** that all accident and sickness forms be approved by the Commissioner.

56-26-202(a) Sets forth the **filing requirement** for group accident and health insurance.

56-26-106(6) Requires a **form number** be in the bottom left hand corner of the face page of each policy, application and rider.

56-26-102(b) Sets forth the requirement for a **loss ratio guarantee** which exempts rates from filing and approval.

56-7-1605(a)(1) Requires a minimum flesch score for **readability certification** of 40.

56-26-126 Requires any insurer who has the right to **refuse renewal** of the insurance to place notice prominently on the face page of the contract.

56-4-218 **Retaliatory fee** for policy filings.

56-7-1605(a)(4) Requires a **table of contents** when the number of policy pages exceeds three pages or 3,000 words.

56-26-129 Provides the insured with a **ten day free look** from receipt of the policy.

56-7-1605(a)(2) Requires a minimum **type size** of 10 points.

56-7-1008 Requires insurers to accept claims filed on a **Uniform claim form**.

REQUIRED & OPTIONAL POLICY PROVISIONS

56-26-109(8) Sets forth the permissible provision for **cancellation of an insurance** contract with 5 days notice and provides for the return of unearned premium.

56-26-108(12) Sets forth the required provision for the **change of beneficiary** must be in a policy.

56-26-109(1) Sets forth the permissible provision for **change in occupation** for risk classification.

56-26-108(6) Sets forth the required provision for **claim forms** being provided with in 15 days which must be in a policy.

56-26-109(9) Sets forth the permissible provision for an insurance policy to **conform with any statutes** that it might be in conflict with at the time of the effective date.

56-26-109(7) Sets forth the permissible provision for **deduction of a premium due** when a claim payment is made.

56-26-108(1) Sets forth the required provision for the **entire contract** which must be in a policy.

56-26-108(3) Sets forth the required provision for the **grace period** which must be in a policy. It is 7 days for weekly payments, 10 days for monthly payments, and 31 for all other payment modes.

56-26-109(10) Sets forth the permissible provision for exclusion of an **illegal occupation**.

56-26-109(11) Sets forth the permissible provision for use of **intoxicants or narcotics**.

56-26-108(11) Sets forth the required provision for **legal actions** being brought within 3 years which must be in a policy.

56-26-109(2) Sets forth the permissible provision for correction of a **misstated age** in a policy.

56-26-108(5) Sets forth the required provision for the **notice of claim** which must be in a policy. The time limit is 20 days.

56-26-109(3) Sets forth the permissible provision for **Other insurance with this insurer** to be used when an insurance company wishes to provide only one contract of insurance to a person or only assume a set liability.

56-26-109(4) Sets forth the permissible provision for **Other insurance with Other insurer** for an expense incurred contract.

56-26-109(5) Sets forth the permissible provision for **Other insurance with Other insurers** for an indemnity policy.

56-26-108(9) Sets forth the required provision for **payment of claims** describing who payments are made to which must be in a policy.

56-26-108(10) Sets forth the required provision for **physical examinations and autopsy** which must be in a policy.

56-26-108(7) Sets forth the required provision for **proof of loss** which is 1 year and ninety days which must be in a policy.

56-26-108(4) Sets forth the required provision for the **reinstatement** of a contract which must be in a policy.

56-26-109(6) Sets forth the permissible provision for **relation of earnings to insurance** to limit the benefits under a disability policy when other disability coverage exists.

56-26-108(2) Sets forth the required provision for the **time limit on certain defenses** which must be in a policy. This sets the 2 year time limit on statements in the application and on pre-existing conditions.

56-26-108(8) Sets forth the required provision for **time payment of claims** immediately upon receipt which must be in a policy.

56-26-113 Allows an insurer to **substitute** any required or permissible provision as long as it is not less favorable to the insured.

SPECIFIC ACTS IN TENNESSEE CODE

56-8-? **Domestic Violence Act** prohibits discrimination based on abuse.

56-25-1101 **Fraternal benefit** society definition and laws.

56-32-201 **Health Maintenance Organization** Act of 1986 sets forth the provisions for HMOs.

56-42-101 **Long Term Care** Insurance Act sets forth nursing home, home health and long term care statutes.

56-7-1425 **Medicare Supplement** Insurance Protection Act

56-7-2003 **Memphis Act** which permits health coverage for low income persons be offered through a non-profit entity and not be subject to our insurance laws.

56-7-2201 **Small Employer** Group Reform Act

56-6-701 **Utilization Review** Act which requires the registration of agents performing health claims review and precertification in Tennessee.

SMALL EMPLOYER GROUP REFORM ACT & GENERAL GROUP REQUIREMENTS

56-7-2203(1) Defines **actuarial certification** as required annually on March 15 for small employer carriers.

56-7-2209(f) Requirement for annual small group rate **actuarial certification** on March 15.

56-7-2203(12) Defines an **eligible employee** for small employer requirements.

56-7-2205 Defines what type of business in the small group market constitutes a **distinct grouping**.

56-26-202(b)(1) Requires a **group** accident & health policy to include a provision of an entire contract and that statements made in the application are representations not warranties.

56-26-202(b)(2) Requires a **group** accident & health policy to include a provision that the insurer will issue an individual **certificate** to the policyholder for distribution to the insured.

56-26-202(c)(3) Requires a **group** accident & health policy to include a provision that the original group may add more persons or **classes** to the original group.

56-7-2208(e) Requires a small employer carrier to offer a **guaranteed issue** basic & standard plan.

56-7-2203(13) Defines **health benefit plan** as to what coverage is subject to the small employer group reform act.

56-7-2203(16) Defines **late enrollee** for the small employer group act.

56-7-2209(a)(4) Permits an insurer to exclude a **late enrollee** from coverage for no more than 18 months.

56-7-2203(19) Defines **pre-existing conditions** as 12 months in the small employer group market.

56-7-2209(a)(1) Requires no more that a 12 month limit for **pre-existing conditions**.

56-7-2209(a)(2) Requires credit for **pre-existing limits** be given for time covered under other group health benefit plans if the coverage is continuous to within 30 days of the effective date in the small group market.

56-7-2203(24) Defines a **small employer** as any employer who has 3 to 25 eligible employees for 50% of the previous year.

56-7-2209(a)(3) Sets forth the allowable reasons for **termination of a small group** health benefit plan.

56-7-2209(b) Sets forth the **small group rating** restrictions.

UNFAIR DISCRIMINATION

56-8-104(8) Sets forth unfair **claims settlement** practices.

56-8-104(6) Defines Unfair discrimination as far as **rating practices and denial of coverage** based on a family member's (but not insured) occupation.

56-8-104(7) Defines **rebating** in insurance sales practices.

56-26-106(8) Sets forth the **limited benefit warning** requirement for limited policy forms.

APPENDIX E:

PROVIDER NETWORK ADEQUACY STANDARDS FOR TENNESSEE PUBLIC EMPLOYEE PLANS

The following text is from the third party administrator (TPA) contract for the public employee health plans. The health plans currently serve 275,000 employees, retirees and their families affiliated with state government, higher education, local education, and local government agencies in Tennessee. We have use the "strikethrough" feature on certain text that would clearly not apply to qualified health plans within the exchange.

A.3. Provider Network.

a. The Contractor shall maintain a provider network in the PPO Grand Division covered by this Contract that provides high quality, cost effective medical services, and provides adequate geographic and service access to members. The Contractor shall contract with medical providers including but not limited to primary care physicians, specialist physicians, nurse practitioners/physician assistants, nurse midwives, hospitals (all levels - primary, secondary and tertiary), skilled nursing facilities, urgent care facilities, convenience clinics, state employee onsite clinics, laboratories, and all other medical facilities, services and providers necessary to provide covered benefits. If the State elects to cover nutrition counseling, the Contractor's provider network shall include registered dieticians/nutritionists and the Contractor must have this network within six (6) months of the State making this decision.

b. The Contractor's provider network shall meet, at minimum, the geographic access standards specified in Contract Attachment B, Liquidated Damages, Liquidated Damage Number 21.

c. The Contractor shall maintain a sufficiently extensive and accessible provider network such that members are able to receive appointments from a geographically-accessible provider within the following appointment standards:

(1) urgent visit: twenty-four (24) hours
(2) wellness visit: two (2) months
(3) primary care routine visit: fourteen (14) days
(4) specialty care routine visit: thirty (30) days

d. The Contractor shall submit a semi-annual report to the State regarding appointment standards, including monitoring activities, findings, and corrective actions (refer also to Contract Attachment C, Reporting Requirements).

e. When requested by the State in writing, the Contractor shall, within ten (10) business days and in writing, report to the State any actions it intends to take to correct any access deficiencies highlighted by reports to the State or otherwise identified by the State (refer also to Contract Attachment C, Reporting Requirements).

~~f. As directed by the State, the Contractor shall develop and implement a high performance network of specialty providers and inpatient hospitals as measured by their adherence to evidence-based clinical protocols and cost efficiency (*e.g.*, cost per episode). Notwithstanding the foregoing, the Contractor may develop a high performance network of primary care providers without State direction. Before implementing a high performance network, the Contractor shall submit its plan for developing and implementing a high performance network to the State, and the plan shall be approved in writing by the State. The Contractor's plan shall include the information specified by the State, including at minimum the (1) quality and cost efficiency measures that the Contractor will use to determine whether a providers satisfies the criteria to be a high performance provider; and (2) proposed member cost-sharing incentives (*e.g.*, lower rates of co-insurance, co-payment in lieu of co-insurance, waiver of or provision of lower deductible amounts) or other incentives for members who receive covered benefits from high performance providers. The State may approve the Contractor's use of such member incentives regardless of whether other third party administrator for medical services have implemented such member incentives.~~

g. The Contractor shall include in its provider network transplant centers that are Medicare-approved transplant programs. The State considers Medicare-approved transplant programs to be Centers of Excellence for each program type (*e.g.*, heart/lung, heart-only, kidney-only) approved by Medicare. The Contractor shall only authorize and pay for organ transplants performed by a transplant program that is approved by Medicare for the applicable transplant (*e.g.*, heart/lung, heart-only, kidney-only). The Contractor may require additional criteria on their network providers over and above the requirements listed above.

~~h.~~ As directed by the State, the Contractor shall maintain a network of Centers of Excellence for each of the following: bariatric surgery, orthopedic surgery, oncology/cancer surgery, and cardiology/cardiac surgery. For bariatric surgery, Centers of Excellence are those bariatric surgery centers designated as Centers of Excellence either by the American College of Surgeons or the American Society for Metabolic and Bariatric Surgery. For the other services, the criteria for Centers of Excellence shall be specified by the State. ~~As directed by the State, the Contractor shall only authorize and pay for procedures performed at Centers of Excellence. Additionally, and as directed by the State, the Contractor shall provide incentives to members to use Centers of Excellence for the specified services (including but not limited to lower member deductibles and co-~~

~~insurance for procedures performed at such facilities). The Contractor may require additional criteria on their network providers over and above the requirements listed above.~~

~~i. As directed and funded by the State, the Contractor shall pay incentive payments, enhanced reimbursement, or per member per month capitation payments to providers based on a disease management flag or other indicator reported to the Contractor by the State or its authorized representative. (See Contract Section A.8.i. for related member incentives.)~~

~~j. As directed and funded by the State, the Contractor shall pay incentive payments, enhanced reimbursements, or per member per month capitation payments to providers with credentialed/accredited "medical homes" as defined by the State. To date, the State has no formal designation of "medical home," but we continue to explore this option and are considering the National Committee for Quality Assurance- (NCQA-) accredited medical home model and others.~~

k. Covered benefits received through network providers located in states contiguous to the State of Tennessee shall be consistent with covered benefits provided through network providers located in Tennessee. The Contractor shall include in its provider network providers, including but not limited to physicians and hospitals, located in states contiguous to the PPO Grand Division covered by this Contract.

If the East PPO Grand Division is covered by this Contract, the Contractor shall include providers with service locations in the following statistical areas, as defined by the U.S. Office of Management and Budget (OMB):

- Alabama – Huntsville/Decatur Combined Statistical Area and Florence-Muscle Shoals Metropolitan Statistical Area (MSA)
- Georgia – Chattanooga/Cleveland/Athens Combined Statistical Area
- North Carolina – Asheville/Brevard Combined Statistical Area
- Virginia – Johnson City/Kingsport/Bristol Combined Statistical Area

If the Middle PPO Grand Division is covered by this Contract, the Contractor shall include providers with service locations in the following statistical areas, as defined by the U.S. Office of Management and Budget (OMB):

- Alabama – Huntsville/Decatur Combined Statistical Area and Florence-Muscle Shoals MSA
- Kentucky – Clarksville MSA

If the West PPO Grand Division is covered by this Contract, the Contractor shall include providers with service locations in the following statistical areas, as defined by the U.S. Office of Management and Budget (OMB):

- Alabama – Florence-Muscle Shoals MSA
- Mississippi and Arkansas – Memphis Metropolitan Statistical Area (MSA)
- Kentucky – Union City, TN - KY Micropolitan Statistical Area

l. The Contractor shall submit a quarterly network changes update report to the State within five (5) business days of the end of each Contract quarter that includes any changes in the Contractor's provider network (refer also to Contract Attachment C, Reporting Requirements).

m. The Contractor shall notify the State in writing of any termination of a hospital or physician group of twenty (20) or more, regardless of whether the termination is initiated by the Contractor or the provider, within one (1) business day of becoming aware of the termination. The Contractor shall also provide written notice to members who received treatment from the hospital or physician group within the last six (6) months. The Contractor shall mail the notice to members no less than thirty (30) calendar days prior to the effective date of the termination.

n. The Contractor shall notify the State in writing if any physician group is not accepting members as new patients. The Contractor shall provide such notice within one (1) business day of becoming aware of the restriction.

o. The Contractor shall not take action to disenroll network primary care providers or hospital providers except for good reason, which may include: inability to negotiate continuance of its provider agreement; provider failure in the credentialing/recredentialing process; non-compliance with provider agreement requirements; provider request for disenrollment; member complaints; suspicion of provider impairment; loss of license or exclusion from participation in Medicare or Medicaid pursuant to Sections 1128 or 1156 of the Social Security Act; or request by the State.

p. Following review and approval by the State, the Contractor shall annually update and print provider directories. During the first calendar year of this Contract, the Contractor shall mail a provider directory to each member who is also the head-of-contract at his/her home address no later than twenty-one (21) days prior to the go-live date. The provider directory shall include provider name, specialty, address and phone number and be organized by county. After the first calendar year of this Contract, the Contractor shall mail a provider directory to each new member who is also the head-of-contract within ten (10) days of the Contractor's receipt of the member's enrollment information. Throughout the term of this Contract the Contractor shall, at a member's request, mail a copy of the current provider directory to the member within ten (10) days of receiving the member's request to have a copy and shall, upon the State's request, distribute provider directories to Agency Benefits Coordinators within fifteen (15) days of the State's request to provide copies. Notwithstanding the foregoing, after the first calendar year of this Contract, the Contractor shall produce and distribute provider directories to all existing members if requested by the State. (In all instances, the

reimbursement of actual costs pursuant to Contract Section C.3.e., shall be applicable.)

q. The Contractor shall maintain the capability to respond to inquiries from members concerning participation by providers in the network, by specialty and by county. Such capability shall be through the call center (see Contract Section A.12.) and an up-to-date internet-based directory of providers on its website (see Section A.14.) that includes provider search capability deemed acceptable by the State. The internet-based provider directory shall accurately reflect network providers who have joined or ceased participation in the network in the past fifteen (15) calendar days and whether or not the provider is accepting members as new patients. The Contractor shall provide the internet-based provider directory on its website on or before the date specified in Contract Section A.21.

r. The Contractor shall provide the State with GeoNetworks® reports on a semi-annual basis showing service and geographic access (refer also to Contract Attachment C, Reporting Requirements). For the first report, and subsequent reports if so directed by the State, the Contractor shall submit two versions of the reports; one mapping to all network providers and one mapping to network providers that are accepting members as new patients. The State shall review the reports and inform the Contractor in writing of any deficiencies. The Contractor shall develop and implement an action plan to correct deficiencies. The State reserves the right to review the action plan and require changes, where appropriate.

s. The Contractor shall submit to the State an annual provider turnover report that includes the Contractor's voluntary and involuntary turnover rate by provider type (refer also to Contract Attachment C, Reporting Requirements).

t. The Contractor shall exercise due diligence and reasonable care in its selection, credentialing, recredentialing, and retention of each network provider. The Contractor shall contract only with providers who are duly licensed to provide such medical services and shall require that all providers maintain all licenses and accreditations in existence at the time of selection as a network provider in order to continue their status as a network provider. The Contractor shall perform on a continuous basis appropriate provider credentialing that assures the quality of network providers. The Contractor shall complete processes necessary to reconfirm the licensure, accreditations, credentials, and standing of network providers no less frequently than every three (3) years.

~~u. The Contractor shall maintain face-to-face, telephonic, and written communication with providers to ensure a high degree of continuity in the provider network and ensure that the providers are familiar with applicable requirements.~~

~~v. The Contractor shall notify all network providers of and enforce compliance with all provisions relating to utilization management and other procedures as required for participation in the Contractor's provider network.~~

~~w. The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of members.~~

~~x. The Contractor shall identify and sanction network providers who fail to meet pre-determined, minimum standards relating to referrals to out-of-network providers.~~

y. As a means to [prevent] "doctor shopping" and mitigate risks relating to fraud, waste, and abuse, the Contractor shall maintain the ability, as may be deemed necessary, to "lock in" or otherwise restrict selected members to one or more specific network providers or group of providers for accessing covered services.

~~z. Any pay-for-performance (P4P) arrangements between the Contractor and a network provider must be prior approved in writing by the State.~~

aa. The Contractor shall notify the State in writing, in a format prior approved by the State in writing, at least thirty (30) days prior to any adjustments to any provider payment terms, including but not limited to provider fee schedules, contract rates, other provider payment arrangements, discounts, rebates, refunds, or credits negotiated with the provider, and the manner in which such adjustments are reasonably likely to affect the cost of claims payments by the State.

bb. If the Contractor is unable to deliver covered benefits through network providers, the Contractor shall arrange and pay for such services to be rendered by out-of-network providers. When the Contractor arranges for covered benefits to be provided through an out-of-network provider, the member's financial liability shall be limited to any cost-sharing that would have applied had the service been rendered by a network provider (*e.g.*, in-network co-insurance percentage and in-network deductible amount). Balance billing is prohibited. The Contractor shall report to the State on a monthly basis all unique care exception requests and whether they were granted or denied (refer also to Contract Attachment C, Reporting Requirements).

cc. In no case shall network providers balance bill for covered benefits. Rather, the member's liability shall be limited to the allowable member cost-sharing.

dd. If the Contractor signs a provider agreement with an inpatient hospital that limits the Contractor's ability to negotiate or sign a provider agreement with another inpatient hospital, the Contractor shall require the network hospital to participate in the annual Leapfrog Hospital Survey (see Contract Section A.22.w.).

21. **Provider/Facility Network Accessibility**		
Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis, the Contractor's provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan members shall have the Access Standard indicated.	
Definition	Provider Group – Urban and Suburban	Access Standard
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Obstetricians/Gynecologists	1 physician within 20 miles
	Pediatricians	1 physician within 20 miles
	Cardiologists	1 physician within 30 miles
	Endocrinologists	1 physician within 30 miles
	Acute Care Hospitals	1 facility within 30 miles
	Provider Group – Rural	Access Standard
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 30 miles
	Obstetricians/Gynecologists	1 physician within 30 miles
	Pediatricians	1 physician within 30 miles
	Cardiologists	
	Endocrinologists	
	Acute Care Hospitals	1 facility within 30 miles
Assessment	One hundred thousand dollars ($100,000) if any of the above listed standards is not met, either individually or in combination. For purposes of measuring compliance with the access standards delineated in this liquidated damage, the Contractor shall provide the State with a GeoAccess report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use GeoAccess' default definitions for urban, suburban, and rural areas. At the Contractor's request, the State may also approve other methodologies, including but not limited to (a) the current GeoAccess standards; (b) the most recent version of the rural-urban commuting area (RUCA) codes as defined by the U.S. Bureau of the Census and the U.S. Department of Agriculture Economic Research Service; (c) the ZIP code approximation of the RUCA codes; (d) the current definition of "rural areas" used by the U.S. Department of Health and Human Services Office of Rural Health Policy; or (e) the most recent definitions of Office of Management and Budget (OMB) with respect to county-level metropolitan and micropolitan areas. Further, the State may specify the use of a particular methodology following the completion of the 2010 decennial Census.	
Measurement	Compliance report is the semi-annual GeoNetworks Analysis submitted by the Contractor. Measured, reported and reconciled semi-annually.	

APPENDIX F:

REQUEST FOR INFORMATION FOR INSURANCE INDUSTRY

REQUEST FOR INFORMATION (RFI) 31865-00700 BY THE
Insurance Exchange Planning Initiative
Division of Health Care Finance & Administration
Department of Finance and Administration
STATE OF TENNESSEE

A. STATEMENT OF INTENT:

The State of Tennessee, Division of Health Care Finance & Administration issues this Request for Information for the purpose of preparing for a potential request for proposals for qualified health plans in the event that Tennessee implements its own health insurance exchange.

B. BACKGROUND:

In March of 2010, the federal Patient Protection and Affordable Care Act (PPACA) was enacted by Congress, imposing significant changes on employer and individual health insurance plans, state Medicaid programs, health care providers and individuals and insurers who purchase insurance benefit plans. Tennessee is evaluating how to best proceed with implementation in a way that protects and supports the interests of the state's citizens and health care community while complying with the legal requirements of federal law. The State drafted a white paper outlining the core issues, which is available online at www.tn.gov\exchange.

C. GENERAL INSTRUCTIONS:

C.1. The State is requesting the following information from all interested parties:

Please see **Attachment A** for a complete list of questions detailing the information sought by the State in this RFI. Parties may respond to all questions, or only those pertinent to their organization's capabilities. For background and more detailed information about the State's insurance exchange planning efforts, please see the white paper referenced above in Section B.

All responses will become public records upon completion of the upcoming Request for Proposal process for the procurement of TPA services. We anticipate releasing the information after the announcement of the TPA contract award(s), which the State tentatively plans for Summer/Fall 2012 (again, in the event that Tennessee were to decide to operate an exchange).

C.2. Please feel free to contact the Insurance Exchange Planning Initiative, Division of Health Care Finance & Administration with any questions regarding this RFI. The main point of contact will be:

Brian Haile, Director
Insurance Exchange Planning Initiative
312 Rosa L. Parks Avenue
Nashville, TN 37243-1102

tel: 615-253-8555
fax: 615-253-8556

D. INSTRUCTIONS FOR RESPONDING

D.1. Submit your response to this Request for Information to:

Alma Chilton, Director of Contracts
Division of Health Care Finance and Administration
310 Great Circle Road
Nashville, TN 37243
tel:615-507-6384
alma.chilton@tn.gov

Please include at least two (2) paper copies and two (2) electronic copies of your response.

D.2. Please reference **Request for Information # 31865-00700** with your response to this request.

D.3. Please respond by November 23, 2011.

Attachment A

As we indicated in the white paper available at www.tn.gov/exchange, we tried to summarize the feedback that we have received from stakeholders over the past 12 months. We would appreciate your feedback and clarifications. In particular, we look forward to your input on several questions that have emerged more recently in our ongoing discussions. For reference, we include these questions below. Again, however, we welcome your thoughts on any issue related to insurance exchange and the choices that Tennessee is confronting.

1. **Benefit Comparability:** (see topic 1 in the white paper) Given the inherent challenges of determining eligibility and processing enrollment for several hundred thousand Tennesseans in the first open enrollment period, a relatively smaller number of choices during the 2014 "onboarding" year may prove more manageable for both applicants and the individual exchange. Of course, the individual exchange could expand the number of choices in subsequent years. We would appreciate your feedback with respect to the following:

   (a) Would you prefer full standardization of benefit designs in 2014 as is done with Medicare Supplement Plans (e.g., one or two standardized benefit designs per metallic tier)? Please note that this would apply **only** to the individual exchange and not the SHOP exchange.

   (b) Notwithstanding the challenges above, would you prefer a more expansive number of choices in 2014 similar to that in Medicare Part D? If so, what policies would you recommend in order to address the operational challenges described above? Again, please note that this would apply **only** to the individual exchange and not the SHOP exchange.

   (c) Would you prefer some hybrid option such as the "Rule of 12"? If so, what improvements or alternatives to the Rule of 12 may make sense? Please provide as much detail as possible about any recommended alternatives. Again, please note that this would apply **only** to the individual exchange and not the SHOP exchange.

2. **Provider Network Adequacy:** (see topic 2 in the white paper) What type of provider network adequacy standards have proven particularly effective in other programs or jurisdictions and warrant further consideration? Please provide as much detail as possible, including specific recommendations on the metrics that you think most appropriate for QHPs.

3. **Provider Networks and Metallic Tiers:** (see topic 1 in the white paper)

   (a) The exchange could build functionality to allow a consumer to "buy up" and pay an additional amount for a broader network. Thus, a single QHP could offer a base premium for the standard network and an add-on monthly fee/rate differential for a broader network (with the same underlying metallic tier and benefit design). To what extent do you imagine that issuers would be interested in this type of functionality? How should an exchange assess whether the development costs of such a feature offers corresponding value?

   (b) To what extent should an issuer be allowed to offer different networks for QHPs in the same metallic tier? For example, should issuers be allowed to offer QHP/Benefit Design 1 with Network 1 and a different QHP/Benefit Design 2 with Network 2?

(c) Given the possible "cherry picking" and other selection effects, to what extent should issuers be allowed to vary network by metallic tier? For example, under what conditions should issuers be allowed to offer a silver-level QHP with a broad network but a gold-level QHP with only a select or narrower network?

4. **Out-of-Network Service Delivery:** We would appreciate your comments regarding default payment standards for services rendered by out-of-network providers.

   (a) Under what conditions might an exchange want to include these types of provisions in QHP contracts? Alternatively, what types of contract provisions or standards have proven particularly effective in other jurisdictions and warrant further consideration?

   (b) If an exchange were to establish such standards, what should they resemble?

5. **Employee Choice in the SHOP Exchange:** (see topic 5 of the white paper) As noted in our comments to the proposed federal regulations, several states are considering the possibility of allowing issuers to provide two rates (or plans) in the SHOP exchange: one for those employers that select a single QHP and a separate rate for those employers that allow for more employee choice. (Because these are different products or QHPs, issuers would be able to bid different rates – or not to bid at all on the full employee choice options.) In this way, states may expand the offerings and choices available, but do so in a way that makes the costs of such choices (in the form of a higher risk premium) more transparent to employers and employees.

   For the purposes of answering the following questions, please assume that the federal government issues guidance that would expressly allow this type of approach.

   (a) Please describe any actuarial concerns or other concerns that you might have in developing rates under this type of approach.

   (b) Given any concerns that you describe in (a), would you recommend the approach described above? Alternatively, what other approach might you recommend?

6. **Participation/Contribution Rates in SHOP Exchange:** (see topic 5 in the white paper) For purposes of the questions below, please assume that federal officials will delegate to state-based SHOP exchanges the responsibility to define employee participation requirements and employer contribution requirements for the SHOP exchange.

   (a) Assume that an employer (i) selects a single QHP or (ii) selects a single issuer and allow employees to choose among that issuer's QHPs in a specified metallic tier. Should the exchange develop standards on either or both of these areas that would be consistent across qualified health plans and/or issuers? Why or why not?

   (b) For purposes of measuring participation rates, we note with interest the formula that Utah currently uses to calculate such rates (see attached). Do you think Tennessee should consider using this formula? Why or why not? If you recommend the Utah formula, what modifications would you make for its use in the context of the exchange (and the Medicaid expansion, affordability/premium tax credits, etc.)?

   (c) Assume that an employer selects only a metallic tier and allows full employee choice within that tier. What may be the optimal way to calculate participation/contribution rates in this context – or should an exchange calculate participation/contribution rates at all? Please describe your reasoning.

7. **Premium Aggregation:** Under the proposed federal rules at 45 § 155.705(b)(4), the SHOP exchange (or its designated vendor) must perform a premium aggregation function. To that end:

   (a) We are mindful of at least two policy imperatives: (a) to ensure that the State does not accept or otherwise have responsibilities for such funds; and (b) to define the fiduciary obligations in sufficient detail in all vendor contracts with a premium aggregation entity, qualified health plan, etc. We would appreciate your suggestions in this regard.

   (b) Several stakeholders recommended frequent reconciliations and various advance payment options in order to mitigate common challenges in the small group market (e.g., with delays in terminating a former employee's insurance, etc.). We would appreciate your recommendations.

8. **Rating Areas:** (see topic 15 in the white paper) We would appreciate your comments on the idea of using hospital referral regions as discussed in the white paper as service/rating areas. More generally, we would approach your insights as to:

   (a) In both TennCare and the public employee plans, rating and service areas are largely coterminous. Outside of those contexts, to what extent should service areas and rating areas be coterminous? Alternatively, under what circumstances should service and rating areas be different?

   (b) What is the optimal population size of a service area and a rating area? Please share the basis for your recommendation(s).

   (c) How should an exchange conceptualize/define rating and service areas if it sought to maximize the number of QHP choices for rural residents? What is the marginal improvement in the number of choices that would be available under such an approach – and what are the costs/downsides of such an approach?

   (d) In what ways (if any) should an issuer be able to vary rates by geography within a rating area (e.g., by county, ZIP code level, etc.)? Please share the basis for your recommendation(s).

9. **Tobacco Use as Rating Factor:** Issuers indicate that the current tobacco rating factor in the individual market in Tennessee exceeds 40% of the base premium, which is roughly consistent with the magnitude of the tobacco use factor allowable under the PPACA (i.e., 50%). However, insurers have noted that they may lack an accurate, cost-effective verification process and a meaningful enforcement mechanism. Some insurers have even argued that they would prefer to operate without a tobacco rating factor – if all of their competitors are forced to do so as well. We would appreciate your feedback on this issue. Specifically:

   (a) Given the expense of and legal constraints on tobacco use testing, what type of any verification would you use beyond the self-attestation of tobacco use by an applicant?

   (b) Were you to subsequently discover that an individual had knowingly misrepresented his/her tobacco use status on his or her application, what recourse would you likely pursue (if any)?

   (c) Assume that state law would continue to allow tobacco use rating outside of the exchange (i.e., in the parallel market). Under what conditions (if any) might it be

advantageous for the exchange to prohibit rating factors for qualified health plans sold therein? What challenges might this pose?

(d) What type of tobacco rating would you recommend for the exchange?

10. **Age as a Rating Factor:** The State has the ability under the PPACA to establish age rating bands for qualified health plans. Based on the evidence from Massachusetts, though, many issuers will use five-year age bands even if the state were to allow one-year age bands. Accordingly:

    (a) Historically, state law and regulations have deferred to insurers to set their own age bands. What challenges (if any) might such an approach cause for reinsurance, risk adjustment, and other programs in the period following implementation of guarantee issue, community-rated individual insurance policies?

    (b) Would you recommend that the exchange adopt standardized definitions of age bands for qualified health plans? If so, what would these be? Please share the basis for your recommendation(s).

11. **Insurance Agents:** (see topic 4 in the white paper) Stakeholders have suggested that the exchange require small employers to work with credentialed agents in order to purchase coverage through the SHOP in the first two years of the SHOP exchange. Consequently, employers would not be able to purchase coverage directly via the SHOP exchange until 2016 or thereafter. Do you agree or disagree with this approach? Please describe the rationale behind your response.

12. **Medicaid Bridge Options:**

    (a) What may be the policy drawbacks and operational challenges of the option to ensure continuity of coverage described in topic 19 of the white paper?

    (b) Are there better, easier ways to both: (i) enable members of a nuclear family to hold coverage through a common insurer/provider network, regardless of their eligibility status (e.g., Medicaid, CHIP, and premium tax credits); and (ii) facilitate continuity of coverage by allowing individuals to retain coverage through the same insurer/provider network if their eligibility status were to change (e.g., from Medicaid to premium tax credits or vice-versa)?

13. **Sustainability:** We would appreciate your suggestions regarding the options described on page 7 of the white paper to support the ongoing costs of an insurance exchange in Tennessee. We also welcome any additional ideas that you might share or other options that may be under discussion elsewhere.

14. **Marketing:** (see topic 10 in the white paper) Because of past marketing abuses, some programs (e.g., TennCare) prohibit marketing by participating carriers while other programs (e.g., Medicare Advantage) issue voluminous administrative rules and highly regulate marketing efforts.

    (a) We would appreciate your feedback regarding the optimal framework/construct for marketing related to QHPs. For example, under what conditions might it make sense to prohibit marketing in 2013-14 but allow QHPs to market themselves thereafter?

(b) To the extent that an exchange permits marketing of QHPs, what existing standards could the exchange borrow and adapt relatively easily? Regarding any set(s) of standards that you reference, please also describe any specific changes that you might recommend.

15. **Open Enrollment:** (see topic 13 in the white paper) Particularly for the individual exchange, we have requested that federal officials delegate to state-run exchanges the ability to alter certain operational details (e.g., dates of effective dates of coverage, dates of open enrollment, etc.). With respect to open enrollment:

    (a) Would you prefer a single open enrollment period for all exchange applicants or open enrollments at different times of the year for different groups (i.e. an open enrollment tied to an applicant's birthday? Would you prefer a standardized open enrollment period in individual exchange – or would you prefer to manage the volume of open enrollment transactions over the course of the calendar year? Please share the basis for your recommendation.

    (b) If an exchange were to use a system of rolling open enrollment periods in the individual exchange, what is the best way to set open enrollment dates? For example, might it be advantageous to synchronize an individual's open enrollment period with their premium tax credit annual eligibility redetermination date? With their birthday?

16. **Minimum Premiums/Premium Floors:** As is currently done in the TennCare MCO bids and Medicaid procurements in other states, the State could establish a minimum premium for qualified health plans in the exchange. This would ensure that the "benchmark" plan for the tax credit valuations is sufficiently large, allowing the State to maximize affordable choices for consumers and federal inflows to Tennessee.

    (a) Do you favor this type of approach, or would you prefer that insurers have complete flexibility in bidding rates? Please describe the rationale for your response.

    (b) If you prefer some sort of minimum floor, what mechanism(s) may be most appropriate? For example, should the exchange simply declare the third-lowest bid in each metallic tier in each rating area to be the "minimum"? What other approaches merit consideration?

17. **Actuarial Uncertainty:** Industry stakeholders stated that one of their largest concerns is the unknown utilization profile of individuals who may enter the exchange (both those who are currently uninsured and who may presently have some form of existing coverage).

    (a) What type(s) of demographic or other data could the State provide to you (and in what form) that may prove helpful to you as you evaluate your participation in an exchange in Tennessee?

    (b) To what extent would a robust reinsurance program make a substantial difference to you and your decision to enter or continue to operate in the Tennessee market? (see topic 8 in the white paper)

    (c) Aside from limiting open enrollments to annual events, what additional policy choices would you recommend to reduce uncertainty?

18. **Competition Policy:** Many of the policy options described above may help to achieve and sustain more competitive markets. We would appreciate your feedback as to how an

exchange could optimize the design of the individual and SHOP exchange that may induce financially stable, high quality health plans to participate in the Tennessee market. Likewise, we would appreciate your candid assessments as to any barriers in the marketplace – and what policy responses you recommend.

APPENDIX G:

GLOSSARY OF WHITE PAPER TERMS AND ACRONYMS

The following is glossary include brief definitions of terms used in this white paper. Several of the terms are specific to the federal Patient Protection and Affordable Care Act (PPACA), and may have other definitions used outside PPACA. These definitions are intentionally short and simple, and are designed solely to assist the reader in understanding the issues discussed in this document.

Actuarial Value: A measure of the average value of benefits in a health insurance plan. It is calculated as the percentage of benefit costs a health insurance plan expects to pay for a standard population, using standard assumptions and taking into account cost-sharing provisions included in a specific plan. Placing an average value on health plan benefits allows different health plans to be compared. The value is determined based on expected benefit costs paid by the plan and not premium costs paid by the enrollee. It also represents an average for a population, and may not reflect the actual cost-sharing experience of an individual, depending on their specific health care needs and utilization of services.

Adverse Selection: People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health insurers try to attract and maintain risk pools, or groups, of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a health plan. Adverse selection may result in higher premiums for the enrollees and, over time, may lead healthier people to drop coverage and enroll in a lower cost plan. The loss of healthier people makes the remaining risk pool even more adverse, which results in even higher premium costs for the enrollees.

Basic Health Plan (BHP): The BHP is an alternative option for certain individuals under PPACA. States may create a Basic Health Plan for uninsured individuals with incomes between 133-200% of Federal Poverty Level who would otherwise be eligible to receive premium subsidies in the exchange. States that choose this option will contract with one or more health plans to provide at least the essential health benefits and must ensure that eligible enrollees do not pay more in premiums than they would have paid in the exchange, and that cost sharing requirements meet certain limits.

CCIIO: Center for Consumer Information and Insurance Oversight, a federal agency created to assist in the oversight and implementation of PPACA.

CMS: Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services that serves as the administrator of the U.S. Medicare, Medicaid and State Childrens' Health Insurance Program (CHIP).

Cost-Sharing: A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.

Cost Shifting: Increasing revenues from some payers to offset losses or lower reimbursement

CoverKids: the name of the Tennessee health insurance **SCHIP** program for eligible children (see SCHIP below).

Deductible: Amount of loss or expense that the insured must pay before the insurance company will assume any liability for a claim.

Employer Mandate: refers to a requirement under PPACA that certain employers must offer and maintain health insurance for their employees or may be required to pay penalties.

Essential Health Benefits (EHB): the term used in PPACA to describe a minimum level of health care benefits that Qualified Health Plans must provide to be approved for inclusion in the exchange. The federal government is required to define EHBs based on a list of categories of care included in the PPACA legislation.

Exchange: In general, an exchange is a purchasing arrangement through which insurers offer and small employers and individuals purchase insurance. PPACA creates specific requirements for exchanges created in the federal health reform law. Under PPACA, each state will have an American Health Benefit Exchange for individual enrollees and a Small Business Health Options Program (SHOP) for qualified small employers purchasing group health benefit plans. Together, these two entities are commonly referred to as an "exchange". States, or the federal government if a state chooses to not operate an exchange, may combine the exchanges into one entity or create two separate organizations. States are encouraged to establish their own exchange, but must comply with federal requirements if they choose to do so. If a state chooses not to create the exchange, the federal government will establish and operate the exchange within that state.

Federal Employee Health Benefits Program (FEHBP): A program that provides health insurance to employees of the U.S. federal government. Federal employees choose from a menu of plans that include fee-for-service plans, plans with a point of service option, and health maintenance organization plans.

Federal Poverty Level (FPL): refers to the level of income the federal government determines is sufficient for an individual or family to meet basic living requirements. Eligibility for federal programs such as Medicaid is based on a percentage of the FPL. Federal tax credits used to subsidize premiums under PPACA are also based on FPL.

Individual Mandate: A requirement in PPACA that all individuals obtain health insurance, with some exceptions for individuals based on income or hardship.

Issuer: The term used in PPACA to refer to an insurer or managed care plan that is approved to "issue" qualified health benefit plans through the exchange.

Liquidated Damages: penalties insurers or managed care organizations pay to the state if they are found to be in violation of certain statutory or regulatory requirements

Managed Care Organization (MCO): a licensed health plan (usually a Health Maintenance Organization) that relies an approved "network" of health care providers to provide care for all plan enrollees. Individuals participating in the MCO's plan must use the network providers to obtain the highest plan benefits. Using providers outside the network usually results in higher costs for the enrollee. The enrollee selects a primary care physician (PCP) who oversees their routine care and coordinates care when a patient needs specialty care or services. Failure to use a PCP to coordinate care and obtain authorization for certain services may result in the MCO denying coverage or paying less towards the cost of the services an enrollee receives.

Medicaid: a federal entitlement program that provides health care and long-term care coverage to certain low-income enrollees. States design their own Medicaid program within guidelines established by the federal government. In Tennessee, the Medicaid program is known as TennCare.

Medicare: a national insurance program administered by the federal government, which provides health insurance benefits to people who meet certain criteria, including eligible senior citizens. The program includes three separate options: Medicare Part A provides hospitalization benefits; Medicare Part B provides medical coverage; and Part D provides prescription drug benefits.

Patient Protection and Affordable Care Act (PPACA): The federal health reform law which includes Public Law 111-148 and Public Law 111-152, known as the Health Care and Education Reconciliation Act. The PPACA is also sometimes referred to as the ACA, or Affordable Care Act.

Preferred Provider Organization (PPO): A managed care arrangement consisting of a network of providers including primary care and specialty physicians, hospitals, pharmacists and other providers. PPOs may contract with an insurer, employer, or third- party administrator (TPA) to provide health care services to a plan's enrollees. Enrollees that use providers outside the PPO may incur higher out of pocket costs, or be denied coverage entirely for those services.

Premium Assistance Tax Credits (PATC): Under PPACA, individuals and families with incomes up to 400% of Federal Poverty Level may qualify for a PATC, which will pay part of the cost of the individual's or family's insurance premium costs. The credit will be paid directly to the health plan the enrollee selects, and the individual/family will be responsible for paying the remainder of the insurance premium. PATCs are only available to qualified enrollees who purchase a plan in the exchange.

Primary Care Provider: A provider, usually a physician specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practitioner, physician assistant or even a health care clinic), who is responsible for providing primary, or routine, health care services and coordinating other necessary health care services for patients.

Qualified Health Benefit Plan (QHP): A term used in PPACA to describe a health insurance plan offered in the exchange that meets certain requirements in order to be approved for participation in the exchange. QHP requirements will be determined by regulation and only QHPs may be sold in the exchange.

Reinsurance: Reinsurance is insurance for insurance companies and employers that self-insure their employees' medical costs. Under PPACA, a temporary reinsurance program will be created to protect insurers against unusually high insurance claims beginning in 2014 when insurers are required to accept all applicants regardless of their health status or pre-existing conditions. By limiting insurers' exposure to very high health costs, the reinsurance program is intended to enable insurers to lower the premiums they charge to employers and individuals and to protect the financial solvency of insurers.

SCHIP: The State Children's Health Insurance Program, a joint state and federal program that provides health care coverage for uninsured children in families that meet specific income requirements. In Tennessee, the program is called CoverKids.

SHOP – Small Business Health Options Program: A health insurance exchange for small businesses with either 1-50 or 1-100 employees depending on decisions of the state or federal

government operating the exchange. The SHOP exchange may be a separate, stand-along organization or certain functions and activities may be merged with the individual exchange.

TennCare – the name used for the Medicaid program offered to qualified low income residents in Tennessee.

U.S. Department of Health and Human Services (HHS): the federal agency with primary responsibility for overseeing enforcement of the Patient Protection and Affordable Care Act.

Wellness Plan: a program designed to promote good health and healthy habits, and prevent development or progression of chronic disease. Successful wellness programs may reduce health care costs, sustain and improve employee health and productivity and reduce employee absenteeism.