Insurance Exchanges:
What Makes Sense for Tennessee?

Background on Insurance Exchanges

The federal Patient Protection and Affordable Care Act (PPACA), as amended, envisions health insurance exchanges as state-level "market organizers" for health insurance options available to individuals and small businesses. These exchanges would primarily serve individuals and small employers. The exchanges will also determine eligibility for TennCare and CoverKids (i.e., Medicaid and the Childrens Health Insurance Program or "CHIP") – as well as eligibility for the federal premium assistance tax credits that offset the costs of insurance purchased through the exchanges.

The federal PPACA encourages states to develop and operate their own health insurance exchanges by 2014. For those states who elect not to do so, the federal government will operate a federalized exchange and make the relevant eligibility determinations for the state and federal programs.

Specific Functions of an Exchange

The federal PPACA requires the insurance exchange to: [1]

- Provide both an individual and a small group insurance exchange website (or "portal");
- Present plan options in a standardized way (i.e., Platinum, Gold, Silver, Bronze);[2]
- 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;[3]
- Determine eligibility for and enroll applicants in public programs such as Medicaid and SCHIP (as required by statute and allowed under forthcoming federal rules, though implementation has yet to be determined);[4]
- Determine eligibility for new tax credits and cost-sharing reductions for persons with modified adjusted gross income between 100 and 400% FPL;[5]
- Facilitate advance payments by Treasury to insurers of individual premium assistance tax credits;[6]
- Determine whether employer-sponsored insurance is "affordable" and, thus, whether certain individuals with access to employer-sponsored coverage are eligible to purchase insurance via the insurance exchange;[7]
- Receive and process "free choice" vouchers for employees who have unaffordable employer-sponsored coverage;[8]
- Operate a consumer assistance (or "Navigator") program;
- Report user and employer data to Treasury;[9] and
- Generate sufficient revenue to be self-sustaining by 2015.

The insurance exchange also has a general responsibility for qualifying plans, communicating information to the Treasury and to employers.

The U.S. Department of Health and Human Services (HHS) has indicated that it will provide funds to states to offset the development and implementation costs associated with state-level insurance exchanges until the exchanges become self-supporting by 2015 as required.[10]

Planning Grant

Many states are concerned about the expansive potential role of a federalized exchange -- particularly with the possibility of *de facto* federalized insurance regulation and federalized Medicaid and CHIP eligibility determinations. Partly for this reason, 48 states and the District of Columbia recently applied for the $1 million grants from HHS, which will fund the planning activities necessary for each state to determine whether it may want to operate its own exchange. These grants require no policy commitments or supplemental funding from the grantee states (i.e., the grants have no strings attached).

Clarifying the state's intent, Governor Bredesen stated the following in his cover letter for Tennessee's planning grant proposal:

> My endorsement of this proposal does not prejudge how the next Governor will approach any of the policy and operational issues with state health insurance exchanges when he takes office on January 15, 2011. The activities in this proposal should give the new Governor and his team the thoughtful policy analysis required for them to make informed decisions. I believe that the new Governor will find this work invaluable, particularly given the compressed decision timeframe and the volume and importance of the key decisions regarding program integration, regulatory changes, governance structure, funding mechanisms, finance, and other matters related to exchanges. Indeed, we developed this proposal keenly aware of the needs related to the upcoming gubernatorial transition.

Consistent with this charge, Tennessee will use the grant funds to formulate the policy options available to the next Governor. Governor Bredesen also designated Brian Haile, currently the Deputy Director of Benefits Administration, to lead this initiative; he will collaborate with the Commissioner of the Department of Commerce & Insurance, the Director of TennCare, and other state officials and external stakeholders. A copy of Tennessee's grant proposal is available at www.tn.gov/nationalhealthreform.

Policy Goal & Evaluative Criteria

If Tennessee were to operate an exchange, we would do so with the express purpose of providing a choice of high-quality health insurance options at the lowest possible price. Accordingly, we will evaluate each option in terms of its ability to meet the State's goal in a manner that is consistent with the following values and considerations:

- Provide meaningful consumer choice of a number of participating insurers
- Facilitate easy comparisons and plan selections by all consumers
- Optimize ability of ordinary lay person to make intelligent, informed choice within a reasonable amount of time
- Ensure rural-urban equity both in terms of network access and insurance cost
- Ensure sustainability of exchange-based insurance options over a minimum period of five years
- Maximize affordability of options for consumers who do not qualify for public subsidies or tax credits
- Maximize federal funds available to Tennessee residents (through refundable tax credits, etc.) to offset their insurance costs

As the first step in this process, we want to work closely with stakeholders to identify all options that (a) meet the stated policy goal and (b) are closely aligned with the above policy considerations.

Addressing Uncertainties

As outlined in our planning grant proposal, we are working to address the current areas of uncertainty:

- Legal risks associated with eligibility determinations under TennCare settlement orders
- Advisability and likely impact of consolidating individual and small group markets
- Applicability of Title 56 insurance coverage requirements
- Risks of adverse selection with insurance exchange and options to mitigate such risks (e.g., market structure, reinsurance, risk adjustment, and risk corridors)

We expect some additional federal guidance at the beginning of CY 2011, and we look forward to receiving substantive guidance from our grant-funded consultants around April-May 2011.

We have also asked HHS to issue guidance on several other key policy questions. In particular, we asked HHS to expedite the provision of regulations regarding broker/agent compensation pursuant to Section 1312(e), as amended by Section 10104, of the federal PPACA.[11] Especially with the small group market, agents and brokers are likely to play a key role, and we need clarification on permissible compensation arrangements as soon as possible.

Ongoing Stakeholder Engagement

Having stated our understanding of the policy goal and the draft evaluative criteria, we welcome stakeholder input. In particular, we would appreciate detailed recommendations as to potential options from the health insurance industry, brokers and agents, consumer advocates, the small business community, and other interested parties.

To "depoliticize" any evaluation and make the process as transparent as possible, we are willing to engage an objective third party (e.g., the consultant funded by the grant) to evaluate these recommendations and other options against the values and considerations that we establish. We will also solicit comments from stakeholders before making any recommendations or reaching decisions.

We plan to convene the first meeting of stakeholders on Friday, October 22, 2010. The meeting will take place at 10:00am in the Multi-Media Room of the Tennessee Tower, 312 Rosa L. Parks Avenue, Nashville, TN 37243. All interested parties are welcome to attend.

Preliminary Questions for Stakeholders

In preparation for the meeting on Friday, October 22, 2010, we would appreciate feedback from stakeholders on the following questions. Interested parties may submit their feedback in writing to insurance.exchange@tn.gov at any time before or after the meeting.

1. **How should Tennessee approach the analysis of whether to merge the individual and group markets? What resources are available to help with this effort?** Regardless of whether Tennessee operates an exchange, we will need to address this question.

   [**Note:** Due to the imminent release of our actuarial consulting RFP funded by the planning grant, we are unable to share the draft scope of work and analytical approach at this time.

However, we will be able to share it as soon as the RFP is released, and we will revise it as appropriate.]

2. **In terms of assessing whether Tennessee should operate its own insurance exchange, what considerations would you add to the list below?**

Pros:

- Allows for control of TennCare eligibility determinations
- Enables State to reinforce health and insurance policy goals
- Allows for regional customization

Cons:

- Administrative costs until 2015
- Risks of politicizing design choices and plan selection criteria
- Risk of capture by special interests

3. **If Tennessee were to operate an insurance exchange, should we combine individual and Small Business Health Options Program (SHOP) portals?** What are the relevant considerations here?

4. **If Tennessee were to operate an insurance exchange, what options would enable the State to meet its policy goal (i.e., providing a choice of high-quality health insurance options at the lowest possible price)?** To what extent are these options consistent with values and considerations underlying the evaluative criteria?

5. **Should Tennessee explore the Basic Health Plan option as a possible successor to CoverTN?**[12] How should we approach the analysis of this question?

After we answer these questions, we believe it would then be appropriate to consider the organizational model and governance structure for an exchange – as well as its sources of revenue. However, we believe it premature to discuss such "second-level" issues at this point in the process.

Federal Request for Comments

The federal government recently issued a request for comments regarding health insurance exchanges. In this request for comments, CMS posed some 126 questions organized in 14 subsections. Comments were due October 4, 2010. HHS will likely post all comments at www.regulations.gov; reference docket ID HHS-OS-2010-0021.

Given the resource constraints at the state, Tennessee decided to focus our comments on those areas with which we have most familiarity or concern. We also contributed our input to the more comprehensive responses provided by the National Governors Association (NGA), the National Association of Insurance Commissioners (NAIC), and other organizations representing state-level perspectives. A copy of Tennessee's response to HHS' request for comments is available at www.tn.gov/nationalhealthreform.

Contact Information

For additional information about the insurance exchange planning initiative in Tennessee or to send your request to join our email distribution list, please email insurance.exchange@tn.gov.

You may also contact:

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Resources

Jost, Timothy Stoltzfus. Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues. A Commonwealth Fund Report, September 30, 2010. Available at http://www.commonwealthfund.org.

Jost, Timothy Stoltzfus. Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues. A Commonwealth Fund Report, July 15, 2010. Available at http://www.commonwealthfund.org.

Kingsdale, Jon and John Bertko. Insurance Reform Exchanges Under Health Reform: Six Design Issues for the States. *Health Affairs*. June 2010; 29(6): 1158-1163.

Utah and Massachusetts currently operate exchanges, though these two states have very different approaches. Visit their exchanges at http://www.exchange.utah.gov/ and https://www.mahealthconnector.org/.

To learn more about state-level insurance exchanges, visit the National Governors Association website at www.nga.org and click on "Health Reform Implementation."

Endnotes

[1] PPACA Section 1311(d)(4). *See generally*, 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.

[2] *See* PPACA Section 1302(d)

[3] *See* PPACA Section 1411(b)(5) and 1501. See generally, Congressional Research Service Memo, "The PPACA Penalty Provision and the Internal Revenue Service" (April 30, 2010), available online at http://healthreform.kff.org/~/media/Files/KHS/docfinder/crsindividualpenalty.pdf).

[4] *See* PPACA Section 1413; Congressional Research Service Report R41210, "Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA" (April 28, 2010), available online at http://www.arkleg.state.ar.us/healthcare/medicaid/Documents/CRS%20Report%204_28_10.pdf.

[5] *See* PPACA Section 1401.

[6] *See* PPACA Section 1412.

[7] If an employer-sponsored plan requires a contribution from members that exceeds 9.5% of the individual's modified adjusted gross income, then the employee may be eligible as a "qualified individual" for the tax credits available via

the insurance exchange.Exchange. Again, such persons would still need to meet the other eligibility requirements (e.g., have adjusted gross incomes between 100-400% FPL, etc.) -- and they must not be enrolled in the employer's plan. *See* new Internal Revenue Code Section 36B(c)(2)(C) as added by PPACA Section 1401(a). Presumably, an otherwise-qualified individual could disenroll from the employer plan and purchase insurance via the insurance exchangeExchange in a subsequent month; however, HHS may elect to impose a look-back requirement so as to exclude persons who recently and voluntarily dropped employer-sponsored insurance. *See* Congressional Research Service Report R41137, "Health Insurance Premium Credits Under PPACA (P.L. 111-148)" (April 6, 2010), available online at http://liberalarts.iupui.edu/economics/uploads/docs/jeanabrahamcrscredits.pdf.

[8] If an employer-sponsored plan requires a member contribution that is between 8.1 and 9.8% of the individual's modified adjusted gross income, and the individual is not a member of the plan, then the individual may qualify for a free choice voucher from the employer. Essentially, the value of the vouches is equivalent to the employer's costs for providing coverage, and the individual can use these funds to purchase any qualified health plan available via the insurance exchange.Exchange. Note, though, that such persons would still need to meet the other eligibility requirements (e.g., have adjusted gross incomes between 100-400% FPL, etc.). *See* PPACA Section 10108. An individual cannot simultaneously be eligible for the tax credits as well as the free choice vouchers. PPACA Section 10108(h)(1),

[9] *See* PPACA Section 1511 *et seq.*; Congressional Research Service Report R41159, "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.

[10] *But see* p. 1 of Tennessee's response to HHS request for comments on insurance exchanges, which is available online at www.tn.gov/nationalhealthreform.

[11] *See* p. 14 of Tennessee's response to HHS request for comments on insurance exchanges, which is available online at www.tn.gov/nationalhealthreform.

[12] *See* PPACA Section 1331(a). For reference, the Basic Health Plan allows states to serve persons with modified adjusted gross incomes between 133-200% FPL. States would receive 95% of value of tax credits that an individual would otherwise get. However, the Basic Health Plan may require an expansion of CoverTN's covered services (e.g., maternity, pharmacy, rehabilitative services). As we noted on p. 5 of our comments to HHS regarding the insurance exchanges, "States that currently operate medical assistance programs for non-elderly, non-disabled childless adults may benefit from a potential new revenue stream in the form of the tax credits for the Basic Health Plan. It is unclear to us as to whether and how other States (i.e., those that do not operate such programs) would benefit -- or how the Basic Health plan may expand access or choice among lower-income residents in those States. We would appreciate some additional policy analysis and guidance on this point."