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.