

Dear ***,

The federal health reform law, known as the Affordable Care Act, provides an unequalled opportunity in coming months to improve the lives of Tennesseans. Tennessee officials will be working between now and 2014 to implement health reform. How well reform will work in Tennessee depends on decisions the state makes, and actions it takes, in the coming months. Citizens and organizations should become involved *now* by participating in the development of policies that will affect Tennesseans for many years to come.

Health reform will:

- Provide financial security by capping the amount a family has to spend for medical care;
- Extend affordable coverage to 600,000 children and adults in working families who now lack insurance;
- Eliminate unfair practices in the insurance market;
- Make health insurance more affordable for small businesses and other employers;
- Invest billions in federal funds in sustaining and improving Tennessee's rural and urban health care infrastructure;
- Improve health care quality and efficiency;
- Lower long term inflation in medical costs.

All Tennesseans have a stake in health reform, but these constituencies, in particular, need to be involved making reform effective:

- Organizations that help people with particular illnesses or care needs, such as cancer or heart disease;
- Health care providers that treat the underserved Tennessee families who are most in need of health coverage;
- Advocates for seniors and children, for whom the availability, quality and affordability of care are important life issues;
- Human service agencies, because health reform is important to those they serve.
- Education advocates, because the billions in federal funding available under the Affordable Care Act, can help relieve severe pressures to trim education budgets.
- Faith communities, who value compassion and justice.

Please join with non-profit agencies, community groups and individuals across Tennessee that are working together to support effective implementation of health reform. They have developed a set of principles to guide the design of the new insurance exchanges through which individuals and small businesses will obtain affordable coverage. We believe these principles reflect the values of Tennesseans and will ensure the success of health reform in our state. We invite you to join with us in helping to ensure that Tennessee adheres to these principles as our state implements health reform. We invite your questions and welcome the opportunity to discuss what health reform means for your organization and those it serves. We look forward to working with you in the year ahead.

Explanation of Guiding Principles for the Tennessee Health Insurance Exchange

1. VIABILITY: The Health Insurance Exchange (Exchange) will be designed to succeed — attractive to both consumers and insurers, well regulated, and financially stable.

To remain viable, the Exchange must work for all stakeholders—health care consumers and providers as well as insurers. This entails that all health plans available through the exchange adhere to regulations consistent with consumer protections promulgated by the U.S. Department of Health and Human Services, in accordance with medical necessity standards and with principles of sound risk management.

Traditionally, the health insurance industry in the United States has used a variety of strategies to guarantee profits for companies and shareholders at the expense of consumers and safety-net providers: increase premium rates; limit enrollment by denying, restricting or rescinding coverage; reduce or limit benefits; and/or establish different risk pools to limit the insurer’s exposure to very expensive beneficiaries. Such practices have differed from state to state, but all were legal in a number of jurisdictions before enactment of the Affordable Care Act (ACA) on March 23, 2010.

Limiting private health coverage in these ways has shifted health care costs to governments, hospitals, safety-net providers, and consumers. Continuing medical inflation has made such cost-shifting unaffordable for all parties. For example, between 2000 and 2008, the number of people in families spending over 10% of their pre-tax income on health care costs increased by nearly 19.9 million—equal to the population of 16 states plus the District of Columbia (Families USA, 4/2009). Since then, Americans have continued to pay higher amounts each year for insurance premiums and cost sharing. Indeed, medical bills have become the main reason for personal bankruptcies, even for those with health insurance.

ACA established health insurance protections in an attempt to right the balance between insurers and the insured, thereby increasing the likelihood that private and public health insurance systems will cover a greater proportion of the uninsured population and remain viable over the long term. On January 1, 2014, the American people will no longer be subject to exclusions for pre-existing medical conditions or arbitrary rate increases when they get sick or have an accident, nor will they be subject to annual or life-time benefit limits. Through the Exchanges, individuals and small employers will be able to compare a variety of coverage options among plans, all of which must offer a set of mandatory (“essential”) benefits, with annual limits on out-of-pocket expenses for enrollees.

Under ACA, insurers are required to spend no less than 85% of premium revenues to pay for medical services in the small and large group market, and no less than 80% in the individual market. Ensuring that health plans meet these mandatory medical loss ratios (MLR) and that brokers’ commissions are not inappropriately calculated as part of the MLR are among the challenges that designers and regulators of Tennessee’s Health Insurance Exchange face to ensure both the affordability of the health plans and their long term financial viability.

2. RISK POOLS: The Exchange will ensure adherence to standards that prevent adverse selection of enrollees in health insurance plans within and outside the Exchange.

The Affordable Care Act includes a number of measures to make sure that exchanges don’t suffer from adverse selection (in which sicker people enroll in coverage through the exchange, leaving healthier, lower-cost enrollees in the outside market):

- Insurers must put all small group enrollees in the same risk pool if they purchase the same plan, regardless of whether they purchase it inside or outside the exchange.
- Insurers must put all individual enrollees who purchase the same plan in the same risk pool,

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regardless of where they buy coverage. (These pools may be further combined if a state merges the small group and individual markets.)

- If the same health plan is sold in and outside the exchange, the premium must be the same in both places.
- The law creates a risk adjustment system to compensate plans that have a disproportionate number of sicker enrollees, whether the plan is in or out of the exchange.

(Families USA, 4/2010)

However, even with these protections, there are a number of ways that adverse selection may occur in the exchange. There are a number of extra protections that states can consider to prevent this from happening:

- ***Make the rules for any insurance markets outside the exchange consistent with rules that apply inside the exchange.*** For example, require that consumer protections pertaining to plan marketing, provider networks, disclosure of plan and rate information, and quality standards apply in the outside market as well to health plans offered through the exchange.
- ***Require insurers to offer the same products inside and outside the exchange.*** Plans in the exchange can only sell bronze level and catastrophic plans if they also sell more comprehensive silver and gold plans. Applying these requirements to insurers outside the exchange as well will prevent companies from selling only thin coverage in the outside market as a way to attract younger and healthier people out of the exchange. Moreover, require insurers selling plans outside the exchange to comply with the same restrictions that govern them when they sell plans in the exchange regarding the sale of less comprehensive coverage. Take steps to make sure that brokers do not have incentives to direct people away from the exchange. Prohibitions on higher broker commissions for selling plans in the outside market (versus the exchange) can help address this potential problem.
- ***Merge the individual and small-group markets over time.*** Having a larger risk pool could attract more insurers to the exchange and spread risks better among enrollees. It could also help reduce administrative costs. Combining markets may cause some shifts in premiums (for example, increased rates for small employers and lower rates for individuals), so the state may want to study the effects of merging these markets before proceeding. States can also wait a few years after the exchange starts to merge the markets, leaving time for both the small group and individual markets to adjust to the new rating rules under the Affordable Care Act.
- ***Ensure that risk-adjustment and risk-pooling requirements work effectively.*** Will the state prohibit insurers that do not sell in the exchange from operating outside the exchange? Requiring the same insurers, or even the same products, in both markets would have a large impact on preventing adverse selection, although it may not be possible if the state wants to pursue a selective contracting arrangement to limit the number of plans sold in the exchange.

“Adverse selection could cause instability in, and even failure of, insurance exchanges over time. Some prior attempts by states to establish health insurance pools similar to the new exchanges have suffered from high premiums and faltering insurer participation after sicker people with greater health costs concentrated in them.” (CBPP, 8/17/10)

Tennessee must find a way to balance stakeholder interests and spread risk. For example, we may want to consider the risk pooling mechanism of AccessTN, which spreads risk among all Tennesseans with health insurance.

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3. CONSUMER REPRESENTATION: The Exchange will ensure that consumers — individuals, families, and small businesses — are well represented in the development of all policies and procedures related to the Exchange.

In this instance, the term ‘consumer’ refers to a wide range of individuals who will be impacted by the health exchanges, including consumers of physical and mental health services, those with disabilities who may require special accommodations in order to access the exchange system, and small business owners and employees who will be utilizing the exchanges. Purposefully including consumers in the planning and implementation of the exchanges will allow the end product to be more responsive to the needs of the people it supports and will improve service quality. Consumer participation is also a means to equalize the relationship between program administrators and individual users. Bringing consumers to the table in all phases of development and implementation will foster consumer confidence and support of the end product.

4. GOVERNANCE: The Exchange will be governed in accordance with standards of transparency and public accountability to insulate it from undue commercial or political pressure.

Whether Tennessee’s Health Insurance Exchange is established as a not-for-profit entity or created as an additional government entity under an existing department (e.g., the Department of Commerce and Insurance), the Exchange should be operated as transparently as possible by complying with all of Tennessee Sunshine Laws. The Exchange shall incorporate either by reference or by statute the federally-required Exchange functions and oversight responsibilities. Senior leadership of the Exchange, whether it be the board members or the Executive Level staff, shall operate the Exchange in a manner that maximizes health insurance coverage for the consumers while ensuring the financial solvency of the Exchange through due diligence and high ethical standards.

5. COVERAGE OPTIONS: The Exchange will provide a manageable number of choices among high-quality, affordable health plans with concise, comparative information on the benefits and costs of options, including geographic service area and provider specialties.

As consumer representatives, we have seen first hand in the Medicare Part D program how having too many choices creates confusion rather than clarity. When people face too many plan choices, particularly if the choices aren’t truly distinct, it becomes harder for them to make a good, informed decision. This problem was encountered by many Medicare Part D enrollees, who were overwhelmed by the large number of prescription drug plan choices in their region. As a result, starting in 2011, the Centers for Medicare and Medicaid Services (CMS) will limit the number of Part D plans that insurers can offer in each region. Contracting only with selected plans can ensure that each plan offered in the exchange provides a valuable, distinct choice for consumers so that they can make informed decisions based on their individual needs. Consumers would rather have 5 or 6 good comparable choices rather than 30 confusing choices.

Another important consideration is transparency with regard to the availability of particular medical specialty services in different geographic service areas. As we have seen in TennCare, in some rural areas the dearth of specialists, including orthopaedists and endocrinologists, has limited timely access to needed medical care.

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6. ENROLLMENT PROCESS: The Exchange will make eligibility determination, enrollment, and renewal or change of health coverage simple, seamless, and consumer-friendly, requiring a single application for all health plan options, including TennCare and CoverKids.

Under the Affordable Care Act:

- The Secretary of Health and Human Services (HHS) will establish a system that will allow individuals and families to apply for whichever forms of assistance they are eligible: premium tax credits (for coverage through state exchanges), Medicaid, or CHIP. Applicants will be screened for eligibility for all three programs and will be referred to the appropriate program for enrollment.”
- The Secretary of HHS will provide states with a single, streamlined application form for all three programs. States may also use their own forms, subject to HHS approval.
- Individuals must be able to submit their application online, in person, by mail, or by phone. They will be able to file applications with either the agency that administers the state exchange, or with the state Medicaid or CHIP agency. (Families USA, 8/2010)

In addition to determining eligibility, the Exchange will determine subsidies for individuals and families with modified adjusted income below four times the federal poverty level (CBO, 11/20/2009).

7. ESSENTIAL HEALTH BENEFITS: The Exchange will ensure that health plan enrollees have access to physical and behavioral health services that adhere to guidelines developed by the American Academy of Pediatrics, the Institute of Medicine, and the Substance Abuse and Mental Health Services Administration.

Ensuring access to essential health benefits is a core focus of health insurance exchanges. Benefits provided through the Exchange must include appropriate preventive, diagnostic, therapeutic, and care coordination services for individuals and families with a variety of health conditions, including acute or chronic illness and behavioral health problems. Covered services shall be deemed appropriate according to their adherence to standards to be established by the U.S. Department of Health and Human Services, based on guidelines developed by/ in collaboration with the American Academy of Pediatrics (AAP), the Institute of Medicine (IOM), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

An essential benefit package for Tennessee must provide services specifically geared toward children, including prenatal and postnatal care, pediatric oral and vision care, and habilitative services. Beyond the essential benefit package, a Tennessee exchange plan must provide children with a comprehensive package of preventive care services, including immunizations, well-child visits, vision and hearing tests, health and behavioral assessments, dental care, and developmental screenings, all with no cost sharing. Subsequent treatment for identified illness or conditions should be incorporated into the plan to ensure that every child is healthy. Parents should be informed that optimal health involves a trusting relationship between the health professional, the child, the family, and the community as partners in health practice. Similar to the Early and Periodic, Screening Diagnosis and Treatment (EPSDT) requirement of Medicaid for children, early detection, intervention and treatment promotes healthier long-term outcomes for children.

All health plan enrollees must have access to appropriate psychosocial and pharmacological interventions for behavioral health problems—mental illness and/or substance use disorders. Behavioral health services are provided by primary care practitioners, psychiatrists, psychologists,

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psychiatric social workers, paraprofessionals and peer counselors, optimally working in multidisciplinary clinical teams. These services must include individualized, community-based resources for the long-term recovery of persons with severe mental illness/ severe emotional disturbance and/or substance dependence. Psychiatric services must include evaluation, stabilization, and medication monitoring. Substance abuse services should be provided by or under the guidance of certified chemical dependency professionals. Effective treatment systems include integrated care for co-occurring mental illness and substance use disorders; motivational enhancement counseling for persons with substance dependence to reduce health risks and work toward readiness for behavioral change; and active involvement of consumers in planning and delivery of services. All health plans must cover behavioral health care in parity with medical care.

8. PROVIDER NETWORK: The Exchange will foster broad access to comprehensive health care of high quality through a diverse, robust network of health care providers.

Having health insurance isn't helpful to patients if quality health care providers who accept the insurance aren't readily available to them when needed. This is particularly true when insurance plans contract with networks of physicians through health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Access to quality care can be especially challenging in rural and other underserved areas of Tennessee. Primary care physicians and midlevel practitioners are often limited in number, and hospitals and specialty care are frequently unavailable locally. If those providers are not included in the health insurance networks, access becomes even more problematic; the distance required to travel for even basic health care needs may not be feasible for many patients.

The Exchange must assure that all enrollees have a choice of plans with networks of quality health care providers within a reasonable geographic distance. Comprehensive primary care and basic specialty care services should be readily available to all. More advanced specialty care will generally be less readily accessible, but should still be available to all who are enrolled.

The Exchange must facilitate the recruitment of high quality providers into the insurance plan networks, and must vigorously monitor insurance plans within the Exchange to assure that an adequate system of quality health care providers is accessible to all enrollees.

Explanation of Guiding Principles for the Tennessee Health Insurance Exchange

Sources consulted in preparing explanation of guiding principles:

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