



**State of Tennessee  
Insurance Exchange Planning Initiative**

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**Best Alternatives to a  
Federal Insurance Exchange  
in Tennessee**

*A Summary of Stakeholder Feedback*

**EXECUTIVE SUMMARY**

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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](mailto: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](http://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).

To this end, the individual exchange would either:

- 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.

In contrast, the SHOP exchange may:

- 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 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 a 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.