



Questions and Answers for the 2010 AccessTN Company Assessment

1) What is the schedule for the 2010 AccessTN Assessment?

The planned schedule is:

2009

December 31 Date as of which Covered Lives Counted in Data Call for 2010 Assessment

2010

April 30 2010 Data Call Notices Mailing to be completed by State

May 31 Data Call (Health Benefit Plan Reporting Forms and Worksheets) Due

June –August State Reporting Reconciliation Period

September 30 2010 Assessment Set – AccessTN Board Meeting

October 15 2010 Notices of Proposed Assessment mailed

November 16 Challenge Period ends 30 days after Proposed Assessment mailed

December 1 Notice of Assessments Target Mail Date

December 31 Date as of which Covered Lives Counted for 2011 Data Call

2011

January 31 Payments Due (or 60 days from Notice of Assessments, if later)

February 15 Notice of Non-compliance for 2010 Assessment

This schedule is subject to change but provides the sequence of assessment activities. AccessTN may also vary this timeline slightly for individual companies (Reporting Entity), such as when AccessTN requests additional information from that company.

Introduction to the AccessTN Programs

2) What is AccessTN?

AccessTN is a nonprofit state entity which offers health coverage of last resort to those who cannot get other insurance because of their health status. It is one of 35 State High-Risk Pools in the country that performed this function in 2009.

AccessTN is part of the **Cover Tennessee** family of programs for uninsured Tennesseans. It is the only Cover Tennessee program that utilizes annual assessments for a portion of its funding.

3) Is Cover Tennessee a newer version of TennCare?

No. TennCare is a medical assistance entitlement program regulated by federal Medicaid guidelines. In contrast, AccessTN is Health Coverage which acts as insurance. The Cover Tennessee programs

have been built specifically to help Tennesseans who do **not** qualify for TennCare or who have been going without health insurance, and in many cases, without health care.

4) What is the connection between AccessTN and the old TCHIP insurance?

None. Tennessee Comprehensive Health Insurance Pool (TCHIP) was Tennessee's state high risk pool until 1994, when TCHIP's approximately 4,500 members were allowed to transition into TennCare. AccessTN is again Tennessee's high risk pool, but AccessTN is a new nonprofit state entity since 2006 and is structured and financed differently than TCHIP.

5) What is the total cost of AccessTN?

The total cost will depend upon the cost of medical claims for our members. The State has appropriated a total of \$23 million in recurring annual funding for AccessTN. The industry assessment will provide additional funding as necessary, up to the amount of the State appropriations for AccessTN.

6) How many members will AccessTN have?

A thirteen member Board of Directors (Board), representing the public and various parts of the health care and insurance businesses, governs the AccessTN program. The Board is chaired by the Commissioner of Finance and Administration (F&A). The Board limits AccessTN enrollment to the number of members that AccessTN has the financial capacity to insure.

The Board has set an initial enrollment capacity of 6,000 members. As of March 2010, AccessTN had approximately 4000 members. The Board will periodically review this enrollment capacity, based on member medical claims and program expenses relative to total funding available from policy premiums, assessments, State appropriations, and any federal grant funds.

Introduction to the AccessTN Assessment

7) Where is the money coming from to pay for AccessTN?

Funding will come from a variety of sources, including:

- Premiums paid by individuals;
- Premium assistance paid by the State;
- Coinsurance and other cost-share by members;
- State Funds for part of operating costs and reserves;
- Federal seed grant to start the program; and
- Assessment on the insurance industry for part of operating costs and reserves.

8) What is the authority for AccessTN to conduct an assessment?

T.C.A. § 56-7-2911(a) says that the deficit incurred by the pool shall be funded through state appropriations and an assessment on Insurers, Insurance Arrangements and Third Party Administrators (TPAs). The Board is authorized to determine the amount and allocation of any assessments and advance interim assessments on Insurers, Insurance Arrangements and TPAs, subject to approval by the Commissioner of Finance and Administration (F&A). The Commissioner shall have the authority to assess Insurers, Insurance Arrangements, and TPAs, and to make advance interim assessments as may be reasonable and necessary for the pool's organizational and interim operating expenses.

AccessTN will only assess for lives it offers Health Coverage as the State High Risk Pool. Any Covered Lives receiving Health Coverage through the federal risk program, when it begins, will not be part of this Assessment.

9) Who handles the assessment?

AccessTN staff, within the F&A Benefits Administration Division, will administer the assessment as authorized by the Board and the Commissioner of Finance and Administration. The Tennessee

Department of Commerce and Insurance (TDCI) will review whether an assessment will create a hazardous operational or financial condition for any insurer.

10) What companies can be assessed for AccessTN?

Any company (Reporting Entity) providing or paying for Health Coverage for Tennessee Covered Lives will be assessed. An Insurer, Health Plan, Reinsurer, Insurance Arrangement, or Third Party Administrator can be assessed for AccessTN. Health Coverage is intended to include all kinds of health benefits plans. Health Coverage can be either fully Insured, self-insured, or a combination of coverage.

11) What materials should my company receive in the AccessTN Data Call packet?

The data call packet for most companies, or Reporting Entities, will include:

- A Cover Letter from the Program Director
- Mandatory Data Call and Notice of Default Assessment
- Health Benefit Plan Reporting Form, including a Covered Lives Worksheet
- Questions and Answers for 2010 Assessment

This will include companies who reported any lives in Health Coverage for the last year even if they had a net assessment of \$0 because of re-assignment of their Tennessee Covered Lives to another Reporting entity.

Some companies which had no lives in Health Coverage lines of business in Tennessee may receive a one-page form called "2010 Company Confirmation-No Tennessee Covered Lives in Health Coverage".

12) Will every company which received a Health Benefit Plan Reporting Form in 2009 receive a reporting form again this year?

No, but every Reporting Entity which reported any assessable Tennessee Covered Lives in Health Coverage (Sections 1 and 2) last year should receive a Health Benefit Plan Reporting Form again this year. Your company should receive a reporting form from us if you reported any Covered Lives in Health Coverage, even if another Reporting Entity was responsible last year for the assessment on those Covered Lives.

If you need to report Tennessee Covered Lives and do not get a reporting packet from us, please contact us at Access.TN@tn.gov or write us at AccessTN, 312 Rosa L. Parks Avenue, Suite 2600, Nashville, Tennessee 37243-1102.

Companies which had no Tennessee lives in Health Coverage products as of December 31, 2008 will be asked by letter to confirm that they have no lives in Health Coverage as of December 31, 2009.

13) Why is AccessTN asking for information on "Type of Coverage" in sections of the Covered Lives Worksheet this year?

This is NOT a required field, but is a great help in determining priority. If your company assigns Tennessee Covered Lives to another company in Section 3 through Section 6 of the worksheet, any detail your company can provide about the type of coverage or services provided by the other Reporting Entity is very helpful. The type of coverage or services information might include:

- Insurance
- Reinsurance
- Stop-loss or Excess-loss Carrier
- Administrative Services Only (ASO/TPA)
- ASO for Behavioral Health Only (BHO))

AccessTN makes every effort to assess only once for each Covered Life when multiple Reporting Entities participate in providing the same Health Coverage to the same individual(s).

It is also important that you provide us enough detail on any Reporting Entity to which you assign any of your company's Tennessee Covered Lives so that we may correctly attribute the re-assigned Covered Lives. For instance, "Blue Cross" is not sufficient for us to know which licensee of the BlueCross BlueShield Association you are referring to. Please tell us "BlueCross BlueShield of Tennessee", or "BlueCross BlueShield of Mississippi". It may also help to provide that company's contact information.

AccessTN will ONLY permit re-assignment of lives to another Reporting Entity if your company provides sufficient detail to evaluate priority of the respective company for assessment.

14) What counts as "Health Coverage"?

"Health Coverage" has a specific meaning for purposes of the AccessTN assessment. "Health Coverage" is any type of individual or group health benefit plan or other Health Coverage. It is **not** just Health Coverage by an Insurer. It also means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes health care services, whether by insurance or otherwise. Note: AccessTN refers to "health insurance coverage" as "Health Coverage" to reduce confusion with health insurers regulated by the State of Tennessee.

15) What is a "Covered Life" for purposes of the AccessTN assessment?

A Tennessee "Covered Life" is a Tennessee resident in a health benefit plan which counts as Health Coverage, even if the coverage was issued in another state. This includes employees on employer coverage, individual policyholders, subscribers, members, or association group (non-employee) certificate holders. It also counts all dependents in these health benefit plans. For purposes of assessment, a Covered Life will be counted as of December 31st of the prior year, even if that individual is no longer covered by the same health benefit plan when the assessment is made. The intent of the assessment is to make sure that the same individual is only counted once for a particular Health Coverage product.

16) What types of insurance are not deemed Health Coverage?

Generally, insurance for which health benefits are only incidental or supplemental to other types of coverage are excluded from Health Insurance Coverage by the statute. Health Coverage does **NOT** include the following insurance product lines: Accident Only, Auto Policy Medical Payment/PIP or Auto Policy Optional Medical With/Without Fault, Credit Only, Dental/Vision Only, Disability Only, General Liability Only or Medical Supplement to Liability Insurance, Long Term Care policies, or Worker's Compensation Coverage.

17) Are there any kinds of Health Coverage excluded from the AccessTN assessment?

Yes, in addition to those policies NOT deemed Health Coverage, some policies and health plans which constitute Health Coverage are excluded from the assessment by statute or the AccessTN Board of Directors. Medicaid (TennCare), State Children's Health Insurance (CoverKids), CHAMPUS, TRICARE, Medicare, including Part D, Medicare Supplement, and Medicare Advantage Plans, are excluded. No TPA, health plan, or fiscal intermediary providing those benefits will be assessed for its Covered Lives in those lines of business.

Hospital indemnity or other fixed indemnity policies, Cancer or other Specified Disease-Only policies are **not** included in the net count for purpose of the AccessTN assessment.

Lives covered by these types of Health Coverage products are reported on the 2010 Health Benefit Plan Reporting Form, in Section 1 of the Worksheet, but will **not** be included in the gross (Section 2 of the worksheet) or net count (Box A) of Covered Lives for purposes of the AccessTN assessment.

18) What about limited benefit plans?

Only specified limited benefit types are excluded from the assessment. The excluded plans are Cancer-only or other single disease only coverage, dental only, or vision only. However, "mini-med" health plans or other limited health plans ARE Health Coverage for purposes of assessment, and they will be subject to the AccessTN assessment.

19) What does the term “Reporting Entity” mean as used in the Covered Lives Worksheet for the Health Benefit Reporting Form?

“Reporting Entity” is a term we use in these materials for any company which has a duty under the Access Tennessee Act to report its Covered Lives in Tennessee for the purpose of assessment. Reporting Entities include companies offering Health Coverage to Tennesseans as an Insurance Arrangement, a Third Party Administrator, an Insurer (including Insurers, Re-insurers, Excess and Stop-loss Carriers) or a combination of coverage. Companies can be Reporting Entities whether or not they are based or licensed in Tennessee and whether or not the Health Coverage that they provide is contracted for in Tennessee or another State.

AccessTN makes every effort to assess only once for each Covered Life when multiple Reporting Entities participate in providing the same Health Coverage to the same individual(s).

It is also important that you provide us enough detail on any Reporting Entity to which you assign any of your company’s Tennessee Covered Lives so that we may correctly attribute the re-assigned Covered Lives. For instance, “Blue Cross” is not sufficient for us to know which licensee of the BlueCross BlueShield Association you are referring to. Please tell us “BlueCross BlueShield of Tennessee”, or “BlueCross BlueShield of Mississippi”. It may also help to provide that company’s contact information.

AccessTN will ONLY permit re-assignment of lives to another Reporting Entity if your company provides sufficient detail to evaluate priority of the respective company for assessment.

20) What counts as an “Insurer” for purposes of assessment?

“Insurer” includes, but is **not** limited to, an insurance company, a health maintenance organization, a preferred provider organization, a hospital and medical service corporation, a surplus lines insurer, an insurer providing stop-loss or excess-loss insurance to a group health plan, a Reinsurer reinsuring health insurance in this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

21) What counts as an “Insurance Arrangement”?

For purposes of assessment, “Insurance Arrangement” means any plan, program, contract or other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or Third Party Administration, health care services or benefits other than through an Insurer. Insurance Arrangement shall include any plan described in T.C.A. § 56-2-121(a) as well as Farm Bureau coverage, Multiple Employer Welfare Arrangements (MEWAs), and self-insured health benefit plans for single Employers and other self-funded entities.

22) What is a “Third Party Administrator”?

For purposes of the assessment, a “Third Party Administrator” (TPA) means any entity that, on behalf of an insurer or insurance arrangement, provides Health Coverage to individuals in Tennessee, receives or collects charges, contributions or premiums for, or adjudicates, processes or settles claims in connection with, any type of health benefit provided in or as an alternative to health insurance coverage. Sometimes, “Administrative Services Only” (ASO) will be used to describe this business.

23) Do all Self-insured Employers have to file a Health Benefit Plan Reporting Form?

No. Self-insured employers (Insurance Arrangements) generally do NOT have to file a Health Benefit Plan Reporting Form with AccessTN under current guidelines IF another Reporting Entity (e.g. Insurer, Reinsurer, Stop-Loss or Excess-loss Carrier, or Third Party Administrator) is providing or administering the group’s Health Coverage and that entity fully reports for the employer group’s Covered Lives.

In most instances, AccessTN can determine the assessment priority for the Health Coverage of the self-insured employer group from the Health Benefit Plan Reporting Forms filed by its benefit plan administrators. AccessTN may seek additional information from the employer group if needed.

AccessTN will work with all Reporting Entities to assure that we assess only once for each Tennessee Covered Life in the employer’s group.

Insurance Arrangements must file a Health Benefit Plan Reporting Form **IF** they provide the Health Coverage and all related benefit and administrative services for their own group.

Also, Multi-Employer Welfare Arrangements and certain other Insurance Arrangements identified by AccessTN must report their Covered Lives by the Health Benefit Plan Reporting Form when requested by AccessTN

24) What happens if there are multiple companies involved in providing a health benefit plan?

The Covered Lives Worksheet included with the 2010 Health Benefit Plan Reporting Form establishes priority among the different entities, based upon the AccessTN statute and Board of Director guidelines, such that only one entity will pay for each covered life for a health benefit plan.

25) What is the priority of Reporting Entities for purposes of assessment?

The Access Tennessee Act establishes the following priority, in instances when multiple entities are providing the health benefit plan for the same individual:

(1) Insurer, in order of priority:

- (a) Primary insurers;
- (b) Primary re-insurers; and
- (c) Re-insurers, Stop-loss, or Excess carriers.

(2) If no Insurer, the Third Party Administrator (TPA).

(3) If no Insurer or TPA, the Insurance Arrangement (self-insured MEWA or single employers, directly or by trust).

The higher-ranked entity pays the assessment and the lower ranked entity will report the covered life but then subtract the covered life from its net count for the AccessTN assessment.

For example, consider a self-insured plan (Insurance Arrangement) that is administered by a TPA but also has stop-loss coverage with a different company for those individuals whose medical claims exceed a certain claims level. In this case, the stop-loss carrier would be primary and will include the Covered Lives of that group in its net count of Covered Lives subject to assessment. The TPA would list the lives on its Covered Lives Worksheet, but would subtract those lives covered by the Stop-loss carrier for the box reflecting the TPA's net assessable lives. Please refer to examples for additional information and clarifications.

26) Is the employer group or Reporting Entity responsible for payment of the assessment?

That will depend upon the financial arrangements between the employer group or individual and the Reporting Entity. The Access Tennessee Act makes the assessment payable by Insurers, including Reinsurers, Stop-loss or Excess-loss carriers, and by Insurance Arrangements and Third Party Administrators (see T.C.A. § 56-7-2911(a)(2)(A)). It also establishes priority among those parties for the assessment.

27) How is the amount of the assessment determined?

After the AccessTN Board determines the AccessTN program's operating deficit for the prior fiscal year (July – June) and the amount of funding needed to pay for the program operations for the next fiscal year (if any), the Board will determine the aggregate assessment amount. The aggregate assessment amount will be numerator of the assessment for the current year. The total number of Tennessee Covered Lives from all reporting entities will become the denominator. The resulting number is the assessment per covered life.

For example, if the operating deficit for FY2010 was \$1,000,000, and the Board determined that the anticipated operating deficit for FY2010 would be \$2,000,000, the combined aggregate assessment amount could be \$3,000,000.

And if the Assessment data call determined the aggregate number of Tennessee Covered Lives to be 3,000,000 lives, the assessment would be \$1.00 per net Covered Life reported by each Reporting Entity.

28) How much does each Reporting Entity have to pay?

Each Reporting Entity would pay a total assessment based upon its net number of Tennessee Covered Lives (Box A of the Covered Lives Worksheet) multiplied by the determined assessment per Covered Life. For example, if Company X reported 30,000 lives in Box A of its Covered Lives Worksheet, its total assessment (using the \$1 assessment per Covered Life from above) would be \$30,000.

29) Can you give some examples of how AccessTN will determine who will pay for the covered life when there are multiple entities involved in the coverage?

Yes, three illustrations that follow show how the Covered Lives Worksheet would treat various entities. The columns of the table provide examples of how the various Reporting Entities would report their lives according to Lines 1-5 and Box A.

Illustration 1: Fully-insured Single Group

Company E is an Employer providing fully-insured group health benefits for 5000 employees through Insurance Company I. T is a Third Party Administrator who administers enrollment and pays claims for I. R is a Reinsurer licensed in Tennessee who will reimburse Company I for covered claims of any of E's covered employees above an attachment point of \$50,000.

Covered Lives Worksheet Section in Calculation for Box A	Worksheet Calculation	Ex. #1 Company E	Ex. #2 Company I	Ex. #3 Company T	Ex. #4 Company R
Reporting Entity Type		N/A	Insurer (First payer)	Third Party Administrator	Insurer (Reinsurer)
Line 1 – Excluded lines Covered Lives	Total Covered Lives in excluded types of Health Coverage	0	0	0	0
Line 2 – Assessable Covered Lives	Total Covered Lives in assessable types of Health Coverage	0	5,000	5,000	5,000
Line 3 – TPA Lives counted by another Reporting Entity	Subtract Insurer Covered Lives from Line 2	0	0	5,000	0
Line 4 – Insurance Arrangement Lives counted by another Reporting Entity	Subtract TPA or Insurer Covered Lives from Line 2	0	0	0	0
Line 5- Reinsurer Lives counted by Primary Insurer	Subtract Primary Insurer Covered Lives from Line 2	0	0	0	5,000
Line 6 – Behavioral or Mental Health Only counted by another Reporting Entity	Subtract Behavioral or Mental Health Covered Lives Only from Line 2	0	0	0	0
Box A- Net Covered Lives Subject to Assessment for Reporting Entity	Remainder after subtracting Lines 3, 4, 5, and 6 from Line 2	0	5,000	0	0

Illustration 2: Self-insured Single Group

Assume that G is a trust providing self-insured group health benefits for 6,000 employees of an affiliated Company E. Company T is a Third Party Administrator who administers enrollment and pays claims for E. R is a Re-insurer licensed in Tennessee who will reimburse E for covered claims of any of E’s employees above and attachment point of \$50,000.

See table below illustrating the assessment calculation for each Reporting Entity. Each Column indicates how that Reporting Entity would complete its Covered Lives Worksheet.

Covered Lives Worksheet Section in Calculation for Box A	Worksheet Calculation	Ex. #5 Company E	Ex. #6 Company G	Ex. #7 Company T	Ex. #8 Company R
Reporting Entity Type		N/A	Insurance Arrangement	Third Party Administrator	Insurer (Reinsurer)
Line 1 – Excluded lines Covered Lives	Total Covered Lives in excluded types of Health Coverage	0	0	0	0
Line 2 – Assessable Covered Lives	Total Covered Lives in assessable types of Health Coverage	0	6,000	6,000	6,000
Line 3 – TPA Lives counted by another Reporting Entity	Subtract Insurer Covered Lives from Line 2	0	0	6,000	0
Line 4 – Insurance Arrangement Lives counted by another Reporting Entity	Subtract TPA or Insurer Covered Lives from Line 2	0	6,000	0	0
Line 5- Reinsurer Lives counted by Primary Insurer	Subtract Primary Insurer Covered Lives from Line 2	0	0	0	0
Line 6 – Behavioral or Mental Health counted by another Reporting Entity	Subtract Behavioral or Mental Health Covered Lives from Line 2	0	0	0	0
Box A- Net Covered Lives Subject to Assessment for Reporting Entity	Remainder after subtracting Lines 3, 4, 5, and 6 from Line 2	0	0	0	6,000

Illustration 3: Companies with multiple product lines and types of business

Company I provides insurance, both individual and group, and also Third Party Administrator (TPA) services in Tennessee for self-insured companies.

As of 12/31/2009, Company I has the 50,000 Fully-insured employer group Covered Lives, 12,000 Medicare Advantage lives, 10,000 Fully-insured Individual lives; 5,000 Fully insured indemnity. Company I has 43,000 lives for which it performs services as a TPA. Those TPA Covered Lives are described below.

Company I's TPA services include coverage to 13,000 association members for Insurance Arrangement A, an association trust. Company I also provides TPA services for 30,000 members in self-insured employer groups, with all of these lives 43,000 reinsured by Reinsurer R using an attachment point of \$50,000.

Company B provides administrative services for the behavioral health only (BHO) part of the health coverage for the 13,000 association members and the 30,000 members in the self-insured employer groups for which Company I, as TPA, administers the medical portion of the Health Coverage.

See table below illustrating the assessment calculation for each Reporting Entity. Each Column indicates how that Reporting Entity would complete its Covered Lives Worksheet.

Covered Lives Worksheet Section in Calculation for Box A	Worksheet Calculation	Ex. #9 Company A	Ex. #10 Company I	Ex. #11 Company R	Ex. #11 Company B
Reporting Entity Type		N/A	Insurer (First payer)	Insurer (Reinsurer)	Behavioral Health TPA
Line 1 – Excluded lines Covered Lives	Total Covered Lives in excluded types of Health Coverage	0	12,000 <u>5,000</u> 17,000	0	0
Line 2 – Assessable Covered Lives of this Reporting Entity	Total Covered Lives in assessable types of Health Coverage	13,000	13,000 30,000 50,000 <u>10,000</u> 103,000	13,000 <u>30,000</u> 43,000	13,000 <u>30,000</u> 43,000
Line 3 – Third Party Administrator (TPA) Lives counted by another Reporting Entity	Subtract Insurer Covered Lives from Line 2	0	13,000 <u>30,000</u> 43,000	0	0
Line 4 – Insurance Arrangement Lives counted by another Reporting Entity	Subtract TPA or Insurer Covered Lives from Line 2	13,000	0	0	0
Line 5- Reinsurer Lives counted by Primary Insurer	Subtract Primary Insurer Covered Lives from Line 2	0	0	0	0
Line 6 – Behavioral or Mental Health counted by another Reporting Entity	Subtract Behavioral or Mental Health Covered Lives from Line 2	0	0	0	13,000 <u>30,000</u> 43,000
Box A- Net Covered Lives Subject to Assessment for Reporting Entity	Remainder after subtracting Lines 3, 4, 5, and 6 from Line 2	0	60,000	43,000	0

In this illustration, Insurance Arrangement A, Insurer I (as TPA), Reinsurer R and BHO B all provide benefits or services for the same 13,000 Covered Lives in their respective capacities. Company A, as

an Insurance Arrangement is the lowest priority Reporting Entity. It may subtract on Line 4 the 13,000 lives it counted on Line 2 of the Covered Lives Worksheet. Company A would have no assessment to pay for this year.

Insurance Company I (as TPA), Reinsurer Company R, and BHO Company B each provide or pay for health care benefits for the same 43,000 lives, in their respective capacities, and would report that on Line 2 of the Covered Lives Worksheet. However, the statute assigns the Reinsurer priority for the purposes of assessment.

Therefore, Company I and Company B, as TPAs, may subtract those 43,000 lives from its total on Line 3 to report its net total Covered Lives in Box A of the Covered Lives Worksheet. Company R, as Reinsurer, must count those 43,000 Covered Lives in Box A.

Note: If Company I were the primary insurer for these 43,000 Covered Lives, rather than contracted as TPA, the result would be different.

If there were no Reinsurer for the Health Coverage for these 43,000 Covered Lives, Company I would also be primary, relative to Company B, because I was the TPA for the medical benefits of the Health Coverage.

30) If there is more than one Reinsurer, which is primary for purposes of the assessment?

Sometimes a Tennessee licensed Reinsurer, which we will call the primary Reinsurer, contracts with a self-insured group or an insurer for excess-loss coverage or reinsurance and then may cede all or part of that financial risk, and sometimes certain administrative services, to another Reinsurer. We'll call the second Reinsurer the assuming Reinsurer. The secondary or assuming Reinsurer may be accredited with the State of Tennessee. The assuming Reinsurer may or may not be licensed to do primary reinsurance business in Tennessee. The Insurer or Reinsurer contracted with the benefit group and licensed to do business in Tennessee is primary for purposes of the AccessTN assessment. This is true even if the assuming Reinsurer contracts for the majority of the financial risk.

Scenario #1: If there is an Insurer which decides to reinsure part of its risk, the Insurer would be primary for purposes of the assessment. Any Reinsurer(s) would include the group's lives in its count of Covered Lives for Section 2 but would also report in Section 5 that those lives should be assigned to the Insurer for assessment. The Reinsurer(s) would have a net count of zero Covered Lives.

Scenario #2: If the group were partially self-insured (e.g. an Insurance Arrangement with reinsurance only) with a primary Reinsurer and an assuming Reinsurer, each Reinsurer would report those Covered Lives in Section 2. The primary Reinsurer would report those lives in Box A and would be financially responsible for assessment for those Covered Lives.

The assuming or accredited Reinsurer would indicate the primary Reinsurer and count on its worksheet, at Section 5, and would have a net count of zero for that group.

31) Is there a limit on how much AccessTN may assess Reporting Entities?

Yes. AccessTN cannot assess insurers and health benefit plans for an aggregate assessment amount greater amount than the aggregate amount of State appropriations for AccessTN.

32) Are there exceptions that allow a company to defer its assessment in a given year?

Reporting Entities will be required to pay their allocated portion of the assessment for all its Covered Lives in assessable Health Coverage. The only exception is when TDCI determines that the assessment for a specific insurer, insurance arrangement, or third party administrator will create a hazardous operational or financial condition for that Reporting Entity.

33) What is an advance interim assessment?

The assessment will always have two parts – the assessment to pay for the pool's deficit for the completed fiscal year and the advance interim assessment. The latter portion is the amount the Board has determined to be necessary to pay for the pool's projected deficit for the next fiscal year.

34) How does the advance interim assessment work?

Each fall, the Board will review the pool's financial results for the prior fiscal year and the actuarial estimate of medical claims for the next fiscal year. The Board will set premiums and enrollment capacity, and will review the state funding available for AccessTN operations. The Board will then set the advance interim assessment, based on the funding necessary to support the pool's operating expenses for the coming fiscal year.

With each fiscal year completed, the amount collected for that fiscal year as an advance interim assessment will be adjusted to match the actual assessment for that fiscal year. For example, if the advance interim assessment for the 2010 fiscal year were set at 40 cents per covered life, but the portion of the actual operating loss funded by the industry assessment was 50 cents per covered life, the company would receive a credit of 40 cents against this year's 50 cent assessment.

The number of Covered Lives used to calculate the advance interim assessment may have changed. Therefore, in practice, AccessTN would offset the aggregate amount due for the current year's assessment by the aggregate amount collected as the advance interim assessment the previous year.

35) What must I complete and return to the State for the Assessment?

Both the 2010 Health Benefit Reporting Form and the Covered Lives Worksheet must be completed and returned.

36) Must my company complete the 2010 Health Benefit Plan Reporting Form if it has no Covered Lives to report this year?

Yes, the 2010 Health Benefit Plan Reporting Form needs to be completed and returned even if there are no Covered Lives to report. For those companies reporting no assessable Health Coverage in Tennessee, AccessTN may direct that company to use a different reporting mechanism the next year.

37) Who do I contact with questions about the assessment?

A special email address has been set up so that AccessTN can promptly address your questions. Please write us at Access.TN@tn.gov. We will make every effort to respond to your email within one business day. You may also write us at AccessTN, 312 Rosa L. Parks Avenue, Suite 2600, Nashville, Tennessee 37243-1102.

38) When will I get a bill?

A Notice of Proposed Assessment will be sent on or about September 30, 2010 for company review. The official Notice of Assessment is scheduled to be sent on or about December 1, 2010.

39) When do I pay?

Payment is due 60 days from the Date of the Notice of Assessment and Invoice, currently scheduled to be sent December 1, 2010. Payment would then need to be received by the State on or before January 31, 2011.

40) How do I pay?

An invoice and specific payment instructions will be included in the Notice of Assessment to be sent on or about December 1, 2010.

41) What is the best way to learn more about the Cover Tennessee programs?

Information about each of the programs is also available at the Cover Tennessee website, www.CoverTennessee.gov, including information on AccessTN.

42) Does Long Term Care (LTC) count as Health Coverage?

No. Long Term Care policies are not deemed Health Coverage. LTC plans are exempt from reporting on all sections of the 2010 Health Benefit Plan Reporting Form and Worksheets, including Section 2.

43) Why did AccessTN add Section 6, about Behavioral Health Only (BHO) services, to this year's Covered Lives Worksheet?

The information in Section 6 will help us determine the priority of the respective Reporting Entities who divide coverage for behavior or mental health benefits from other medical benefits.

Coverage for Behavioral Health Only (BHO) or other mental health benefits is Health Coverage. In the event that Health Coverage for the same group is divided between two Reporting Entities of the same type (e.g. both ASO), the provider of medical services will be primary for purposes of the assessment.

Note: If the respective Reporting Entities have different levels of statutory priority for assessment - e.g. one Reporting Entity is an Insurer and one Reporting Entity is providing administrative services only (ASO) - the statutory priority will control regardless of which entity is providing BHO benefits.

44) What is the effect of the Patient Protection and Affordable Health Care Act on the Assessment?

No effect. That legislation was not enacted as of the time for which Reporting Entities are reporting covered lives – December 31, 2009.

More information will be provided in the course of next year's assessment. However, the federal risk pool has no effect on this year's AccessTN assessment. Operating losses related to the federal risk pool will be paid by the federal government.