The Department of Health and Human Services (HHS) on July 11, 2011 released two sets of proposed regulations to implement the new Affordable Insurance Exchanges ("exchanges") as required by the Patient Protection and Affordable Care Act (Affordable Care Act). The first proposed regulation outlines a framework that will enable states to build insurance exchanges and the second proposed regulation addresses standards related to reinsurance, risk corridors, and risk adjustment to assure stability in these newly established markets. This Aon Hewitt report focuses mainly on the first proposed regulation regarding building an exchange.

According to the preamble of the proposed regulation on building an exchange, the exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing power as large businesses.

Establishing a Health Insurance Exchange

The proposed regulations that outline a framework for building exchanges covers the following: 1) sets forth the federal requirements that states must meet if they elect to establish and operate an exchange; 2) outlines minimum requirements that health insurance issuers must meet to participate in an exchange and offer qualified health plans (QHPs); and 3) provides basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP). The preamble states that the "intent of this proposed rule is to afford states substantial discretion in the design and operation of an exchange." The preamble further states that this proposed rule does not address all of the exchange provisions in the Affordable Care Act and that additional guidance on the establishment and operation of exchanges will be provided in future proposed rules.

Approval of State Exchanges

In general, the proposed regulations provide that each state must receive written approval or conditional approval of its exchange plan in order to be approved to operate. Although the statute requires HHS to approve state exchanges no later than January 1, 2013, there will be systems development and contracting activities that continue to occur in 2013. To accommodate states that are making progress toward the operational date of January 1, 2014, the proposed regulations provide for a conditional approval that would presume that the state’s exchange would be operational by January 1, 2014, even if it cannot demonstrate complete readiness on January 1, 2013.

The proposed regulations also include an approval process for a state that does not have in place an approved or conditionally approved exchange plan and operational readiness assessment by January 1, 2013. The regulations propose to allow states the flexibility of seeking approval to operate an
exchange even if a state is not approved to operate by January 1, 2013. In this situation, a state electing to seek initial approval of its exchange after January 1, 2013 must comply with the standards and process set forth in the proposed regulations.

**Operating or Ceasing to Operate an Exchange After 2014**

The proposed regulations set forth standards for states electing to operate an exchange after 2014. The proposed regulations provide that a state must have in effect an approved or conditionally approved exchange plan at least 12 months prior to the first effective date of coverage. Further, the proposed regulations assume that the first effective date of coverage will fall on January 1 of any given year because of the standardized annual open enrollment periods, so the approval or conditional approval would have to be in effect by January 1 of the prior year. Conversely, the proposed regulations set standards for if a state determines after January 1, 2014 that it no longer wants to operate an exchange, in which case the state must notify HHS of its decision 12 months prior to ceasing its operations. In either situation, the exchange would have to develop a plan jointly with HHS to facilitate the transition from a federally-facilitated exchange to a state exchange or vice versa.

**Federal-State Partnerships**

According to the preamble, HHS has pursued various forms of collaboration with states to facilitate, streamline, and simplify the establishment of an exchange in every state. These efforts have shown that states may find it advantageous to partner with HHS to share business functions in order to reduce redundancy, promote efficiency, and address the tight implementation deadlines. Examples in the preamble of such shared business functions include eligibility and enrollment, financial management, and health plan management systems and services. To the extent that an exchange establishes such arrangements, the exchange remains responsible for ensuring that all federal requirements related to contracted functions are met. The preamble states that HHS is exploring different partnership models that would meet the needs of states and exchanges.

**Contracting With an Exchange**

The Affordable Care Act provides that a state may establish an exchange as a state agency or as a non-profit organization, and may choose to contract with other eligible entities to carry out various functions of the exchange. The proposed regulations provide that a state may elect to allow an exchange to contract with an eligible entity to carry out one or more responsibilities of the exchange. Eligible entities are those that are incorporated under and subject to the laws of one or more states, have demonstrated experience on a state or regional basis in the individual and small group health insurance markets and in benefits coverage, and are not health insurance issuers or treated as a health insurance issuer as a member of the same controlled group. An eligible entity may also be the state Medicaid agency.

**Stakeholder Consultation**

An exchange must regularly consult on an ongoing basis with certain stakeholders, including educated health care consumers who are enrollees in QHPs; individuals and entities with experience in facilitating enrollment in health coverage; advocates for enrolling hard to reach populations, which include individuals with a mental health or substance abuse disorder; small businesses and self-employed individuals; state Medicaid and Children’s Health Insurance Program (CHIP) agencies;
federally-recognized Indian tribes that are located within such exchange’s geographic area; public health experts; health care providers; large employers; health insurance issuers; and agents and brokers.

Transition for Existing State Health Insurance Exchanges

Unless an exchange is determined to be non-compliant, HHS will otherwise presume that an existing state exchange meets the standards if the exchange was in operation prior to January 1, 2010 and the state has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Affordable Care Act.

Navigators

Navigators conduct public education to raise awareness about the exchanges, facilitate enrollment in QHPs, and provide referrals to state agencies for enrollees with any grievances, complaints, or questions. The proposed regulations would require an exchange to award grant funds to public or private entities to serve as Navigators. Navigators must be capable of carrying out their required duties and must demonstrate to the exchange that the entity has existing relationships, or could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible to enroll in a QHP through the exchange. The preamble notes, however, that an entity need not have the ability to form relationships with all relevant groups in order to be eligible for Navigator funding. Navigators must also meet any licensing, certification, or other standards prescribed by the state or exchange, if applicable, and not have a conflict of interest during the term as Navigator.

Further, the proposed regulations provide that an exchange would have to include entities from at least two of the following categories for receipt of a Navigator grant:

- Community and consumer-focused nonprofit groups;
- Trade, industry, and professional associations;
- Commercial fishing industry organizations, ranching, and farming organizations;
- Chambers of commerce;
- Unions;
- Resource partners of the Small Business Administration;
- Licensed agents and brokers; and
- Other public or private entities that meet the requirements of this section. Other entities may include but are not limited to Indian tribes, tribal organizations, urban Indian organizations, and state or local human service agencies.

Navigators may not include health insurance issuers, and a Navigator must not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP. However, according to the preamble, these provisions would not preclude a Navigator from receiving compensation from health insurance issuers in connection with enrolling individuals, small employers, or large employers in non-QHPs outside of an exchange.
Single Streamlined Application

The Affordable Care Act requires HHS to develop and provide to each state a single, streamlined form that may be used to apply for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the basic health program (BHP), if a BHP is operating in the exchange service area, and must be structured to maximize an applicant’s ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for the programs. The proposed regulations describe a single streamlined application and standards for any alternative application developed by the exchange that incorporate both eligibility and enrollment in order to limit the amount of information and number of times an individual must make submissions to receive an eligibility determination and complete the enrollment process. If an exchange seeks to use an alternative application, it must be approved by HHS. According to the preamble, HHS plans to create both a paper-based and web-based dynamic application.

Initial and Annual Open Enrollment Periods

The regulations propose that qualified individuals and enrollees may begin or change coverage in a QHP only during the initial open enrollment period, the annual open enrollment period, or a special enrollment period for which the qualified individual or enrollee has been determined eligible.

The proposed regulations set forth the initial enrollment period as October 1, 2013 through February 28, 2014. HHS explains in the preamble to the proposed regulations that they chose to extend the initial enrollment period beyond January 1, 2014 in order to allow for outreach and education beyond the first potential date of coverage. The effective date of coverage for the initial open enrollment period is proposed to be based on the date on which the exchange receives a QHP selection from an individual to allow appropriate time for QHP issuers to process QHP selections. Therefore, under the proposed rules, for a QHP selection received by the exchange on or before December 22, 2013, the exchange must ensure an effective date of January 1, 2014. If a QHP selection is received by the exchange between the first and twenty-second day of any subsequent month during the initial open enrollment period, the exchange must ensure an effective date on the first day of the following month. If a QHP selection is received by the exchange between the twenty-third and last day of the month for any month between December, 2013 and February 28, 2014, the exchange must ensure an effective date of either the first day of the following month or the first day of the second following month.

In general, HHS proposes to apply this approach to effective dates for the annual open enrollment period and for special enrollment periods as well. In addition, the proposed regulations provide the exchange with flexibility to work with QHP issuers to implement selections received between the twenty-third and last day of the month on either the first of the following month or the first of the second following month, which allows the exchange and QHP issuers to choose to process enrollments more quickly to the extent possible.

The proposed regulations provide for an annual open enrollment period that would run from October 15 through December 7 of each year, starting in October 2014 for coverage beginning January 1, 2015. Alternatively, HHS is considering an annual open enrollment period from November 1 through December 15 of each year to provide a 45-day window close to the end of the year that would be easy to remember.

For special enrollment periods, the regulations propose a standard length of 60 days for each special enrollment period from the date of the triggering event unless the applicable regulation provides
otherwise. The proposed regulations specify the situations in which a special enrollment period must be offered. These include:

- Loss of other minimum essential coverage, and if a dependent loses other minimum essential coverage, the enrollee would be eligible for a special enrollment period as well.
- Gaining a dependent or becoming a dependent through marriage, birth, adoption, or placement for adoption.
- Gaining status as a citizen, national, or lawfully present individual in the U.S.
- Errors in enrollment caused by an officer, employee, or agent of the exchange or HHS, or its instrumentalities.
- Adequately demonstrating to the exchange that the QHP substantially violated a material provision of its contract in relation to the individual and their dependents.
- Becoming newly eligible or newly ineligible for advance payments of the premium tax credit or having a change in eligibility for cost-sharing reductions.
- Having new QHPs offered through the exchange available as a result of a permanent move.
- Special rights for Indians to join or change plans once per month.
- Exceptional circumstances as determined by the exchange or HHS, such as natural disasters.

Terminations of Coverage

Under the proposed regulations, the exchange must determine the form and manner in which coverage in a QHP may be terminated. The proposed regulations provide that an exchange must permit an enrollee to terminate his or her coverage in a QHP with appropriate notice to the exchange or the QHP. According to the preamble, HHS expects that most voluntary termination requests will generally occur in situations in which an enrollee in a QHP has obtained other minimum essential coverage.

The proposed regulations also set forth situations where the exchange may terminate an enrollee’s coverage in a QHP and must permit a QHP issuer to terminate such coverage. These situations include that: 1) the enrollee is no longer eligible for coverage in a QHP through the exchange; 2) the enrollee becomes covered in other minimum essential coverage; 3) payments of premiums for coverage of the enrollee cease, provided that the grace period for enrollees receiving advance payments of the premium tax credit has elapsed; 4) the enrollee’s coverage is rescinded; 5) the QHP terminates or is decertified by the exchange; or 6) the enrollee changes from one QHP to another during the annual open enrollment period, or a special enrollment period.

The proposed regulations would also require an exchange to establish maintenance of records procedures for termination of coverage, track the number of individuals for whom coverage has been terminated and submit that information to HHS on a monthly basis, establish terms for reasonable accommodations to individuals with mental or cognitive conditions, and retain records in order to facilitate audit functions.
Under the proposed regulations, terminations are proposed to become effective:

- On the date specified by the enrollee if termination is requested by the enrollee and the exchange and QHP have a reasonable amount of time from the date on which the enrollee provides notice to terminate coverage. If there is not a reasonable amount of time from the date the enrollee provides notice, the last day of coverage would be the first day after a reasonable amount of time has passed;
- The day before the effective date of the new coverage if the termination is by the exchange or a QHP because an enrollee obtained new minimum essential coverage. According to the preamble, this proposed provision is intended to ensure that an enrollee is not covered under two forms of minimum essential coverage simultaneously because it would make an individual ineligible for the premium tax credit;
- The day before the effective date of coverage in a new QHP if an enrollee changes QHPs; or
- The fourteenth day of the month if the notice of termination is sent by the exchange or termination is initiated by the QHP no later than the fourteenth day of the previous month or the last day of the month if the notice of termination is sent by the exchange or termination is initiated by the QHP no later than the last day of the previous month.

**Stand-Alone Dental Coverage**

The proposed regulations would require an exchange to allow limited scope stand-alone dental plans to be offered provided that the plan furnishes at least the pediatric essential dental benefit required in the essential health benefits provision. The dental plan could be offered as a stand-alone plan or in conjunction with a QHP. However, a health plan can still be certified as a QHP even if it does not offer the pediatric essential dental benefit, provided that a stand-alone dental plan is offered through the exchange. The preamble states that HHS is considering that an exchange require stand-alone dental plan issuers to comply with any QHP certification requirements deemed relevant and necessary.

**SHOP Exchanges**

Under the Affordable Care Act, each state that chooses to operate an exchange must also establish insurance options for small businesses through a Small Business Health Options Program (SHOP). The SHOP can be merged with the individual market exchange or run separately. The proposed regulations would require a SHOP to comply with all the required functions of an exchange except for those specific to the individual market such as eligibility determinations and individual premium payments. The preamble encourages SHOPs to consider options to calculate and display the net employee contribution to the premium for different plans and different family compositions, after any employer contribution has been subtracted from the full premium amount.

To qualify for a SHOP exchange, an employer must be a small employer, which is defined in the Affordable Care Act as “an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year”, with the exception that a state may elect to limit enrollment in the small group market to employers with no more than 50 employees until January 1, 2016. The preamble states that under the Public Health Services Act, employer size is determined by counting all employees, including part-time and seasonal employees. Part-time workers would be counted in the same manner as full-time workers, while seasonal employees would be counted proportionately to the number of days they work.
Under the proposed regulations, states would be permitted to allow insurers in the large group market to offer health plans inside of the SHOP beginning in 2017. In states that elect this option, large employers could make an employee eligible for the SHOP if it provides all full-time employees with the opportunity to enter the SHOP. The preamble to the proposed regulations notes that the states are required to consider “excess premium growth” outside of the SHOP when considering whether to allow large employers to purchase coverage through the SHOP. The comparison of premium variations inside and outside the SHOP may serve as a kind of “due diligence” in decision making to guard the exchanges from absorbing higher costs if they find significant variances in premiums for the larger groups that might be allowed to purchase coverage through the SHOP, relative to those employers and health plans already using the SHOP.

The proposed regulations provide that if a state merges the individual market and the small group market risk pools, the SHOP may permit a qualified employee to enroll in any QHP meeting the following requirements of the small group market: deductible maximums set forth in the Affordable Care Act and levels of coverage. If a state does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

Under the proposed regulations, QHPs in the SHOP would be required to follow the special enrollment periods required for the individual market exchanges, except for becoming a new citizen, national, or lawfully present individual and changes in eligibility or new eligibility for advance payments of the premium tax credit or cost-sharing reductions since neither are available to qualified employees in the SHOP.

The proposed regulations would allow SHOPS to choose additional ways for qualified employers to offer one or more plans to their employees. The preamble provides examples such as allowing employees to choose any QHP offered in the SHOP at any level; allowing employers to select specific levels from which an employee may choose a QHP; allowing employers to select specific QHPs from different levels of coverage from which an employee may choose a QHP; or allowing employers to select a single QHP to offer employees. The proposed regulations also set standards related to premium aggregation by the SHOP so that employers receive a single monthly bill for all QHPs and to pay a single monthly amount to the SHOP.

The proposed regulations provide that the SHOP would require all QHPs to make any change to rates at a uniform time that is either quarterly, monthly, or annually. Enrollment in a SHOP would be permitted on a rolling basis; therefore, employers would be subject to different rates based on the month or quarter in which they purchase coverage. Any rate changes would apply only to new coverage and annual renewals and would still be subject to applicable rate review justification. According to the preamble, if an employee is hired during the plan year or changes coverage during the plan year during a special enrollment period, the rates set at the beginning of the plan year must be the rates quoted to the employee.

**Standards for Certification of QHPs**

An exchange may only offer QHPs, and the proposed regulations set forth the standards for health plans to be certified as a QHP. The proposed regulations allow an exchange to determine which health plans will be certified as QHPs. Exchanges may use an “any qualified plan” strategy that would certify all health plans as QHPs solely on the basis that such plans meet and agree to comply with the minimum certification requirements. Alternatively, an exchange could undertake a competitive bidding or selective contracting process, similar to some state Medicaid programs that would limit QHP participation to only
those plans that ranked highest in terms of certain exchange criteria. An exchange may also choose to negotiate with health insurance issuers on a case-by-case basis.

The proposed regulations provide that an exchange may also implement selection criteria beyond the minimum certification standards, such as: 1) reasonableness of the estimated costs supporting the calculation of the health plan’s premium and cost-sharing levels; 2) past performance of the health insurance issuer; 3) quality improvement activities; 4) enhancements of provider networks, including the availability of network providers to new patients; 5) service area of the QHPs (the size of a service area and the amount of choice afforded to the consumers within that service area); and 6) premium rate increases from years preceding the exchange operation and proposed rate increases.

However, an exchange is prohibited from excluding a plan: 1) on the basis that the plan is a fee-for-service plan; 2) through the imposition of premium price controls; or 3) on the basis that the health plan provides treatments necessary to prevent patients’ deaths in circumstances the exchange determines are inappropriate or too costly.

A QHP issuer must offer through the exchange at least one QHP in the silver coverage level and at least one QHP in the gold coverage level as defined in the Affordable Care Act; a child-only plan at the same level of coverage as any QHP offered through the exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21; and a QHP at the same premium rate without regard to whether the plan is offered through an exchange, or whether the plan is offered directly from the issuer or through an agent.

A QHP issuer, including an issuer of a multi-state QHP, may vary premiums for a QHP or a multi-state QHP by the geographic rating area. A QHP issuer must cover all of the following groups using some combination of the following categories: individuals, two-adult families, one-adult families with a child or children, and all other families.

The proposed regulations codify the Affordable Care Act provision regarding the transparency standards for QHPs. Thus, the proposed regulations require QHPs to disclose: 1) claims payment policies and practices; 2) periodic financial disclosures; 3) data on enrollment; 4) data on disenrollment; 5) data on the number of claims that are denied; 6) data on rating practices; 7) information on cost sharing and payments with respect to any out-of-network coverage; and 8) information on enrollee rights under Title I of the Affordable Care Act.

The preamble notes that these same requirements will also apply to all group health plans and health insurance issuers in the individual and group markets under Section 2715A of the PHS Act. The preamble states that HHS will work closely with the Departments of Labor and Treasury to ensure that these reporting standards are applied appropriately across the insurance market.

**Reinsurance, Risk Corridors, and Risk Adjustment**

The second set of proposed regulations suggests standards for the establishment of two temporary programs designed to minimize the negative effects of adverse selection in the first three years of the exchanges becoming operational as well as a permanent risk adjustment program. All three programs are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets.
The transitional reinsurance program and temporary risk corridor program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented. The reinsurance program, which is a state-based program, is aimed at reducing the uncertainty of insurance risk in the individual market by making payments for high-cost cases. According to the preamble, this program will attenuate individual market rate increases that might otherwise occur because of the immediate enrollment of individuals with unknown health status, potentially including, at the state’s discretion, those currently in state high risk pools. The risk corridor program, which is a federally-administered program, is aimed at protecting against uncertainty in setting rates in the exchange by limiting the extent of issuer losses (and gains). Under the risk corridor program, an issuer of a QHP whose gains are greater than three percent of the issuer’s projections must remit charges to HHS, while HHS must make payments to an issuer of a QHP that experiences losses greater than three percent of the issuer’s projections. The preamble states that on an ongoing basis, the risk adjustment program is intended to provide adequate payments to health insurance issuers that attract high-risk populations (such as those with chronic conditions). Under this program, generally, funds are transferred from issuers with lower risk enrollees to issuers with higher risk enrollees.

Future Regulations

The preamble of the proposed regulations on implementing an exchange states that HHS intends to issue rules in the future addressing topics including, but not limited to:

- Standards for individual eligibility for participation in the exchange, advance payments of the premium tax credit, cost-sharing reductions, and related health programs and appeals of eligibility determinations;
- Standards outlining the exchange process for issuing certificates of exemption from the individual responsibility requirement and payment;
- Defining essential health benefits, actuarial value, and other benefit design standards; and
- Standards for exchanges and QHP issuers related to quality.

More Information

Both sets of proposed regulations will appear in the July 15, 2011 Federal Register. Comments on both sets of proposed rules must be submitted by September 28, 2011. In the interim, HHS intends to hold extensive consultations with interested stakeholders as well as conduct listening sessions throughout the country to gather input.


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