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ACA Impact on State Regulatory Authority: Health Plans Outside Exchanges

Section 1321(d) of the federal Patient Protection and Affordable Care Act (ACA) specifically states that "nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title" meaning that states can go beyond the federal law but if a state's laws or regulations prevent a federal law from being implemented, then that law or regulation is preempted. This document is intended to serve as a resource for states in reviewing their own state laws and regulations for flexibility when implementing the ACA.

Core Area	ACA Provisions	Clear Preemptions of State Authority	Potential Preemptions of State Authority
Licensure	ACA 1324(b)(12) states that if a CO-OP plan or a multistate plan is not subject to either state or federal licensure laws in a specific state no other health insurance coverage can be subject to state or federal licensure laws.		While the "level playing field" clause expressly contemplates that state licensing laws are preserved, even for federally established programs, HHS has the authority to determine that they are structured or applied in an "unlevel" manner, in which case the entire law is preempted as applied to private health insurance issuers.
Solvency	ACA 1324(b)(12) states that if a CO-OP plan or a multistate plan is not subject to either state or federal solvency laws in a specific state no other health insurance coverage can be subject to state or federal solvency laws.		Restrictions on rating and market practices could interfere with troubled insurers' state-approved or state-directed recovery plans. While the "level playing field" clause expressly contemplates that state solvency laws and financial requirements are preserved, even for federally established programs, HHS has the authority to determine that a state solvency or financial law is structured or applied in an "unlevel" manner, in which case the entire law is preempted as applied to private health insurance issuers.

Essential Health Benefits	ACA 2707 (a) requires individual and small group plans to ensure that coverage includes the essential health benefits package required under section 1302(a). ACA 1302(b)-All non-grandfathered individual and small group plans must provide essential health benefits	Insofar as a State does not require all the benefits included in the selected benchmark plan, the ACA requires benefits beyond those mandated under State law. Insofar as a State has mandated coverage of a benefit, which is not otherwise an EHB, since 12/31/11, 45 CFR 155.170(a)(2) requires that the State must either fund it or repeal it.	Post-2015, HHS may dictate that certain State mandates are not essential, and therefore are to be funded by the State. This may force the State to repeal mandates or apply them, if permitted under State law, in a discriminatory manner. A State may be dissuaded from adopting other mandates due to this rule.
Actuarially Equivalent Substitutions	45 CFR 156.115(b)-Substitution of benefits (other than prescription drugs) within a category of services is permitted on an actuarially equivalent basis.	Insofar as a State does not specify benefits or dictate substitution rules, the ACA dictates policy design beyond that mandated under State law.	
Actuarial Value	ACA 2707 (a) requires individual and small group plans to ensure that coverage includes the essential health benefits package required under section 1302(a). ACA 1302(d) requires all non-grandfathered individual and small group plans, other than catastrophic plans, provide benefits with actuarial values of 60, 70, 80, or 90 percent. 45 CFR 156.140 allows health plans to have a de minimis variation of +/- 2 percentage points. As proposed in 45 CFR 156.155, under limited circumstances an issuer may offer a catastrophic plan in lieu of a health plan that meets one of these levels of coverage.	Whereas current state laws may allow issuers to offer plans with any actuarial value, these provisions restrict the actuarial value of plans to 60, 70, 80, or 90 percent with a de minimis variation of +/- 2 percent.	

Cost-Sharing Limitations	ACA 1302(c) requires all non-grandfathered individual and small group health plans to have out-of-pocket limits no greater than those applicable to high deductible health plans in 2014, adjusted for premium growth. Small group plan deductibles must be limited to $2,000 individual/$4,000 family. ACA 1302(c)(2). PHSA 2707 applies the cost-sharing limitations in ACA 1302 (c)(1) and (2) to group health plans. 45 CFR 156.130(b)(3) – A health plan's annual deductible may exceed the annual deductible limit if that plan may not reasonably reach the actuarial value of a given level of coverage as defined in § 156.140 of this subpart without exceeding the annual deductible limit.	Insofar as a State does not impose limits on cost-sharing, or permits more disparity in its limitations, the ACA dictates limitations beyond those mandated under State law.	
Discriminatory Benefit Design	ACA 1302(b)(4)(B) prohibits the Secretary from defining essential health benefits in a way that would discriminate against individuals because of their age, disability, or expected length of life. 45 CFR 156.125—An issuer does not provide EHBs if its benefit design or the implementation of its benefit design discriminates based upon an individual's age, expected length of life, present or predicted disability, degree of medical dependency, or other health conditions.	This provision dictates policy design beyond what might be mandated under State law.	This provision might be interpreted as preempting state laws that permit medical necessity limitations on coverage or promote the cost-effective delivery of benefits, except to the extent that they constitute the kind of "reasonable medical management techniques" permitted by HHS under 45 CFR 156.125(c).
Clinical Trials	PHSA 2709 – A non-grandfathered health plan may not discriminate on the basis of participation in a clinical trial and must cover routine patient costs of individuals in clinical trials for treatment of cancer or other	Insofar as a State does not mandate coverage of routine patient costs incurred during a clinical trial, the ACA requires benefits beyond those mandated under State law.	

	life-threatening conditions. PHSA 2709(h) – nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.		
Mental Health Parity	ACA 1563(c)(4)—Extends mental health parity requirements to non-grandfathered individual plans. 45 CFR 156.115(a)(3) incorporates mental health parity requirements into EHB requirements applicable to all non-grandfathered individual and small group plans.	Insofar as a State does not require the coverage of mental health benefits, or requires the coverage but does not require parity, whether in the individual or small group market, the ACA requires benefits beyond those mandated under State law.	
Preexisting Condition Exclusions	PHSA 2704—Prohibits the imposition of a preexisting condition exclusion by all group plans and non-grandfathered individual market plans.	Current laws in every state permit preexisting condition exclusions, subject to the limitations imposed by HIPAA and such other limitations that state law might provide. By requiring full coverage of preexisting conditions, the ACA requires benefits beyond those mandated under State law.	
Rate Review	ACA 1252-Requires state rating requirements to be applied uniformly to all carriers. 45 CFR 154.215 – Requires for all non-grandfathered individual and small group market rate increases submission of a Rate Filing Justification in a manner prescribed by the Secretary.	Section 1252 preempts any state law establishing different standards for different types of carriers or types of coverage. Examples could include state laws providing different standards for nonprofits or HMOs, or state laws establishing "affordable" plans to be offered at cost.	If a state has specific "competitive rating" laws specifically granting insurers meeting certain conditions the right to be free from certain filing or rate approval requirements, those laws could be effectively preempted by federal review under Section 2794. Otherwise, Section 2794 does not actually preempt state law, but it does provide incentives for states to reconfigure their rate implementation processes to conform to the ACA.

Rate filing standards	45 CFR 154.215— A Rate Filing Justification must be submitted to HHS for all non-grandfathered individual and small group market rate changes. The justification must include: (1) Unified Rate Review Template (developed by HHS); (2) Written description justifying the rate increase; (3) Rate filing documentation to support the data provided in (1). Part (2) is only required for filings that meet or exceed the rate review threshold and are therefore "subject to review". Reviews will be performed by the State or CMS.	The new requirements at 45 CFR 154.215 represent a change from state requirements and consequently preempt prior state requirements.	Discourages states from continuing to collect rate information different from the content and format of the HHS template.
Rating rules	PHSA 2701-Prohibits the use of rating factors in the individual and small group markets other than: whether a plan covers an individual or a family; rating area; age, except that such rate shall not vary by more than 3 to 1 for adults; and tobacco use, except that such rate shall not vary by more than 1.5 to 1.	Except in states that already limit rating to the specified factors in one or both markets, preempts laws establishing different permitted factors or allowing insurers to use any actuarially justified rating factors.	
Age bands	PHSA 2701(a)(1)(A)(iii)-Limits use of age rating to 3:1. 45 CFR 147.102—Requires the use of uniform age rating bands specified by HHS and a uniform age rating curve specified by HHS, unless the state specifies its own curve.	The 3:1 limitation preempts any laws that permit wider variation, or that permit insurers' rates to reflect the full actuarially determined difference in costs. The uniform curve preempts any state laws under which insurers and regulators have discretion in determining which rating bands and rate relativities are appropriate in light of actuarial evaluations of the risk and business needs.	

Geographic variation	PHSA 2701(a)(1)(A)(ii) prohibits a "premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market" from varying such rate from the "rating area, as established in accordance with paragraph (2)." Section 2701(a)(2) (A) and (B) require each state to establish one or more rating areas within the state and gives the Secretary of HHS the authority to review the rating areas established by each state. 45 C.F.R. 147.102(b) allows a state to establish one or more rating areas within a state. A state's rating areas must be based on counties, three-digit zip codes, or metropolitan statistical areas and non-metropolitan statistical areas, as define by OMB, and will be presumed adequate if: the state established by law, rule, regulation, bulletin or other executive action uniform rating areas for the entire state as of Jan. 1, 2013; or the state establishes by law, rule, regulation, bulleting, or other executive action after Jan. 1, 2013, uniform rating areas for the entire state that are no greater in number than the number of metropolitan statistical areas in the state plus one.	If state law relating to rating areas is inconsistent with federal standards, it is preempted. States with uniform rating areas for the entire state established as of January 1, 2013, will not be preempted.	45 C.F.R. 147.102(b)(4) allows states to submit a proposal to CMS for approval of more than the number of metropolitan statistical areas in the state plus one, provided such rating areas are based on counties, three-digit zip codes, or metropolitan statistical areas and non-metropolitan statistical areas as defined by OMB.

Tobacco use	PHSA 2701(a)(1)(A)(iv) – premium rates for individual and small group plans may not vary more than 1.5:1 for tobacco use. 45 CFR 147.102(a)(iv)-Limits the use of tobacco use as a rating factor to 1.5:1, applicable only to the individuals in a family that smoke. Small group plans may impose the tobacco rating factor only in connection with the offering of a wellness program (e.g. smoking cessation) to give a tobacco user the opportunity to avoid paying the full amount of the tobacco rating factor.	These provisions limit the use of tobacco as a rating factor in the individual market, and entirely prohibit insurers from using tobacco in the small group market for the traditional rating purpose of recovering the costs associated with increased risk. This preempts any state laws that impose less restrictive limitations on tobacco rating, or that permit insurers' rates to reflect the full actuarially determined difference in costs.	
Family composition	PHSA 2701(a)(1)(A)(i) – premium rates for individual and small group plans may vary on whether such plan covers an individual or family. 45 CFR 147.103(c)(1)— Requires that family premiums be determined by adding the premiums for each family member, including only the first three children under age 21. States with pure community rating may establish uniform family tiers.	Preempts any state laws that allow or require insurers to establish different family tiers, and/or to charge a family unit a different rate than the sum of the applicable individual rates.	
Single risk pool	ACA 1312(c)-All issuers of non-grandfathered individual and small group products must consider all enrollees in their individual products to be members of a single risk pool for that individual market segment and all enrollees in their small group products to be members of a single risk pool for that small group market segment.	Preempts any state laws that allow or require separate blocks of business to be rated based on their own experience, including any laws authorizing or encouraging the formation of purchasing alliances or other separately rated groups established to control costs or to provide a platform for offering affordable coverage. ACA 1312(c)(4) explicitly preempts any state law requiring grandfathered	

		health plans to be subject to the single risk pool requirement.	
Medical Loss Ratios	PHSA 2718-Health plans in the individual and small group markets must provide rebates if they fail to meet minimum loss ratio standards.	Preempts or undermines any state laws that contemplate a prospective rating methodology, that allow insurers to charge rates intended to recover costs not contemplated by the federal formula, that use different formulas or procedures, or that establish lower minimum loss ratio levels.	To the extent that state programs are not preempted outright, the burdens of coordinating state and federal rebate programs is likely to make the state program unworkable as a practical matter.
Marketing	45 CFR 156.225(a) requires QHP issuers to comply with any applicable State laws and regulations regarding marketing by health insurance issuers.	None. This provision only applies to QHPs.	
Discriminatory Marketing Practices	ACA 1311(c)(1)(A)—Qualified Health Plans may not employ marketing practices that discourage enrollment by individuals with significant health needs. 45 C.F.R. 156.2255(a) requires QHPs comply with any applicable State laws and regulations regarding marketing by health insurance issuers. 45 C.F.R. 156.2255(b) prohibits QHPs from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.	None. These provisions only apply to QHPs.	
Required Disclosures	PHSA 2715—Health plans must provide a Summary of Benefits and Coverage to enrollees. PHSA 2715A—Health plans must disclose information on claims, financials, enrollment, rating practices, and out-of-network coverage to the Secretary of HHS and the State insurance	ACA 2715(e) clearly states that the standards developed under Section 2715(a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under Section 2715(a).	

	commissioner. PHSA 2794-Plans must provide justification for any potentially unreasonable rate increase.	These provisions may preempt any state laws regarding disclosures and justification for rate increases.	
Consumer Protection/Unfair Trade Practices	PHSA 2705-An issuer may not establish eligibility standards based upon any health-status related factor. PHSA2702-An issuer in the individual or group markets must accept every employer or individual that applies for such coverage.	Some states prohibit statements on any plan materials that suggest a plan or product has been endorsed or approved by a government entity. All MSP plans can have a statement that the plan has been certified by OPM. OPM does not regard this is a preemption of state authority. 45 CFR 800.113	
Network Adequacy	ACA 1311(c)(1)(B) – requires QHPs include a sufficient choice of providers in its network as well as information regarding in-network and out-of-network providers.	None. These provisions only apply to QHPs.	
Essential Community Providers	ACA 1311(c)(1)(C) requires QHPs to include within their networks, where available, essential community providers that serve predominately low-income, medically-underserved individuals. 45 CFR 156.235-A QHP must have a sufficient number of essential community providers, where available.	None. This provision only applies to QHPs.	
Provider Directories	45 CFR 156.230-A QHP issuer must submit its provider directory (or directories) to the Exchange electronically and make a printed version available to potential enrollees upon request. The directory must identify providers that are not accepting new patients.	None. This provision only applies to QHPs.	
Accreditation	ACA 1311(c)(1)(D)(i) and ACA 1311 (c)(1)(D)(ii) requires a qualified health plan to be either accredited or receive accreditation within a specific time period by an accreditation organization	None. The accreditation requirement does not apply outside of an Exchange.	Making unaccredited insurers ineligible to participate in the Exchange might operate as a de facto restriction on the outside market.

	recognized by the Secretary on quality measures, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.		
Enrollment in Coverage	ACA 2702(b)(1) allows issuers to restrict enrollment in coverage to open and special enrollment periods. 45 CFR 147.104(b)-A health plan may restrict enrollments to open and special enrollment periods.	If a plan outside of the Exchange decides to limit enrollment to open and specific enrollment periods, the enrollment periods must mirror the enrollment periods in the Exchange. An issuer may have longer enrollment periods than those required in the Exchange but the enrollment periods must include the timeframe outlined for the Exchange.	
Termination of Coverage	PHSA2712- A health insurance issuer may not rescind coverage except in the case of fraud or intentional misrepresentation of material fact.	This provision may preempt state laws regarding rescission of coverage.	
Transitional Reinsurance	ACA 1341 – each state shall establish a reinsurance program, subsidized by the entire market, to assist individual-market carriers in covering high-risk enrollees in the first three years of the guaranteed-issue, community-rated market. If a state does not establish a program, HHS will establish a reinsurance program in the state. Proposed amendments to 45 CFR 153.220 and 153.230 create a single national reinsurance pool, with contribution and payment rates determined on a nationwide basis	Some states already have reinsurance programs established under state law that perform the same or similar functions. To the extent that those programs do not meet the specific standards set forth in the ACA or added by the implementing regulations, these programs are preempted or made unworkable. The proposed nationwide pooling amendments will preempt state laws requiring the assessments collected on business within the state to be used for the purpose of supporting the state's own market.	If state rating laws prohibit "cross-subsidies" from the group market to support the individual market, those laws might be effectively preempted. Also, even though the stated intent of the regulation is to establish attachment points that do not crowd out the commercial reinsurance market, HHS is substituting its judgment in that regard for the judgment of carriers and regulators.