Adopted by the Health Insurance and Managed Care (B) Committee, June 27, 2013

ACA Impact on State Regulatory Authority: Qualified Health Plans

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 1301(a)(1)(C) requires that issuers of qualified health plans are licensed and in good standing in each State in which such issuer offers health insurance coverage. 45 CFR 156.200(b)(4)-all issuers must be licensed and in good standing with the State. 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.	None.	Licensure is necessary, but not sufficient, to make a carrier eligible to operate on the Exchange, which must establish its own eligibility process for issuers. This could have the effect of interfering, as a practical matter, with the state's authority to decide which insurers are eligible to do business in the state. 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 1301(a)(1)(C) requires that issuers of qualified health plans are licensed and in good standing in each State in which such issuer offers health insurance coverage. 45 CFR 156.200(b)(4)-all issuers must be licensed and in good standing with the State. 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. 45 CFR 800.115 requires MSPP issuers to comply with solvency standards set by each state. OPM may enter into MOUs with states to work out a process by which OPM is informed of any payment to an MSPP issuer of state guaranty funds.	None.	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.
Form Review	ACA 1334(b(2) requires an issuer entering into a contract to be a multistate plan be licensed in each State and subject to all requirements of state law not inconsistent with Section 1334. 45 CFR 800.113 requires an MSPP issuer to comply with Federal and State laws relating to benefit plan material or information.		45 CFR 800.113 allows OPM to enter into MOUs with states to define a state's and OPM's respective roles in review of benefit plan materials or information. MSPP issuers must comply with state laws governing benefit plan materials or information, however, that does not include policy or contract forms.

Essential Health Benefits	ACA 1301(a) requires that QHPs include the essential health benefits package. ACA 1311 (d)(3)(B)(i) and (ii) allows a State to require a QHP to offer benefits in addition to the essential health benefits as long as the state assumes the cost. 45 CFR 156.200 requires QHPs to comply with benefit design standards as defined in 45 CFR 156.20. Benefit design standards as defined in 45 CFR 156.20 includes the essential health benefit package. ACA 1334(c)(1) requires multi-State plans to offer a benefit package that is uniform in each State and consists of the essential benefits. 45 CFR 800.105(b)(1) requires a multi-State plan to offer a benefits package in all States, that is substantially equal to: the EHB-benchmark plan in each State in which it operates; or any EHB-benchmark plan selected by OPM.	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. An MSPP issuer may select as its benchmark plan, either each state's EHB benchmark or one of three benchmarks selected by OPM. If a state does not allow for substitutions within categories of EHBs, then the MSPP issuer must use the state benchmark, not one of the OPM benchmarks.	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. Ultimate authority for review and approval of a MSPP issuer's EHB package rests with OPM.
Actuarially equivalent Substitutions	45 CFR 156.115(b) allows 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. An MSP issuer may select as its benchmark plan, either each state's EHB benchmark or one of three benchmarks selected by OPM. If a state does not allow for substitutions within categories of EHBs, then the MSPP issuer must use the state benchmark, not one of the OPM benchmarks.	Where a MSPP issuer employs substitutions within categories of EHBs (if permitted by a state), the Office of Personnel Management (OPM) has invited comment as to whether evidence of actuarial equivalence of substitutions should be submitted to "the OPM in addition to, or in lieu of" submission to a state. 45 CFR 800.105(d)

Actuarial Value	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. QHPs must offer at least one Silver (70%) and one Gold (80%) level package. ACA 1301(a)(1)(ii). In addition, QHPs must offer child-only versions of each plan offered through the exchange. ACA 1302(f). 45 CFR 156.140 allows qualified 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).
Meaningful Difference	General guidance on Federally Facilitated Exchanges states there must be a meaningful difference between the plans offered by an issuer on a Federally-Facilitated Exchange.	Insofar as a State does not preclude very similar benefit designs, the ACA dictates policy design beyond that mandated under State law.	
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 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.	Insofar as a State does not mandate coverage of routine patient costs incurred in a clinical trial, the ACA requires benefits beyond those mandated under State law.	

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. 45 CFR Part 800.201 - Subjects MSPs to a State's rate review process, including a State's Effective Rate Review Program, or the HHS rate review process in a State that does not perform rate review. In the event a State withholds approval of an MSP rate filing, OPM retains authority to make the final decision to approve rates for participation in the MSPP.	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. Standards for "effective" state rate review programs, if more stringent than existing state standards, will preempt state standards. If states are not found to have effective programs, HHS will conduct the reviews, preempting state action in this area.	On the Exchange, the Exchange would have the power to deny a carrier the ability to participate even if the insurance regulator had determined that those rates were necessary to maintain the financial health of the carrier. Furthermore, for multistate plans, preemptive authority might be asserted for rates negotiated by OMB on a nationwide basis, even if the rates in some states might be inadequate or excessive under those states' laws. In general, if a state has specific "competitive rating" laws 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. 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	ACA 1311(e)(2) – requires QHPs seeking certification to submit a justification for any premium increase prior to implementation of the increase. The Exchange may use this information to determine whether a QHP may be available on an Exchange. 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.
Rate increase history	ACA 1311(e)(2) – requires QHPs seeking certification to submit a justification for any premium increase prior to implementation of the increase. The Exchange may use this information to determine whether a QHP may be available on an Exchange. 45 CFR 155.1020(b) – Exchange must consider an issuer's rating practices in deciding whether to allow it to offer QHPs on the Exchange.		Extends the impact of rate review to the issuer's ability to sell other products whose rates have not been found unreasonable, gives decision making authority to someone other than the insurance regulator, and in states not deemed to have "effective rate review," applies federal rather than state standards to determine whether issuers have "patterns or practices of excessive or unjustified premium increases."

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. ACA 1301(a)(1)(C)(iii) – Rates for a QHP may not vary based on whether it is sold on or off the Exchange or on whether it is sold with or without a producer. 45 CFR 800.202 - MSP issuers shall be subject to the same rating factors as other health plans, including any allowable, narrower rating factors (such as a narrower tobacco ratio employed by a state).	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 for individual and small group plans 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	PHSA2701(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)." PHSA 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 CFR 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 January 1, 2013; or the state establishes by law, rule, regulation, bulletin, or other executive action after January 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	These provisions limit the use of tobacco as a rating factor in the individual market, and limits 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	

	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.	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. 45 CFR Part 800.201(g) – An MSP issuer must consider all enrollees in an MSP to be in the same single risk pool as all enrollees in all other plans in the individual or small group market.	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	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

		the federal formula, that use different formulas or procedures, or that establish lower minimum loss ratio levels.	unworkable as a practical matter. OPM has reserved its authority to establish a MLR requirement that is specific to MSPs, in addition to the MLR that each health insurance issuer must meet in each state market segment. 45 CFR 800.203
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.	
Producer Licensing	ACA Section 1311(i)(2)(B) licensed agents and brokers are allowed to participate in the navigator program. 45 CFR 155.220 requires agents and brokers enrolling qualified individuals in the Exchange to register with the Exchange, receive training regarding QHP options, and comply with the Exchange's privacy and security standards. A December 2012 FAQ document produced by CMS noted that "a state or Exchange cannot require Navigators to hold a producer license (i.e. a license as an agent or broker) for the purpose of carrying out any of the duties required of Navigators in section 1311(i)(3) of the ACA and 45 C.F.R. section 155.210(e).	These provisions do not preempt state laws regarding the licensure of agents and brokers. They do, however, impose further requirements on agents and brokers enrolling qualified individuals in the Exchanges.	
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. 156.225(a) requires QHPs comply with any applicable State laws and regulations regarding	These provisions may preempt state laws regarding the marketing of health insurance plans.	

	marketing by health insurance issuers. 45 C.F.R. 156.225(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.		
Required Disclosures	ACA 2715(a)—Health plans must provide a Summary of Benefits and Coverage to enrollees. ACA 1311(e)(3)—Health plans must disclose and submit information on transparency of coverage to HHS, the Exchange, and the State Insurance Commissioner. PHSA 2794-Plans must provide justification for any potentially unreasonable rate increase.	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). These provisions may preempt 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. PHSA 2702-An issuer in the individual or group markets must accept every employer or individual that applies for such coverage. 45 CFR 156.200(e)—A QHP issuer may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.	Some states prohibit statements on any plan materials that suggest a plan or product has been endorsed or approved by a government entity. All MSPs 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. 45 CFR 156.230 – QHPs must have a provider network that is sufficient and includes essential community providers. For MSP issuers, OPM proposes to mirror the HHS standard as set forth in 45 CFR 156.230.	An Exchange (the State in plan management) must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees. Failure to set this minimum standard would result in preemption.	The exchange must require that a QHP maintain a network of sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay. The Exchange rules seek comments as to whether requiring standards consistent with the NAIC *Managed Care Plan Network Adequacy Model Act* which may result in that model becoming a floor to avoid preemption. OPM has not decided whether it will or will not exempt MSP issuers from state-specific network adequacy standards in excess of those set forth in 45 CFR 156.230.
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.	This provision may preempt state laws regarding network adequacy for qualified health plans.	
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. QHPs can satisfy the requirement by providing Web links to their online provider directories. The directory must identify providers that are not	This provision may preempt state laws relating to provider directories for QHPs.	

	accepting new patients.		
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 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. 45 CFR 156.275 requires a qualified health plan to be either: accredited on the basis of local performance in specific categories by an accrediting entity recognized by HHS or accredited within the timeframe established by the Exchange. QHPs must maintain accreditation so long as the QHP issuer offers QHPs. 45 CFR 155.1045 requires Exchanges to establish an accreditation period for QHP issuers not accredited. QHPs not accredited in 2013 for the 2014 coverage year must schedule or plan to schedule a review of QHP policies and procedures of the applying QHP issuer with a recognized accrediting entity. For an issuer's second and third year of QHP certification, it must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products. Prior to the QHP issuer's fourth year and every subsequent year or certification, a QHP issuer must be fully accredited.	Insofar as a state has standards for accreditation of health plans, this provision may preempt those standards for issuers of QHPs.	

	45 C.F.R. 156.275(c)(1)(i) allows an accrediting entity to apply to HHS for recognition as an accrediting entity. 45 CFR 156.275(c)(1)(iv)—NCQA and URAC are recognized accrediting entities. For certification purposes, Exchanges must accept accreditation from all HHS-recognized accrediting agencies.		
Quality Improvement	ACA 1311(g)-A QHP must implement a provider payment structure that provides increased reimbursement or other incentives for improving health care quality, in accordance with guidelines to be established by HHS. ACA 1311(h)-A QHP may not contract with a hospital with more than 50 beds unless the hospital utilizes a patient safety evaluation system and has a mechanism for post-discharge education and follow-up.	These provisions may preempt any state laws regarding issuers' quality incentives for QHPs.	
Enrollment in Coverage	ACA 2702(b)(1) allows issuers to restrict enrollment in coverage to open and special enrollment periods. 45 CFR 155.410 requires Exchanges to provide an initial open enrollment period (Oct. 1, 2013 to March 31, 2014) and annual enrollment periods for benefit years beginning on or after Jan. 1, 2015 (October 15 to December 7). 45 CFR 155.725 requires a SHOP Exchange to provide an initial open enrollment period (Oct. 1, 2013 to March 31, 2014) and permit qualified employers to purchase coverage at any point during the year.	The Act, as well as the Exchange rules and the market rules affecting enrollment outside the Exchange, require open enrollment periods annually as well as special enrollment exceptions that allow enrollment of individuals at times other than open enrollment. Failure to require these open enrollment and special enrollment requirements would result in preemption.	

Termination of Coverage	PHSA 2712- A health insurance issuer may not rescind coverage except in the case of fraud or intentional misrepresentation of material fact. 45 CFR 155.430-A QHP must comply with Exchange termination procedures.	ACA 2712 may preempt state laws regarding rescission of coverage.	
Navigators	ACA 1311(i) – an Exchange shall establish a Navigator program to conduct public outreach and raise awareness of the availability of qualified health plans, facilitate enrollment in qualified health plans, and provide information to potential enrollees of qualified health plans regarding premium tax credits and cost-sharing subsidies. ACA Section 1311(i)(4)(A) – the Secretary shall establish standards for navigators including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate. 45 CFR 155.210 requires an Exchange to establish a Navigator program which includes a set of training standards to be met by all entities and individuals carrying out Navigator functions. According to a Dec. 10, 2012 FAQ document from CMS, Navigators operating in Federally-Facilitated Exchanges and state partnership Exchanges will have to "successfully participate in an HHS-developed and administered training program, which will include a certification examination pursuant to 45 CFR 155.210(b)."		December 10, 2012 FAQ document regarding Exchanges allows states to impose Navigator-specific licensing or certification requirements upon individuals and entities "so long as such licenses or certifications are not preempted by the requirement to award to different types of entities identified in 45 CFR 155.210(c)(2), such as producer licenses." State requirements upon Navigators may not prohibit them from carrying out statutorily-required activities of Navigators.

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.
External Review	ACA 2719 (b)(1) and (2) requires group health plans and health insurance issuers offering group or individual health insurance coverage to comply with either a State's external review process if it meets at minimum the process set forth in the *Uniform Health Carrier External Review Model Act* or implement an effective external review process that meets minimum standards establish by the Secretary of HHS.	State external review laws that do not provide consumer protections equal to or greater than the consumer protections set forth in the *Uniform Health Carrier External Review Model Act* promulgated by the NAIC will be preempted by the minimum external review standards established by HHS.	Under the MSP Program proposed regulation, MSPs would be subject to the OPM's external review process. It is unclear whether this would also preempt state external review processes. 45 CFR 800.504