

Preemption and State Flexibility in PPACA

The Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148) greatly expands federal involvement in health insurance oversight, introducing new federal minimum standards that will extend guaranteed issue to the individual market, require the use of adjusted community rating, prohibit pre-existing condition exclusions, limit rescissions, and require adherence to minimum loss ratios, among others. As the process of implementing the statute moves forward, it will be critical for states to understand how the federal law interacts with their own statutes and regulations.

Overview

Title I of PPACA, which includes most of the new federal standards that relate to health insurance coverage, contains the following provision:

No Interference With State Regulatory Authority—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.¹

This provision mirrors provisions in HIPAA that amended the Public Health Service Act and ERISA,² effectively allowing states to adopt and enforce laws and regulations that afford greater consumer protections while ensuring a basic level of protections across the country. In practice, this means that, beginning on the effective date for each provision, any state law that does not meet the federal minimum standards will be preempted, and the federal Department of Health and Human Services will assume regulatory authority for that provision of federal law. If a state already has a requirement that at least meets the federal standards, or adopts one in the future, then it would retain the authority to enforce it. For example, PPACA requires that insurers in all markets comply with adjusted community rating standards with a maximum variation for age of 3:1.³ Most states do permit the use of health status and allow greater variation for age than the federal standards allow, preventing the application of the federal requirements. States that adopt the new federal standards by 2014, when the federal rating rules take effect, will retain the ability to enforce their new rating rules, as would states that adopt more stringent standards, such as pure community rating.

Other provisions of the legislation create new programs to help people access health insurance coverage, such as temporary high risk pools⁴ and health insurance Exchanges⁵. These programs are, where possible, implemented at the state level, with a federal fallback to ensure that they are available in states that decline, or are unable, to implement them. HHS Secretary Kathleen Sebelius sent a letter to every state on April 2nd asking them to provide an initial declaration of their intent to apply for federal funds to operate the high risk pool program, or whether they would prefer for the federal government to operate the program directly in their state. Similarly, PPACA envisions health insurance Exchanges developed and operated by the States. The Secretary will determine in January 2013 which states are on track to operate health insurance Exchanges that meet the standards specified in the law. If she determines that a state has not made sufficient progress toward this end, or if it decides not to operate an Exchange, the federal government will contract with a nonprofit entity to operate an Exchange in that state.

Specific Areas of Preemption

PPACA also contains a number of other provisions that specifically preempt different types of state law.

¹ §1321(d)

² Public Health Service Act §§2723(a), 2746(a); Employee Retirement Income Security Act §704(a)

³ PHSA §2701, as added by PPACA §1201

⁴ §1101

⁵ §§1311-1324

Grandfathering: The law requires all non-grandfathered health plans to maintain a single risk pool for each of the individual and small group markets. It also specifies that any state law requiring insurers to include grandfathered plans in these pools is preempted.

Multi-State Plans: The law also creates new multi-state plans overseen by the U.S. Office of Personnel Management, the agency that administers the Federal Employees' Health Benefits Program (FEHBP). These plans will eventually be sold through the Exchanges in every state. While states may require that these plans comply with mandated benefits laws, any state laws that do not apply to FEHBP plans will not apply to multi-state plans either.

Interstate Compacts: Beginning in 2016, two or more states may enter into interstate compacts to facilitate the sale of health insurance policies across state lines. Insurers would be able to sell policies in all compacting states using the laws and regulations of a primary state. Certain consumer protection laws in the purchaser's home state would continue to apply, however.

State Flexibility

PPACA also contains a number of provisions that provide states with the opportunity to take advantage of some additional flexibility. The first of these provisions allows states to establish "Basic Health Programs" to provide coverage to individuals between 100% and 200% of the federal poverty level⁶. This coverage could be provided by private carriers under a contract with the state using funds that otherwise would have been provided to these individuals as subsidies through the Exchange. If a state elects to offer a basic health programs, those between 100% and 200% of the federal poverty level would no longer be eligible to purchase coverage through the Exchange.

The second provision would, beginning in 2017, allow states to apply to the Secretary of HHS for waivers of requirements for:

- Plans offered through the Exchange
- Administration of the Exchange
- Reduced cost-sharing in plans offered through the Exchange
- Premium subsidies
- Employer and individual mandates

States applying for these waivers must provide coverage at least as comprehensive as what would be offered through the Exchanges using funds that would otherwise be provided to state residents as tax credits or subsidies.

⁶ §1331