Pre-Emption Chart
Kentucky Regulation and Federal PPACA Law

Provision	PPACA Notes[1]	PPACA Applicability	PPACA Statute / Code of Federal Regulations	Pre-emption
	Kentucky Statute/Regulation	***KY Applicability***	***Kentucky Revised Statute (KRS)***	
Pre-existing condition exclusions	A plan may not impose any pre-existing condition exclusions.	All plans except grandfathered individual market plans	PHSA 2704 45 CFR §147.108	Kentucky law pre-empted
	Kentucky statute does allow a plan to impose a pre-existing condition exclusion.	*all health benefit plans*	*304.17A-220; 304.17A-230*	
Fair health insurance premiums	Premiums may only vary by: Age (3:1 maximum) Tobacco (1.4:1 maximum in Kentucky) Geographic rating area Whether coverage is for an individual or a family Each state shall establish one or more rating areas for the purposes of geographic rating. The Secretary shall review them and determine their adequacy. If they are not adequate, or if a state fails to establish them, the Secretary may establish rating areas for the state.	Non-grandfathered fully-insured small group and individual plans. Fully insured large group plans in states that allow them to purchase through the Exchange.	PHSA 2701 45 CFR §147.108	Kentucky law pre-empted
	In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area.	*All health benefit plans.*	*304.17A-0952(6)*	
	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for	All non-	PHSA 2709	

[1] All PPACA information comes from: The NAIC PPACA Section-by-Section Analysis: http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf

Coverage for individuals participating in approved clinical trials	items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.	grandfathered plans	n/a	No
	(2) A health benefit plan shall not exclude coverage for routine patient health care costs that are incurred in the course of a cancer clinical trial if the health benefit plan would provide coverage for the routine patient health care costs had they not been incurred in a cancer clinical trial. *(3) The coverage that may not be excluded under this section shall be subject to all terms, conditions, restrictions, exclusions, and limitations that apply to any other coverage under the policy, plan, or contract, including the treatment under the policy, plan, or contract of services performed by participating and nonparticipating providers.*	*all health benefit plans*	*304.17A-136*	
Comprehensive health insurance coverage	All plans must include the essential benefits package required of plans sold in the Exchanges and must comply with limitations on annual cost-sharing for plans sold in the Exchanges. (See §§ 1302(a) and (c).) If a carrier offers coverage in one of the tiers of coverage specified for the Exchanges, they must also offer that coverage as a plan open only to children under age 21.	All non-grandfathered plans	PHSA 2707 n/a	No
	no corresponding state statutory requirement	*n/a*	*n/a*	
Prohibition on Excessive Waiting	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.	All group plans	PHSA 2708 45 CFR 146.111	No, but federal law does limit the waiting period, so state law would have to comply with the limit
	(6)(g) "waiting period" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.	*Group health plans*	*304.17A-220(6)(g)*	

[1] All PPACA information comes from: The NAIC PPACA Section-by-Section Analysis: http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf

Pre-Emption Chart
Kentucky Regulation and Federal PPACA Law

Non-discrimination in health care	Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks. Plans may not discriminate against individuals or employers based upon: • Whether they receive subsidies • Whether they provide information to state or federal investigators or cooperate in the investigation of a violation of the Fair Labor Standards Act	All non-grandfathered plans	PHSA 2706 45 CFR §156.125	No
	A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.	*all health benefit plans*	*304.17A-270*	
Guaranteed availability of coverage	Insurers must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon open or special enrollment periods. Further, if a plan sponsor in the small group market is unable to meet employer contribution or group participation requirements, the insurer may limit availability of coverage to an annual enrollment period of November 15 - December 15.	Non-grandfathered fully-insured plans	PHSA 2702 45 CFR §147.104	Kentucky law pre-empted in individual market because there is no statute regarding guaranteed availability 17A-200(3)(a) and 17A-200(b) are pre-empted
	304.17A-200: applies to small group only *(3) insurer that offers health benefit plan coverage in small group market shall accept every small employer that applies for coverage and shall accept for enrollment under this coverage every individual eligible for the coverage who applies* *(a) notwithstanding the above, insurer may establish group participation rules requiring a minimum number of participants* *(b) terms and participation rules must be uniformly applicable to small employers in small group market...* *304.17A-250* *(6) hospice care must be covered at least equal to Medicare* *(7) plans shall coordinate benefits with other health plans under KRS 304.18-085*	*guaranteed availability applies to health benefit plans issued to small groups; hospice requirements*	*304.17A-200*	

[1] All PPACA information comes from: The NAIC PPACA Section-by-Section Analysis: http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf

	(8) if incentives are given for obtaining health care services from certain health care providers shall not imply that the health care provider is a participant in or an affiliate of an approved or selected provider network unless the provider has agreed in writing to such representation (applies with provider part of a preferred provider network) *(9) self-insured plan may select any third party administrator to adjust or settle claims for persons covered under the self-insured plan* *(10) if a health insurer fails to issue a premium rate quote within 30 days of receiving an application, the insurer shall be required to issue coverage to the individual and not impose any pre-existing condition exclusions. If an insurer refuses to cover an individual with a high-cost condition, the insurer must provide a denial letter within 20 days of the request for coverage and shall refer the person to Kentucky Access* *(12) no individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer.*	*apply to all health benefit plans; other requirements cited apply to health benefit plans in the individual market*	*304.17A-250(6), (7), (8), (9), (10), and (12)*	17A-250(10) and 17A-250(12) are pre-empted
	Insurers must renew coverage or continue it in force at the option of the plan sponsor or the individual. Exceptions: Nonpayment of premiums, fraud, violation of participation or contribution rules, termination of plan, enrollees' movement outside of service area, or association membership ceases.	All non-grandfathered fully-insured plans.	PHSA 2703 45 CFR §147.106	

[1] All PPACA information comes from: The NAIC PPACA Section-by-Section Analysis: http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf

Pre-Emption Chart
Kentucky Regulation and Federal PPACA Law

Guaranteed renewability of coverage	*304.17A-240:* *(1) Except as provided in this section, an insurer shall renew or continue in force a health benefit plan at the option of the insured.* *(2) An insurer may nonrenewal, cancel, or discontinue a health benefit plan based only on one or more of the following:* *(a) insured has failed to pay premiums in accordance with terms of the plan* *(b) insured has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact* *(c) insured has engaged in intentional and abusive noncompliance with material provisions* *(d) insurer is ceasing to offer coverage in the individual or small group market* *(e) network plans - the individual no longer resides, lives, or works in the service area or in an area for which the insurer is authorized to do business* *(f) association - the membership of the individual or employer in the association on the basis of which the coverage is provided ceases* *(g) group - the group no longer meets participation requirements...* *304.14-240* *An insurance policy terminating by its terms at a specified expiration date and otherwise not renewable, may be renewed or extended at the option of the insured...*	*all health benefit plans*	*304.17A-240*	17A-240(2)(c) is preempted
	A plan may not establish rules for eligibility based on any of the following health status-related factors: • Health status • Medical condition • Claims experience • Receipt of health care • Medical history • Generic information • Evidence of insurability (including conditions arising out of domestic violence) • Disability • Any other health-status related factor deemed appropriate by the Secretary Health promotion and disease prevention programs that base the conditions for obtaining a premium discount or any other reward upon a health status-related factor must limit such rewards to	Non-grandfathered	PHSA 2705 45 CFR §147.102	

[1] All PPACA information comes from: The NAIC PPACA Section-by-Section Analysis: http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf

Prohibiting discrimination against individual participants and beneficiaries based on health status (Cont.)	30% of the cost of coverage. The Secretaries of HHS, Labor and Treasury may increase the cap on rewards up to 50% if deemed appropriate. Wellness programs must be reasonably designed to promote health or prevent disease and must give eligible individuals the opportunity to qualify for the reward at least once per year, and rewards must be made available to all similarly situated individuals. Existing wellness programs established before March 23, 2010, may continue to be carried out. A health contingent wellness program where a member must satisfy a standard related to a health factor can offer the following awards: • discount or rebate of a premium or contribution waiver of all/part of a cost-sharing mechanism • absence of a surcharge • value of a benefit not otherwise provided for in the plan • other financial or non-financial incentives or disincentives Creates a Wellness Program Demonstration Program in 10 states to allow states to design wellness programs for individual market enrollees.	individual market plans	45 CFR §146.121 45 CFR §156.125	304.17A-200: No (as long as there is no statute relating to the individual market that conflicts with this law) 304.17A-098: No (though the federal law does appear to cap the limit on the premium discount at 30% if based upon a health-status related factor- so the state would have to abide by that limit)
	304.17A-200: applies to small group only *(1) may not establish rules for eligibility based on any of the following health-status related factors:* *(a) health status* *(b) medical condition, including both physical and mental illness,* *(c) claims experience,* *(d) receipt of health care,* *(e)medical history,* *(f) genetic information,* *(g) evidence of insurability, including conditions arising out of acts of domestic violence; and* *(h) disability.* *(2)...Nothing in this subsection shall prevent the insurer from establishing premium discounts or rebates modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.*	*requirements regarding eligibility rules apply to health benefit plans in the*	304.17A-200	

[1] All PPACA information comes from: The NAIC PPACA Section-by-Section Analysis: http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf

	304.17A-098: *(1) An insurer may offer a voluntary wellness or health improvement program that allows for rewards or incentives including, but not limited to:* *(a) merchandise* *(b) gift cards* *(c) debit cards* *(d) premium discounts or rebates* *(e) contributions toward a member's health savings account* *(f) modification to copayment, deductible, or coinsurance amounts* *(g) any combination of the incentives authorized by paragraphs (a) through (f)* *(2) any reward or incentive established shall not be deemed an inappropriate inducement to obtain or retain insurance...* *(4) Nothing in this section shall prohibit an insurer from offering incentives or rewards to members for adherence to a voluntary wellness or health improvement program, if otherwise allowed by state or federal law*	*small group market; wellness programs apply to all health benefit plans*	304.17A-098	
Date of Filing	A QHP issuer must submit rate and benefit information to the Exchange and it must submit justification of a rate increase prior to the implementation of the increase.	individual and small group plans	45 CFR 156.210	Kentucky law is pre-empted as it applies to the filing of rate increases.
	A rate filing under this section may be used by the insurer on and after the date of filing with the commissioner prior to approval by the commissioner. A rate filing shall be approved or disapproved by the commissioner within sixty (60) days after the date of filing. Should sixty (60) days expire after the commissioner receives the filing before approval or disapproval of the filing, the filing shall be deemed approved	*individual and small group health benefit plans*	*304.17A-095*	
12 Month Rate Guarantee	Limited open enrollment periods: for individuals enrolled in non-calendar year plans, they will have a limited open enrollment period that is 30 calendar days prior to the date the policy year ends in 2014. QHP issuer must set rates for an entire benefit year, or for the SHOP, plan year	individual and small group plans	45 CFR 147.104 45 CFR 155.420 45 CFR 156.210	Kentucky law is pre-empted to allow for limited enrollment periods in 2014
	The rates for each policyholder shall be guaranteed for twelve (12) months at the rate in effect on the date of issue or date of renewal.	*individual and small group health benefit plans*	*304.17A-095(4)*	

[1] All PPACA information comes from: The NAIC PPACA Section-by-Section Analysis: http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf

Pre-Emption Chart
Kentucky Regulation and Federal PPACA Law

Product Discontinuance	Discontinuing a particular product: notice in writing must be provided at least 90 calendar days before coverage is to be discontinued; issuer offers, on a guaranteed availability basis, the option to purchase any other health insurance coverage being offered by that insurer; in exercising option to discontinue the product, insurer must act without regard to claims experience or any health-status related factor Discontinuing all coverage: notice in writing must be provided at least 180 days before coverage is to be discontinued; all health insurance polices in the state in the applicable market or markets are discontinued and not renewed; insurer may not issue coverage in the applicable market for a period of 5 years beginning on the date of discontinuance of the last coverage not renewed.	all full-insured plans	45 CFR 147.106	No
	(a) In any case in which an insurer decides to discontinue offering a particular type of health benefit plan, coverage of the type may be discontinued by the insurer upon approval by the commissioner only if: *1. The insurer provides notice to each insured provided coverage of this type in the market of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage;* *2. The insurer offers, to each insured provided coverage of this type, the option to purchase any other health benefit plan currently of that type being offered by the insurer in that market; and* *3. In exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph 2. of this paragraph, the insurer acts uniformly without regard to any health status-related factor of enrolled insureds or insureds who may become eligible for coverage.* *(b)1. Subject to paragraph (a)3. of this subsection, in any case in which an insurer elects to discontinue offering all health benefit plans in Kentucky, health benefit plans may be discontinued by the insurer only if:* *a. The insurer provides notice to the commissioner and to each insured of the discontinuation at least one hundred eighty (180) days prior to the date of the expiration of the coverage; and* *b. All health benefit plans issued or delivered for issuance in Kentucky are discontinued and coverage under the health benefit plans is not renewed.* *2. In the case of a discontinuation under subparagraph 1. of this paragraph, the insurer may not provide for the issuance of any health benefit plans in Kentucky during the five (5) year period beginning on the date of the discontinuation of the last health benefit plan not so renewed.*	*all health benefit plans*	*304.17A-240(3)*	

[1] All PPACA information comes from: The NAIC PPACA Section-by-Section Analysis: http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf