CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 101 **Date: August 19, 2011**

SUBJECT: Chapter 10, "MA Organization Compliance with State Law and Preemption by Federal Law"

I. SUMMARY OF CHANGES: This manual update includes new and revised sections that provide detailed, up-to-date information, the relevant Code of Federal Regulations citations for all requirements, and an updated glossary of terms.

NEW / REVISED MATERIAL = EFFECTIVE DATE: August 19, 2011
IMPLEMENTATION DATE: August 19, 2011

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/ Table of Contents
R	10/10/Introduction
R	10/20/State Licensure Requirement
N	10/20.1/General
N	10/20.2/State Licensure of Marketing Representatives
R	10/30/Federal Preemption of State Law
N	10/30.1/General
N	10/30.2/Extent of Federal Preemption with Respect to State Regulation of MA Plans
R	10/40/Medicare Secondary Payer (MSP) Rules
R	10/50/State Premium Taxes or Other Fees Imposed on Federal Payment to MA Organizations
R	10/60/Examples of Federal Preemption Scenarios

III. FUNDING: No additional funding is currently provided by CMS; contractor activities are to be carried out within their own FY 2011 and/or future operating budgets determined by the organizations.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Medicare Managed Care Manual
Chapter 10 - MA Organization Compliance with State Law and Preemption by Federal Law

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10 – *Introduction*

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)

The contents of this chapter are governed by §1856(b)(3) of the Social Security Act (the Act) as amended by the Medicare Modernization Act of 2003 (MMA) and by regulations set forth in 42 CFR 422, Subpart I. This chapter reflects CMS' current interpretation of the provisions pertaining to Federal preemption of State law and is subject to change.

20 – *State Licensure Requirement*

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)
42 CFR 422.400

20.1 – General

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)

Each Medicare Advantage (MA) organization must be licensed under State law as a risk-bearing entity. As provided in section 20 of chapter 1 of this manual, this means the entity is licensed or otherwise authorized by the State to assume risk for offering health insurance or health benefits coverage, such that the entity is authorized to accept prepaid capitation for providing, arranging, or paying for comprehensive health services under an MA contract.

For further discussion of MA State licensure requirements, refer to section 20.1 of Chapter 11 of this manual ("MA Application Procedures and Contract Requirements").

20.2 – State Licensure of Marketing Representatives

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)

As described in section 120.1 of chapter 3 of this manual ("Medicare Marketing Guidelines"), if there are State certification/licensure requirements for marketing representatives, MA organizations must limit their employment of marketing representatives to only those who meet such requirements.

30 – *Federal Preemption of State Law*

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)
42 CFR 422.402

30.1 – General

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)

The scope of Federal preemption is broad. MA standards set forth in 42 CFR 422 supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans, with the exception of licensing laws and regulations and laws and regulations relating to plan solvency. In other words, unless they pertain to licensure and/or solvency, State laws

and regulations that regulate health plans do not apply to MA plans offered by MA organizations.

State laws and regulations that are pre-empted because they relate to ''State licensing'' are limited to State requirements for becoming State licensed, and do not extend to any requirement that the State might impose on licensed health plans that, in the absence of Federal preemption, must be met as a condition for maintaining a State license. Examples of State licensing requirements include filing articles of incorporation with the appropriate State Agency, having a particular organizational structure or governance (e.g., in some states, being non-profit).

State licensing laws do not extend to rules that govern the activities of health plans on an ongoing basis even if compliance with such requirements is a condition for retaining a State license. In other words, States may not purport to exempt a law from preemption on the grounds that it is a licensure law by imposing requirements not generally associated with obtaining a license as a condition of retaining a license. For example, a State licensing law may not be written so as to set forth ongoing marketing, quality assurance, or network adequacy requirements for MA plans by making such requirements a condition of retaining a State license.

30.2 - Extent of Federal Preemption with Respect to State Regulation of MA Plans

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)

All State standards, including those established through case law, are preempted to the extent that they would specifically regulate health plans (including MA plans), with the exceptions of State licensing and solvency laws. Other State health and safety standards, or generally applicable standards, that are not specific to health plans are not preempted**.**

CMS defers to the States on whether an entity meets the requirements to become State licensed or whether an entity has adequate financial solvency to be risk bearing.
However, State licensure requirements cannot impose any condition that CMS does not determine to be a licensure requirement. For example, a State licensure requirement that governs whether an organization is fit to serve as a health insurer is acceptable, but a requirement that governs how an entity operates its insurance upon receipt of a health insurance license is improper.

In general, a valid State licensure requirement is one that determines whether an entity is capable of offering health insurance in the State at the time of application. We differentiate between requirements that govern the fitness of an organization to serve as a health insurer or risk bearing entity and the requirements that govern the ongoing operation of how, where, and to whom it provides benefits.

We have not in the regulations or this chapter set forth specific parameters of what would be considered, as there may be legitimate aspects of State licensure that we have not encountered and could not necessarily anticipate. We recognize that there still may be questions about the extent of allowable State regulations. We address these specific preemption questions in cooperation with States on a case-by-case basis. .

40 - Medicare Secondary Payer (MSP) Rules

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)

A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for the services *for* which Medicare is not the primary payer. The MA organization may exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations at 42 CFR Part 411, Subparts B through D. *For more information on the MSP regulations, refer to section 140 of Chapter 4 of this manual.*

50 - State Premium Taxes or Other Fees Imposed on Federal Payment to MA Organizations

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)
42 CFR 422.404

Our regulations at 42 CFR 422.404 prohibit States from imposing a premium tax, fee, or any other *charge* on: *1) the* payment CMS makes to MA organizations (on behalf of MA enrollees), *2)* payments made by MA enrollees to MA plans*, or 3) payments made* by a third party to a MA plan on a beneficiary's behalf.

60 - *Examples of Federal Preemption Scenarios*

(Rev.101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11)

The following table presents example scenarios in which a question of Federal preemption is present and answers whether or not Federal law would preempt State law in each.

Example Scenario	Preemption by Federal Law?
An MA organization applies to a State to offer a new MA PPO plan in the State. The organization offering the proposed PPO plan indicates that it will offer its plan to Medicare beneficiaries in the entire State. The State denies the license on the basis that the organization lacks the financial solvency to serve the entire state.	*No* – Federal law does not preempt State solvency requirements. States may decline to license an MA plan to operate in a State if the State determines that the organization offering the MA plan does not meet State solvency requirements. The State may also elect to limit the service area for which the plan is licensed based on the financial resources (i.e., solvency) of the MA organization proposing to offer the MA plan.
An MA HMO plan currently being offered in a State seeks to expand its service area from 6 counties to *all counties in* the State. The MA organization requests that the State certify that	*Yes* – In this case, Federal law preempts State law. The State has already licensed the MA organization as a risk-bearing entity, and CMS has comprehensive network and organizational

the scope of its license allows it to be offered in the entire State. The State denies the service area expansion request on the basis that the plan has not demonstrated to the State that it has adequate network and organizational systems capacity to serve the entire State.	capacity standards. An MA plan is only required to meet Federal standards. States may not review or impose State standards for network or organizational capacity
An MA organization that is currently offering an MA HMO plan requests certification from a State to offer an MA private fee-for-service (PFFS) plan to serve Medicare beneficiaries in the entire State under its existing State license. The State denies the request on the basis that the PFFS product must be licensed as an indemnity insurance product and cannot be offered by the MA organization under a State HMO license.	No – A State may require that an MA plan offered in the State operate within the scope of its license. In this case the MA organization seeking to offer an MA PFFS plan in the State must meet the licensure requirements for an indemnity insurance product. *NOTE*: The scope of State licensure requirements is restricted by Federal preemption authority as described in section 30 of this chapter.
An MA HMO plan currently being offered in a State is out of compliance with the State's licensure solvency standards, has a negative net worth (liabilities exceed assets), and the State is allowing the plan to continue to operate under its license and a corrective action plan.	*No and Yes – The State's solvency standards are applied to determine licensure by a State. CMS has a requirement, separate from State licensure requirements, that plans must demonstrate that the MA organization has a fiscally sound operation which, at the very least, maintains a positive net worth (total assets exceed total liabilities). In this example, any CMS action would be based on contract compliance and would not be licensure related.*