program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for benefits that at a minimum consist of the essential health benefits described in section 18022(b) of this title;

(B) whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved, or, in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status;

(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of title 26) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(e)(2) of such title); and

(D) who has not attained age 65 as of the beginning of the plan year.

Such term shall not include any individual who is not a qualified individual under section 18032 of this title who is eligible to be covered by a qualified health plan offered through an Exchange.

(2) Eligible individuals may not use Exchange

An eligible individual shall not be treated as a qualified individual under section 18032 of this title eligible for enrollment in a qualified health plan offered through an Exchange established under section 18033 of this title.

(f) Secretarial oversight

The Secretary shall each year conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—

(1) eligibility verification requirements for participation in the program;

(2) the requirements for use of Federal funds received by the program; and

(3) the quality and performance standards under this section.

(g) Standard health plan offerors

A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.

(h) Definitions

Any term used in this section which is also used in section 36B of title 26 shall have the meaning given such term by such section.

(2) Requirements

The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part A of this subchapter.

(B) Part B of this subchapter.

(C) Section 18071 of this title.

(D) Sections 36B, 4980H, and 5000A of title 26.

(3) Pass through of funding

With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 1 of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be deter-
means—

(6) Definition

In this section, the term “Secretary” means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(b) Granting of waivers

(1) In general

The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 18022(b) of this title and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title as would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title as would provide; and

(D) will not increase the Federal deficit.

(2) Requirement to enact a law

(A) In general

A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) Termination of opt out

A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) Scope of waiver

(1) In general

The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) Limitation

The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) Determinations by Secretary

(1) Time for determination

The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) Effect of determination

(A) Granting of waivers

If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

\(^3\)So in original. Probably should be preceded by “the”.

§ 18053. Provisions relating to offering of plans in more than one State

(a) Health care choice compacts

(1) In general

Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—

(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;

(B) the issuer of any qualified health plan to which the compact applies—

(i) would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;

(ii) would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State with regard to the standards described in clause (i) (including allowing access to records as if the insurer were licensed in the State); and

(iii) must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(2) State authority

A State may not enter into an agreement under this subsection unless the State enacts a law after March 23, 2010, that specifically authorizes the State to enter into such agreements.

(3) Approval of compacts

The Secretary may approve interstate health care choice compacts under paragraph (1) only if the Secretary determines that such health care choice compact—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 18022(b) of this title and offered through Exchanges established under this title; 1

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title; 1 would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide;

(D) will not increase the Federal deficit; and

(E) will not weaken enforcement of laws and regulations described in paragraph (1)(B)(i) in any State that is included in such compact.

(4) Effective date

A health care choice compact described in paragraph (1) shall not take effect before January 1, 2016.


REFERENCES IN TEXT

This title, where footnoted in subsec. (a)(3)(A) to (C), is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter.

1 See References in Text note below.