(B) Denial of waiver

If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.[4]

(e) Term of waiver

No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

(Pub. L. 111–148, title I, §1332, Mar. 23, 2010, 124 Stat. 203.)

REFERENCES IN TEXT

Part I of subtitle E, referred to in subsec. (a)(3), is part I (§§1401–1415) of subtitle E of title I of Pub. L. 111–148, which enacted subchapter IV of this chapter and section 36B of Title 26, Internal Revenue Code, amended section 405 of this title, sections 280C, 6103, and 7213 of Title 26, and section 1324 of Title 31, Money and Finance, and enacted provisions set out as a note under section 36B of Title 26. For complete classification of part I to the Code, see Tables.

This title, where footnoted in subsecs. (a)(3) and (b)(1)(A) to (C), is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

The Administrative Procedures Act, referred to in subsec. (a)(4)(B)(iii), probably means the Administrative Procedure Act, act June 11, 1946, ch. 324, 60 Stat. 237, which was classified to sections 1001 to 1011 of former title 5 and which was repealed and reenacted as subchapter II (§551 et seq.) of chapter 5, and chapter 7 (§701 et seq.), of Title 5, Government Organization and Employees, by Pub. L. 89–554, Sept. 6, 1966, 80 Stat. 378. See Short Title note preceding section 551 of Title 5.

The Social Security Act, referred to in subsec. (a)(5), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to subchapters XVIII (§1395 et seq.), XIX (§1396 et seq.), and XXI (§1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

This Act, referred to in subsec. (b)(1)(A), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119, known as the Patient Protection and Affordable Care Act. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

§ 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[1] 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.

(b) Repealed. Pub. L. 111–148, title X, §10104(p), Mar. 23, 2010, 124 Stat. 902

(Pub. L. 111–148, title I, §1333, title X, §10104(p), Mar. 23, 2010, 124 Stat. 206, 902.)

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 and enacted, amended, and

[4] So in original. Probably should be ''therefor.''

[1] See References in Text note below.

transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

AMENDMENTS

2010—Subsec. (b). Pub. L. 111–148, § 10104(p), struck out subsec. (b) which provided authority and requirements for health insurance issuers to offer nationwide qualified health plans.

§ 18054. Multi-State plans

(a) Oversight by the Office of Personnel Management

(1) In general

The Director of the Office of Personnel Management (referred to in this section as the ''Director'') shall enter into contracts with health insurance issuers (which may include a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark), without regard to section 6101 of title 41 or other statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State. Such plans shall provide individual, or in the case of small employers, group coverage.

(2) Terms

Each contract entered into under paragraph (1) shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Director shall ensure that health benefits coverage is provided in accordance with the types of coverage provided for under section 2701(a)(1)(A)(i) of the Public Health Service Act [42 U.S.C. 300gg(a)(1)(A)(i)].

(3) Non-profit entities

In entering into contracts under paragraph (1), the Director shall ensure that at least one contract is entered into with a non-profit entity.

(4) Administration

The Director shall implement this subsection in a manner similar to the manner in which the Director implements the contracting provisions with respect to carriers under the Federal employees health benefit program[1] under chapter 89 of title 5, including (through negotiating with each multi-state[2] plan)—

(A) a medical loss ratio;

(B) a profit margin;

(C) the premiums to be charged; and

(D) such other terms and conditions of coverage as are in the interests of enrollees in such plans.

(5) Authority to protect consumers

The Director may prohibit the offering of any multi-State health plan that does not meet the terms and conditions defined by the Director with respect to the elements described in subparagraphs (A) through (D) of paragraph (4).

(6) Assured availability of varied coverage

In entering into contracts under this subsection, the Director shall ensure that with respect to multi-State qualified health plans offered in an Exchange, there is at least one such plan that does not provide coverage of services described in section 18023(b)(1)(B)(i) of this title.

(7) Withdrawal

Approval of a contract under this subsection may be withdrawn by the Director only after notice and opportunity for hearing to the issuer concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5.

(b) Eligibility

A health insurance issuer shall be eligible to enter into a contract under subsection (a)(1) if such issuer—

(1) agrees to offer a multi-State qualified health plan that meets the requirements of subsection (c) in each Exchange in each State;

(2) is licensed in each State and is subject to all requirements of State law not inconsistent with this section, including the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] or a requirement of this title;[3]

(3) otherwise complies with the minimum standards prescribed for carriers offering health benefits plans under section 8902(e) of title 5 to the extent that such standards do not conflict with a provision of this title;[3] and

(4) meets such other requirements as determined appropriate by the Director, in consultation with the Secretary.

(c) Requirements for multi-State qualified health plan

(1) In general

A multi-State qualified health plan meets the requirements of this subsection if, in the determination of the Director—

(A) the plan offers a benefits package that is uniform in each State and consists of the essential benefits described in section 18022 of this title;

(B) the plan meets all requirements of this title[3] with respect to a qualified health plan, including requirements relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage in each State Exchange;

(C) except as provided in paragraph (5), the issuer provides for determinations of premiums for coverage under the plan on the basis of the rating requirements of part A of title XXVII of the Public Health Service Act; and

(D) the issuer offers the plan in all geographic regions, and in all States that have adopted adjusted community rating before March 23, 2010.

[1] So in original. The words ''employees health benefit program'' probably should be capitalized.

[2] So in original. Probably should be ''multi-State''.

[3] See References in Text note below.