(A) funds provided under the agreement shall be used only to provide premium and cost-sharing assistance to residents of the territory obtaining health insurance coverage through the Exchange; and

(B) the premium and cost-sharing assistance provided under such agreement shall be structured in such a manner so as to prevent any gap in assistance for individuals between the income level at which medical assistance is available through the territory's Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and the income level at which premium and cost-sharing assistance is available under the agreement.

(c) Appropriation and allocation

(1) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated for purposes of payment pursuant to subsection (a) $1,000,000,000, to be available during the period beginning with 2014 and ending with 2019.

(2) Allocation

The Secretary shall allocate the amount appropriated under paragraph (1) among the territories for purposes of carrying out this section as follows:

(A) For Puerto Rico, $925,000,000.

(B) For another territory, the portion of $75,000,000 specified by the Secretary.

(Pub. L. 111–148, title I, §1323, as added Pub. L. 111–152, title I, §1204(a), Mar. 30, 2010, 124 Stat. 1055.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (b)(2)(B), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XIX of the Act is classified generally to subchapter XIX (§1396 et seq.) of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

PRIOR PROVISIONS

A prior section 18043, Pub. L. 111–148, title I, §1323, Mar. 23, 2010, 124 Stat. 192, which related to establishment of community health insurance option, was repealed by Pub. L. 111–148, title X, §10104(m), Mar. 23, 2010, 124 Stat. 902.

§ 18044. Level playing field

(a) In general

Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 18042 of this title, or a multi-State qualified health plan under section 18054 of this title, is not subject to such law.

(b) Laws described

The Federal and State laws described in this subsection are those Federal and State laws relating to—

(1) guaranteed renewal;
(2) rating;
(3) preexisting conditions;
(4) non-discrimination;
(5) quality improvement and reporting;
(6) fraud and abuse;
(7) solvency and financial requirements;
(8) market conduct;
(9) prompt payment;
(10) appeals and grievances;
(11) privacy and confidentiality;
(12) licensure; and
(13) benefit plan material or information.

(Pub. L. 111–148, title I, §1324, title X, §10104(n), Mar. 23, 2010, 124 Stat. 199, 902.)

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, §10104(n), substituted '', or a multi-State qualified health plan under section 18054 of this title'' for '', a community health insurance option under section 18043 of this title, or a nationwide qualified health plan under section 18053(b) of this title''.

PART D—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

§ 18051. State flexibility to establish basic health programs for low-income individuals not eligible for medicaid

(a) Establishment of program

(1) In general

The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 18022(b) of this title to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) Certifications as to benefit coverage and costs

Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—

(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of title 26) offered to the individual through an Exchange; and

(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—

(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and

(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and

(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 18022(b) of this title.

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax credits and cost-sharing reductions allowable with respect to either plan.

(b) Standard health plan

In this section, the term ''standard heath plan'' means a health benefits plan that the State contracts with under this section—

(1) under which the only individuals eligible to enroll are eligible individuals;

(2) that provides at least the essential health benefits described in section 18022(b) of this title; and

(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

(c) Contracting process

(1) In general

A State basic health program shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 18022(b) of this title.

(2) Specific items to be considered

A State shall, as part of its competitive process under paragraph (1), include at least the following:

(A) Innovation

Negotiation with offerors of a standard health plan for the inclusion of innovative features in the plan, including—

(i) care coordination and care management for enrollees, especially for those with chronic health conditions;

(ii) incentives for use of preventive services; and

(iii) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan.

(B) Health and resource differences

Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing conditions or other health status-related factors.

(C) Managed care

Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market.

(D) Performance measures

Establishing specific performance measures and standards for issuers of standard health plans that focus on quality of care and improved health outcomes, requiring such plans to report to the State with respect to the measures and standards, and making the performance and quality information available to enrollees in a useful form.

(3) Enhanced availability

(A) Multiple plans

A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.

(B) Regional compacts

A State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(4) Coordination with other State programs

A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], the State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.

(d) Transfer of funds to States

(1) In general

If the Secretary determines that a State electing the application of this section meets the requirements of the program established under subsection (a), the Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined under paragraph (3).

(2) Use of funds

A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.

(3) Amount of payment

(A) Secretarial determination

(i) In general

The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 95 percent of the premium tax credits under sec-

tion 36B of title 26, and the cost-sharing reductions under section 18071 of this title, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subchapter.

(ii) Specific requirements

The Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals described in clause (i), including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled. This determination shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty.

(iii) Certification

The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(B) Corrections

The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations under subparagraph (A) for any preceding fiscal year.

(4) Application of special rules

The provisions of section 18023 of this title shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

(e) Eligible individual

(1) In general

In this section, the term ''eligible individual'' means, with respect to any State, an individual—

(A) who a[1] resident of the State who is not eligible to enroll in the State's medicaid 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 18031 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.

(Pub. L. 111–148, title I, §1331, title X, §10104(*o*), Mar. 23, 2010, 124 Stat. 199, 902.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (c)(4) and (e)(1)(A), (B), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XIX and XXI of the Act are classified generally to subchapters 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.

[1] So in original. Probably should be preceded by ''is''.

This Act, referred to in subsec. (d)(3)(A)(iii), 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.

AMENDMENTS

2010—Subsec. (d)(3)(A)(i). Pub. L. 111–148, § 10104(*o*)(1), substituted ''95 percent'' for ''85 percent''.

Subsec. (e)(1)(B). Pub. L. 111–148, § 10104(*o*)(2), inserted '', 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'' before semicolon at end.

§ 18052. Waiver for State innovation

(a) Application

(1) In general

A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(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] 36B of title 26 or under part I 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[2] 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 determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) Waiver consideration and transparency

(A) In general

An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) Regulations

Not later than 180 days after March 23, 2010, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act,[2] or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) Report

The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) Coordinated waiver process

The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq., 1397aa et seq.], and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) Definition

In this section, the term ''Secretary'' means—

(A) the Secretary of Health and Human Services with respect to waivers relating to

[1] So in original. Probably should be ''section''.

[2] See References in Text note below.

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[2] as certified by Office[3] 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[2] would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title[2] 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.

(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

[3] So in original. Probably should be preceded by ''the''.

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

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 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

[1] See References in Text note below.

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

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

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.

[3] See References in Text note below.

(2) States may offer additional benefits

Nothing in paragraph (1)(A) shall preclude a State from requiring that benefits in addition to the essential health benefits required under such paragraph be provided to enrollees of a multi-State qualified health plan offered in such State.

(3) Credits

(A) In general

An individual enrolled in a multi-State qualified health plan under this section shall be eligible for credits under section 36B of title 26 and cost sharing assistance under section 18071 of this title in the same manner as an individual who is enrolled in a qualified health plan.

(B) No additional Federal cost

A requirement by a State under paragraph (2) that benefits in addition to the essential health benefits required under paragraph (1)(A) be provided to enrollees of a multi-State qualified health plan shall not affect the amount of a premium tax credit provided under section 36B of title 26 with respect to such plan.

(4) State must assume cost

A State shall make payments—

(A) to an individual enrolled in a multi-State qualified health plan offered in such State; or

(B) on behalf of an individual described in subparagraph (A) directly to the multi-State qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in paragraph (2).

(5) Application of certain State rating requirements

With respect to a multi-State qualified health plan that is offered in a State with age rating requirements that are lower than 3:1, the State may require that Exchanges operating in such State only permit the offering of such multi-State qualified health plans if such plans comply with the State's more protective age rating requirements.

(d) Plans deemed to be certified

A multi-State qualified health plan that is offered under a contract under subsection (a) shall be deemed to be certified by an Exchange for purposes of section 18031(d)(4)(A) of this title.

(e) Phase-in

Notwithstanding paragraphs (1) and (2) of subsection (b), the Director shall enter into a contract with a health insurance issuer for the offering of a multi-State qualified health plan under subsection (a) if—

(1) with respect to the first year for which the issuer offers such plan, such issuer offers the plan in at least 60 percent of the States;

(2) with respect to the second such year, such issuer offers the plan in at least 70 percent of the States;

(3) with respect to the third such year, such issuer offers the plan in at least 85 percent of the States; and

(4) with respect to each subsequent year, such issuer offers the plan in all States.

(f) Applicability

The requirements under chapter 89 of title 5 applicable to health benefits plans under such chapter shall apply to multi-State qualified health plans provided for under this section to the extent that such requirements do not conflict with a provision of this title.[3]

(g) Continued support for FEHBP

(1) Maintenance of effort

Nothing in this section shall be construed to permit the Director to allocate fewer financial or personnel resources to the functions of the Office of Personnel Management related to the administration of the Federal Employees Health Benefit Program under chapter 89 of title 5.

(2) Separate risk pool

Enrollees in multi-State qualified health plans under this section shall be treated as a separate risk pool apart from enrollees in the Federal Employees Health Benefit Program under chapter 89 of title 5.

(3) Authority to establish separate entities

The Director may establish such separate units or offices within the Office of Personnel Management as the Director determines to be appropriate to ensure that the administration of multi-State qualified health plans under this section does not interfere with the effective administration of the Federal Employees Health Benefit Program under chapter 89 of title 5.

(4) Effective oversight

The Director may appoint such additional personnel as may be necessary to enable the Director to carry out activities under this section.

(5) Assurance of separate program

In carrying out this section, the Director shall ensure that the program under this section is separate from the Federal Employees Health Benefit Program under chapter 89 of title 5. Premiums paid for coverage under a multi-State qualified health plan under this section shall not be considered to be Federal funds for any purposes.

(6) FEHBP plans not required to participate

Nothing in this section shall require that a carrier offering coverage under the Federal Employees Health Benefit Program under chapter 89 of title 5 also offer a multi-State qualified health plan under this section.

(h) Advisory board

The Director shall establish an advisory board to provide recommendations on the activities described in this section. A significant percentage of the members of such board shall be comprised of enrollees in a multi-State qualified health plan, or representatives of such enrollees.

(i) Authorization of appropriations

There is authorized to be appropriated, such sums as may be necessary to carry out this section.

(Pub. L. 111–148, title I, § 1334, as added Pub. L. 111–148, title X, § 10104(q), Mar. 23, 2010, 124 Stat. 902.)

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsecs. (b)(2) and (c)(1)(C), is act July 1, 1944, ch. 373, 58 Stat. 682. Part A of title XXVII of the Act is classified generally to part A (§ 300gg et seq.) of subchapter XXV of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

This title, referred to in subsecs. (b)(2), (3), (c)(1)(B), and (f), 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.

CODIFICATION

In subsec. (a)(1), ''section 6101 of title 41'' substituted for ''section 5 of title 41, United States Code,'' on authority of Pub. L. 111–350, § 6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

PART E—REINSURANCE AND RISK ADJUSTMENT

§ 18061. Transitional reinsurance program for individual market in each State

(a) In general

Each State shall, not later than January 1, 2014—

(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 18041(b) of this title the provisions described in subsection (b); and

(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

(b) Model regulation

(1) In general

In establishing the Federal standards under section 18041(a) of this title, the Secretary, in consultation with the National Association of Insurance Commissioners (the ''NAIC''), shall include provisions that enable States to establish and maintain a program under which—

(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3);[1] and

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.

(2) High-risk individual; payment amounts

The Secretary shall include the following in the provisions under paragraph (1):

(A) Determination of high-risk individuals

The method by which individuals will be identified as high risk individuals for pur-

[1] So in original. A second closing parenthesis probably should precede the semicolon.