vate 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[1] 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 maxi-

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

mize 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 section 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[2] 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.

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

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