

(b) Study and report on application of privacy and security requirements to non-HIPAA covered entities

(1) Study

Not later than one year after February 17, 2009, the Secretary, in consultation with the Federal Trade Commission, shall conduct a study, and submit a report under paragraph (2), on privacy and security requirements for entities that are not covered entities or business associates as of February 17, 2009, including—

(A) requirements relating to security, privacy, and notification in the case of a breach of security or privacy (including the applicability of an exemption to notification in the case of individually identifiable health information that has been rendered unusable, unreadable, or indecipherable through technologies or methodologies recognized by appropriate professional organization or standard setting bodies to provide effective security for the information) that should be applied to—

- (i) vendors of personal health records;
- (ii) entities that offer products or services through the website of a vendor of personal health records;
- (iii) entities that are not covered entities and that offer products or services through the websites of covered entities that offer individuals personal health records;
- (iv) entities that are not covered entities and that access information in a personal health record or send information to a personal health record; and
- (v) third party service providers used by a vendor or entity described in clause (i), (ii), (iii), or (iv) to assist in providing personal health record products or services;

(B) a determination of which Federal government agency is best equipped to enforce such requirements recommended to be applied to such vendors, entities, and service providers under subparagraph (A); and

(C) a timeframe for implementing regulations based on such findings.

(2) Report

The Secretary shall submit to the Committee on Finance, the Committee on Health, Education, Labor, and Pensions, and the Committee on Commerce of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report on the findings of the study under paragraph (1) and shall include in such report recommendations on the privacy and security requirements described in such paragraph.

(c) Guidance on implementation specification to de-identify protected health information

Not later than 12 months after February 17, 2009, the Secretary shall, in consultation with stakeholders, issue guidance on how best to implement the requirements for the de-identification of protected health information under section 164.514(b) of title 45, Code of Federal Regulations.

(d) GAO report on treatment disclosures

Not later than one year after February 17, 2009, the Comptroller General of the United States shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report on the best practices related to the disclosure among health care providers of protected health information of an individual for purposes of treatment of such individual. Such report shall include an examination of the best practices implemented by States and by other entities, such as health information exchanges and regional health information organizations, an examination of the extent to which such best practices are successful with respect to the quality of the resulting health care provided to the individual and with respect to the ability of the health care provider to manage such best practices, and an examination of the use of electronic informed consent for disclosing protected health information for treatment, payment, and health care operations.

(e) Report required

Not later than 5 years after February 17, 2009, the Government Accountability Office shall submit to Congress and the Secretary of Health and Human Services a report on the impact of any of the provisions of this Act on health insurance premiums, overall health care costs, adoption of electronic health records by providers, and reduction in medical errors and other quality improvements.

(f) Study

The Secretary shall study the definition of “psychotherapy notes” in section 164.501 of title 45, Code of Federal Regulations, with regard to including test data that is related to direct responses, scores, items, forms, protocols, manuals, or other materials that are part of a mental health evaluation, as determined by the mental health professional providing treatment or evaluation in such definitions and may, based on such study, issue regulations to revise such definition.

(Pub. L. 111-5, div. A, title XIII, § 13424, Feb. 17, 2009, 123 Stat. 276.)

REFERENCES IN TEXT

This subchapter, referred to in subsec. (a)(1), was in the original “this subtitle”, meaning subtitle D (§13400 et seq.) of title XIII of div. A of Pub. L. 111-5, Feb. 17, 2009, 123 Stat. 258, which is classified principally to this subchapter. For complete classification of subtitle D to the Code, see Tables.

This Act, referred to in subsec. (e), means div. A of Pub. L. 111-5, Feb. 17, 2009, 123 Stat. 116, see section 4 of Pub. L. 111-5, set out as a note under section 1 of Title 1, General Provisions. For complete classification of div. A to the Code, see Tables.

CHAPTER 157—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

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SUBCHAPTER I—IMMEDIATE ACTIONS TO PRESERVE AND EXPAND COVERAGE

§ 18001. Immediate access to insurance for uninsured individuals with a preexisting condition

(a) In general

Not later than 90 days after March 23, 2010, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) Administration

(1) In general

The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) Eligible entities

To be eligible for a contract under paragraph (1), an entity shall—

- (A) be a State or nonprofit private entity;
- (B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and
- (C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(3) Maintenance of effort

To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) Qualified high risk pool

(1) In general

Amounts made available under this section shall be used to establish a qualified high risk

pool that meets the requirements of paragraph (2).

(2) Requirements

A qualified high risk pool meets the requirements of this paragraph if such pool—

(A) provides to all eligible individuals health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage;

(B) provides health insurance coverage—

(i) in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs; and

(ii) that has an out of pocket limit not greater than the applicable amount described in section 223(c)(2) of title 26 for the year involved, except that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial value limit under clause (i);

(C) ensures that with respect to the premium rate charged for health insurance coverage offered to eligible individuals through the high risk pool, such rate shall—

(i) except as provided in clause (ii), vary only as provided for under section 300gg of this title (as amended by this Act and notwithstanding the date on which such amendments take effect);

(ii) vary on the basis of age by a factor of not greater than 4 to 1; and

(iii) be established at a standard rate for a standard population; and

(D) meets any other requirements determined appropriate by the Secretary.

(d) Eligible individual

An individual shall be deemed to be an eligible individual for purposes of this section if such individual—

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 18081 of this title);

(2) has not been covered under creditable coverage (as defined in section 300gg(c)(1) of this title as in effect on March 23, 2010) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and

(3) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

(e) Protection against dumping risk by insurers

(1) In general

The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

(2) Sanctions

An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual who, based on criteria established by

the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program. The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of money or other financial consideration for disenrolling from the coverage.

(B) In the case of prior coverage obtained directly from an issuer or under an employment-based health plan—

(i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or

(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)—

(I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or

(II) the prior coverage is a policy for which duration of coverage form¹ issue or health status are factors that can be considered in determining premiums at renewal.

(3) Construction

Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing States from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(f) Oversight

The Secretary shall establish—

(1) an appeals process to enable individuals to appeal a determination under this section; and

(2) procedures to protect against waste, fraud, and abuse.

(g) Funding; termination of authority

(1) In general

There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, \$5,000,000,000 to pay claims against (and the administrative costs of) the high risk pool under this section that are in excess of the amount of premiums collected from eligible individuals enrolled in the high risk pool. Such funds shall be available without fiscal year limitation.

(2) Insufficient funds

If the Secretary estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit.

¹ So in original. Probably should be "from".

(3) Termination of authority**(A) In general**

Except as provided in subparagraph (B), coverage of eligible individuals under a high risk pool in a State shall terminate on January 1, 2014.

(B) Transition to Exchange

The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through a high risk pool established under this section into qualified health plans offered through an Exchange. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

(4) Limitations

The Secretary has the authority to stop taking applications for participation in the program under this section to comply with the funding limitation provided for in paragraph (1).

(5) Relation to State laws

The standards established under this section shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to qualified high risk pools which are established in accordance with this section.

(Pub. L. 111-148, title I, §1101, Mar. 23, 2010, 124 Stat. 141.)

REFERENCES IN TEXT

This Act, referred to in subsec. (c)(2)(C)(i), 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 below and Tables.

The date on which such amendments take effect, referred to in subsec. (c)(2)(C)(i), is the date on which the amendments by Pub. L. 111-148 to section 300gg of this title take effect, which is Jan. 1, 2014. See section 1255 of Pub. L. 111-148, set out as an Effective Date note under section 300gg of this title.

SHORT TITLE OF 2014 AMENDMENT

Pub. L. 113-235, div. M, §1, Dec. 16, 2014, 128 Stat. 2767, provided that: "This division [enacting section 18014 of this title] may be cited as the 'Expatriate Health Coverage Clarification Act of 2014'."

SHORT TITLE

Pub. L. 111-148, §1(a), Mar. 23, 2010, 124 Stat. 119, provided that: "This Act [see Tables for classification] may be cited as the 'Patient Protection and Affordable Care Act'."

EX. ORD. NO. 13765. MINIMIZING THE ECONOMIC BURDEN OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT PENDING REPEAL

Ex. Ord. No. 13765, Jan. 20, 2017, 82 F.R. 8351, provided: By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. It is the policy of my Administration to seek the prompt repeal of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended (the "Act"). In the meantime, pending such repeal, it is

imperative for the executive branch to ensure that the law is being efficiently implemented, take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open healthcare market.

SEC. 2. To the maximum extent permitted by law, the Secretary of Health and Human Services (Secretary) and the heads of all other executive departments and agencies (agencies) with authorities and responsibilities under the Act shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications.

SEC. 3. To the maximum extent permitted by law, the Secretary and the heads of all other executive departments and agencies with authorities and responsibilities under the Act, shall exercise all authority and discretion available to them to provide greater flexibility to States and cooperate with them in implementing healthcare programs.

SEC. 4. To the maximum extent permitted by law, the head of each department or agency with responsibilities relating to healthcare or health insurance shall encourage the development of a free and open market in interstate commerce for the offering of healthcare services and health insurance, with the goal of achieving and preserving maximum options for patients and consumers.

SEC. 5. To the extent that carrying out the directives in this order would require revision of regulations issued through notice-and-comment rulemaking, the heads of agencies shall comply with the Administrative Procedure Act and other applicable statutes in considering or promulgating such regulatory revisions.

SEC. 6. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

EX. ORD. NO. 13813. PROMOTING HEALTHCARE CHOICE AND COMPETITION ACROSS THE UNITED STATES

Ex. Ord. No. 13813, Oct. 12, 2017, 82 F.R. 48385, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Policy.* (a) It shall be the policy of the executive branch, to the extent consistent with law, to facilitate the purchase of insurance across State lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people. The Patient Protection and Affordable Care Act (PPACA), however, has severely limited the choice of healthcare options available to many Americans and has produced large premium increases in many State individual markets for health insurance. The average exchange premium in the 39 States that are using www.healthcare.gov in 2017 is more than double the average overall individual market premium recorded in 2013. The PPACA has also largely failed to provide meaningful choice or competi-

tion between insurers, resulting in one-third of America's counties having only one insurer offering coverage on their applicable government-run exchange in 2017.

(b) Among the myriad areas where current regulations limit choice and competition, my Administration will prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs).

(i) Large employers often are able to obtain better terms on health insurance for their employees than small employers because of their larger pools of insurable individuals across which they can spread risk and administrative costs. Expanding access to AHPs can help small businesses overcome this competitive disadvantage by allowing them to group together to self-insure or purchase large group health insurance. Expanding access to AHPs will also allow more small businesses to avoid many of the PPACA's costly requirements. Expanding access to AHPs would provide more affordable health insurance options to many Americans, including hourly wage earners, farmers, and the employees of small businesses and entrepreneurs that fuel economic growth.

(ii) STLDI is exempt from the onerous and expensive insurance mandates and regulations included in title I of the PPACA. This can make it an appealing and affordable alternative to government-run exchanges for many people without coverage available to them through their workplaces. The previous administration took steps to restrict access to this market by reducing the allowable coverage period from less than 12 months to less than 3 months and by preventing any extensions selected by the policyholder beyond 3 months of total coverage.

(iii) HRAs are tax-advantaged, account-based arrangements that employers can establish for employees to give employees more flexibility and choices regarding their healthcare. Expanding the flexibility and use of HRAs would provide many Americans, including employees who work at small businesses, with more options for financing their healthcare.

(c) My Administration will also continue to focus on promoting competition in healthcare markets and limiting excessive consolidation throughout the healthcare system. To the extent consistent with law, government rules and guidelines affecting the United States healthcare system should:

(i) expand the availability of and access to alternatives to expensive, mandate-laden PPACA insurance, including AHPs, STLDI, and HRAs;

(ii) re-inject competition into healthcare markets by lowering barriers to entry, limiting excessive consolidation, and preventing abuses of market power; and

(iii) improve access to and the quality of information that Americans need to make informed healthcare decisions, including data about healthcare prices and outcomes, while minimizing reporting burdens on affected plans, providers, or payers.

SEC. 2. *Expanded Access to Association Health Plans.* Within 60 days of the date of this order, the Secretary of Labor shall consider proposing regulations or revising guidance, consistent with law, to expand access to health coverage by allowing more employers to form AHPs. To the extent permitted by law and supported by sound policy, the Secretary should consider expanding the conditions that satisfy the commonality-of-interest requirements under current Department of Labor advisory opinions interpreting the definition of an "employer" under section 3(5) of the Employee Retirement Income Security Act of 1974. The Secretary of Labor should also consider ways to promote AHP formation on the basis of common geography or industry.

SEC. 3. *Expanded Availability of Short-Term, Limited-Duration Insurance.* Within 60 days of the date of this order, the Secretaries of the Treasury, Labor, and Health and Human Services shall consider proposing regulations or revising guidance, consistent with law, to expand the availability of STLDI. To the extent permitted by law and supported by sound policy, the Sec-

retaries should consider allowing such insurance to cover longer periods and be renewed by the consumer.

SEC. 4. *Expanded Availability and Permitted Use of Health Reimbursement Arrangements.* Within 120 days of the date of this order, the Secretaries of the Treasury, Labor, and Health and Human Services shall consider proposing regulations or revising guidance, to the extent permitted by law and supported by sound policy, to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.

SEC. 5. *Public Comment.* The Secretaries shall consider and evaluate public comments on any regulations proposed under sections 2 through 4 of this order.

SEC. 6. *Reports.* Within 180 days of the date of this order, and every 2 years thereafter, the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor and the Federal Trade Commission, shall provide a report to the President that:

(a) details the extent to which existing State and Federal laws, regulations, guidance, requirements, and policies fail to conform to the policies set forth in section 1 of this order; and

(b) identifies actions that States or the Federal Government could take in furtherance of the policies set forth in section 1 of this order.

SEC. 7. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

EX. ORD. NO. 13877. IMPROVING PRICE AND QUALITY TRANSPARENCY IN AMERICAN HEALTHCARE TO PUT PATIENTS FIRST

Ex. Ord. No. 13877, June 24, 2019, 84 F.R. 30849, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Purpose.* My Administration seeks to enhance the ability of patients to choose the healthcare that is best for them. To make fully informed decisions about their healthcare, patients must know the price and quality of a good or service in advance. With the predominant role that third-party payers and Government programs play in the American healthcare system, however, patients often lack both access to useful price and quality information and the incentives to find low-cost, high-quality care. Opaque pricing structures may benefit powerful special interest groups, such as large hospital systems and insurance companies, but they generally leave patients and taxpayers worse off than would a more transparent system.

Pursuant to Executive Order 13813 of October 12, 2017 (Promoting Healthcare Choice and Competition Across the United States) [set out above], my Administration issued a report entitled "Reforming America's Healthcare System Through Choice and Competition." The report recommends developing price and quality transparency initiatives to ensure that healthcare patients can make well-informed decisions about their care. In particular, the report describes the characteristics of the most effective price transparency efforts: they distinguish between the charges that providers bill and the rates negotiated between payers and pro-

viders; they give patients proper incentives to seek information about the price of healthcare services; and they provide useful price comparisons for “shoppable” services (common services offered by multiple providers through the market, which patients can research and compare before making informed choices based on price and quality).

Shoppable services make up a significant share of the healthcare market, which means that increasing transparency among these services will have a broad effect on increasing competition in the healthcare system as a whole. One study, cited by the Council of Economic Advisers in its 2019 Annual Report, examined a sample of the highest-spending categories of medical cases requiring inpatient and outpatient care. Of the categories of medical cases requiring inpatient care, 73 percent of the 100 highest-spending categories were shoppable. Among the categories of medical cases requiring outpatient care, 90 percent of the 300 highest-spending categories were shoppable. Another study demonstrated that the ability of patients to price-shop imaging services, a particularly fungible and shoppable set of healthcare services, was associated with a per-service savings of up to approximately 19 percent.

Improving transparency in healthcare will also further protect patients from harmful practices such as surprise billing, which occurs when patients receive unexpected bills at highly inflated prices from out-of-network providers they had no opportunity to select in advance. On May 9, 2019, I announced principles to guide efforts to address surprise billing. The principles outline how patients scheduling appointments to receive facility-based care should have access to pricing information related to the providers and services they may need, and the out-of-pocket costs they may incur. Having access to this type of information in advance of care can help patients avoid excessive charges.

Making meaningful price and quality information more broadly available to more Americans will protect patients and increase competition, innovation, and value in the healthcare system.

SEC. 2. Policy. It is the policy of the Federal Government to ensure that patients are engaged with their healthcare decisions and have the information requisite for choosing the healthcare they want and need. The Federal Government aims to eliminate unnecessary barriers to price and quality transparency; to increase the availability of meaningful price and quality information for patients; to enhance patients’ control over their own healthcare resources, including through tax-preferred medical accounts; and to protect patients from surprise medical bills.

SEC. 3. Informing Patients About Actual Prices. (a) Within 60 days of the date of this order [June 24, 2019], the Secretary of Health and Human Services shall propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format using consensus-based data standards that will meaningfully inform patients’ decision making and allow patients to compare prices across hospitals. The regulation should require the posting of standard charge information for services, supplies, or fees billed by the hospital or provided by employees of the hospital. The regulation should also require hospitals to regularly update the posted information and establish a monitoring mechanism for the Secretary to ensure compliance with the posting requirement, as needed.

(b) Within 90 days of the date of this order, the Secretaries of Health and Human Services, the Treasury, and Labor shall issue an advance notice of proposed rule-making, consistent with applicable law, soliciting comment on a proposal to require healthcare providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care.

(c) Within 180 days of the date of this order, the Secretary of Health and Human Services, in consultation with the Attorney General and the Federal Trade Commission, shall issue a report describing the manners in which the Federal Government or the private sector are impeding healthcare price and quality transparency for patients, and providing recommendations for eliminating these impediments in a way that promotes competition. The report should describe why, under current conditions, lower-cost providers generally avoid healthcare advertising.

SEC. 4. Establishing a Health Quality Roadmap. Within 180 days of the date of this order, the Secretaries of Health and Human Services, Defense, and Veterans Affairs shall develop a Health Quality Roadmap (Roadmap) that aims to align and improve reporting on data and quality measures across Medicare, Medicaid, the Children’s Health Insurance Program, the Health Insurance Marketplace, the Military Health System, and the Veterans Affairs Health System. The Roadmap shall include a strategy for establishing, adopting, and publishing common quality measurements; aligning inpatient and outpatient measures; and eliminating low-value or counterproductive measures.

SEC. 5. Increasing Access to Data to Make Healthcare Information More Transparent and Useful to Patients. Within 180 days of the date of this order, the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury, Defense, Labor, and Veterans Affairs, and the Director of the Office of Personnel Management, shall increase access to de-identified claims data from taxpayer-funded healthcare programs and group health plans for researchers, innovators, providers, and entrepreneurs, in a manner that is consistent with applicable law and that ensures patient privacy and security. Providing access to this data will facilitate the development of tools that empower patients to be better informed as they make decisions related to healthcare goods and services. Access to this data will also enable researchers and entrepreneurs to locate inefficiencies and opportunities for improvement, such as patterns of performance of medical procedures that are outside the recommended standards of care. Such data may be derived from the Transformed Medicaid Statistical Information System (T-MSIS) and other sources. As part of this process, the Secretary of Health and Human Services shall make a list of priority datasets that, if de-identified, could advance the policies set forth by this order, and shall report to the President on proposed plans for future release of these priority datasets and on any barriers to their release.

SEC. 6. Empowering Patients by Enhancing Control Over Their Healthcare Resources. (a) Within 120 days of the date of this order, the Secretary of the Treasury, to the extent consistent with law, shall issue guidance to expand the ability of patients to select high-deductible health plans that can be used alongside a health savings account, and that cover low-cost preventive care, before the deductible, for medical care that helps maintain health status for individuals with chronic conditions.

(b) Within 180 days of the date of this order, the Secretary of the Treasury, to the extent consistent with law, shall propose regulations to treat expenses related to certain types of arrangements, potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses under section 213(d) of title 26, United States Code.

(c) Within 180 days of the date of this order, the Secretary of the Treasury, to the extent consistent with law, shall issue guidance to increase the amount of funds that can carry over without penalty at the end of the year for flexible spending arrangements.

SEC. 7. Addressing Surprise Medical Billing. Within 180 days of the date of this order, the Secretary of Health and Human Services shall submit a report to the President on additional steps my Administration may take to implement the principles on surprise medical billing announced on May 9, 2019.

SEC. 8. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

EX. ORD. NO. 13951. AN AMERICA-FIRST HEALTHCARE PLAN

Ex. Ord. No. 13951, Sept. 24, 2020, 85 F.R. 62179, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Purpose.* Since January 20, 2017, my Administration has been committed to the goal of bringing great healthcare to the American people and putting patients first. To that end, my Administration has taken monumental steps to improve the efficiency and quality of healthcare in the United States.

(a) My Administration has been committed to restoring choice and control to the American patient.

On December 22, 2017, I signed into law the repeal of the burdensome individual-mandate penalty, liberating millions of low-income Americans from a tax that penalized them for not purchasing health-insurance coverage they did not want or could not afford. Through Executive Order 13813 of October 12, 2017 (Promoting Healthcare Choice and Competition Across the United States) [set out above], my Administration has expanded coverage options for millions of Americans in several ways. My Administration increased the availability of renewable short-term, limited-duration healthcare plans, providing options that are up to 60 percent cheaper than the least expensive alternatives under the Patient Protection and Affordable Care Act (ACA) [Pub. L. 111-148] and are projected to cover 500,000 individuals who would otherwise be uninsured. My Administration expanded health reimbursement arrangements, which have been projected by the Department of the Treasury to reach 800,000 businesses and over 11 million employees and to expand coverage to more than 800,000 individuals who would otherwise be uninsured. My Administration also issued a rule to increase the availability of association health plans for small businesses, which, upon implementation of the rule, are projected to cover up to 400,000 previously uninsured individuals for on average 30 percent less cost.

As set forth in the Economic Report of the President (February 2020), my Administration's expansion of health savings accounts will further help millions of Americans pay for health expenditures by allowing them to save more of their own money free from Federal taxation, and will especially help Americans with chronic conditions who now have more flexibility to enroll in plans that fit their complicated care needs and can be paired with a tax-advantaged account.

At the beginning of the current COVID-19 pandemic, my Administration acted to dramatically increase the accessibility and availability of telehealth services for Medicare beneficiaries, enabling millions of individuals to use these services. Pursuant to Executive Order 13941 of August 3, 2020 (Improving Rural Health and Telehealth Access) [42 U.S.C. 254c note], the Secretary of Health and Human Services will make permanent many of the new policies that improve the accessibility and availability of telehealth services. In addition, pursuant to that order, the Secretary of Health and Human Services and the Secretary of Agriculture will

develop and implement a strategy to improve the physical and communications healthcare infrastructure available to rural Americans.

Through our State Relief and Empowerment Waivers, my Administration has given States additional health-insurance flexibility, which has expanded health-insurance coverage options for consumers and lowered costs for patients. These waivers allow States to move away from the ACA's rigid structure and are estimated to have lowered premiums by approximately 11 percent in Wisconsin, 20 percent in Minnesota, and 43 percent in Maryland. Due to actions my Administration took, like the State Relief and Empowerment Waivers, after years of dwindling choices and escalating prices, plan options for consumers increased and for 2019, for the first time ever, benchmark premiums actually decreased on Healthcare.gov. For 2020, the average benchmark premium dropped by nearly 4 percent.

After the prior Administration spent tens of billions of dollars creating electronic health records systems unable to accurately or effectively record and communicate patient data, my Administration has paved the way for a new wave of innovation to allow patients to safely send their own medical records to care providers of their choosing. My Patients over Paperwork initiative has cut red tape for doctors and nurses so they can spend more time with their patients, which the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) has estimated to save over 40 million hours of wasted time for providers and suppliers between 2017 and 2021.

(b) My Administration has been ceaseless in its efforts to lower costs to make healthcare more affordable for American patients.

Under my tenure, prescription drugs saw their largest annual price decrease in nearly half a century. For three consecutive years, we have approved a record number of generic drugs. The Council of Economic Advisers has estimated that these approvals saved patients \$26 billion in the first 18 months of my Administration alone. As part of the Further Consolidated Appropriations Act, 2020 [Pub. L. 116-94], I signed into law the Creating and Restoring Equal Access to Equivalent Samples Act [see 21 U.S.C. 355-2], which will pave the way for even more generic drugs and is projected to save taxpayers \$3.3 billion from 2019 to 2029.

CMS has acted to offer Medicare beneficiaries prescription drug plans with the option of insulin capped at \$35 in out-of-pocket expenses for a 30-day supply. We are also reducing Government payments to overcharging hospitals participating in the 340B Drug Pricing Program by instead paying rates that more accurately reflect the hospitals' acquisition costs, which CMS estimated would save Medicare beneficiaries \$320 million on copayments for drugs alone.

As a result of Executive Order 13937 of July 24, 2020 (Access to Affordable Life-Saving Medications) [42 U.S.C. 254b note], low-income Americans who receive care from a federally qualified health center will have access to insulin and injectable epinephrine at prices lower than ever before. Under Executive Order 13938 of July 24, 2020 (Increasing Drug Importation to Lower Prices for American Patients) [21 U.S.C. 384 note], my Administration will be the first to complete a rule-making to authorize the safe importation of certain lower-cost prescription drugs from Canada. Pursuant to Executive Order 13939 of July 24, 2020 (Lowering Prices for Patients by Eliminating Kickbacks to Middlemen) [42 U.S.C. 1320a-7b note], my Administration is taking action to eliminate wasteful payments to middlemen by passing drug discounts through to patients at the pharmacy counter without increasing premiums for beneficiaries or cost to Federal taxpayers. And my Administration is taking action to ensure that Medicare patients receive the lowest price that drug companies offer comparable foreign nations through Executive Order 13948 of September 13, 2020 (Lowering Drug Prices by Putting America First) [42 U.S.C. 1395u note].

As part of the Further Consolidated Appropriations Act, 2020, I also signed into law the repeal of the med-

ical device tax, the annual fee on health-insurance providers, and the “Cadillac” tax on certain employer-sponsored health insurance, which threatened to dramatically increase the cost of healthcare for working families.

My Administration is transforming the black-box hospital and insurance pricing systems to be transparent about price and quality. Regardless of health-insurance coverage, two-thirds of adults in America still worry about the threat of unexpected medical bills. This fear is the result of a system under which individuals and employers are unable to see how insurance companies, pharmacy benefit managers, insurance brokers, and providers are or will be paid. One major culprit is the practice of “surprise billing,” in which a patient receives unexpected bills at highly inflated prices from providers who are not part of the patient’s insurance network, even if the patient was treated at a hospital that was part of the patient’s network. Patients can receive these bills despite having no opportunity to select around an out-of-network provider in advance.

On May 9, 2019, I announced four principles to guide congressional efforts to prohibit exorbitant bills resulting from patients’ accidentally or unknowingly receiving services from out-of-network physicians. Unfortunately, the Congress has failed to act, and patients remain vulnerable to surprise billing.

In the absence of congressional action, my Administration has already taken strong and decisive action to make healthcare prices more transparent. On June 24, 2019, I signed Executive Order 13877 (Improving Price and Quality Transparency in American Healthcare to Put Patients First) [set out above], directing certain agencies—for the first time ever—to make sure patients have access to meaningful price and quality information prior to the delivery of care. Beginning January 1, 2021, hospitals will be required to publish their real price for every service, and publicly display in a consumer-friendly, easy-to-understand format the prices of at least 300 different common services that are able to be shopped for in advance.

We have also taken some concrete steps to eliminate surprise out-of-network bills. For example, on April 10, 2020, my Administration required providers to certify, as a condition of receiving supplemental COVID-19 funding, that they would not seek to collect out-of-pocket expenses from a patient for treatment related to COVID-19 in an amount greater than what the patient would have otherwise been required to pay for care by an in-network provider. These initiatives have made important progress, although additional efforts are necessary.

Not all hospitals allow for surprise bills. But many do. Unfortunately, surprise billing has become sufficiently pervasive that the fear of receiving a surprise bill may dissuade patients from seeking appropriate care. And research suggests a correlation between hospitals that frequently allow surprise billing and increases in hospital admissions and imaging procedures, putting patients at risk of receiving unnecessary services, which can lead to physical harm and threatens the long-term financial sustainability of Medicare.

Efforts to limit surprise billing and increase the number of providers participating in the same insurance network as the hospital in which they work would correspondingly streamline the ability of patients to receive care and reduce time spent on billing disputes.

On May 15, 2020, HHS released the Health Quality Roadmap to empower patients to make fully informed decisions about their healthcare by facilitating the availability of appropriate and meaningful price and quality information. These transformative actions will arm patients with the tools to be active and effective shoppers for healthcare services, enabling them to identify high-value providers and services, and ultimately place downward pressure on prices.

My Administration has cracked down on waste, fraud, and abuse that direct valuable taxpayer resources away from those who need them most. My Administration implemented a “site neutral” payment

system between hospital outpatient departments and physicians’ offices, to ensure Medicare beneficiaries are charged the same price for the same service regardless of where it takes place, which CMS estimates will save them approximately \$160 million in co-payments for 2020. We also changed the rules to enable Government watchdogs to proactively identify and stop perpetrators of fraud before money goes out the door.

(c) My Administration has been dedicated to providing better care for all Americans.

This includes a steadfast commitment to always protecting individuals with pre-existing conditions and ensuring they have access to the high-quality healthcare they deserve. No American should have to risk going without health insurance based on a health history that he or she cannot change.

In an attempt to justify the ACA, the previous Administration claimed that, absent action by the Congress, up to 129 million (later updated to 133 million) non-elderly people with what it described as pre-existing conditions were in danger of being denied health-insurance coverage. According to the previous Administration, however, only 2.7 percent of such individuals actually gained access to health insurance through the ACA, given existing laws and programs already in place to cover them. For example, the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191] has long protected individuals with pre-existing conditions, including individuals covered by group health plans and individuals who had such coverage but lost it.

The ACA produced multiple other failures. The average insurance premium in the individual market more than doubled from 2013 to 2017, and those who have not received generous Federal subsidies have struggled to maintain coverage. For those who have managed to maintain coverage, many have experienced a substantial rise in deductibles, limited choice of insurers, and limited provider networks that exclude their doctors and the facilities best suited to care for them.

Additionally, approximately 30 million Americans remain uninsured, notwithstanding the previous Administration’s promises that the ACA would address this intractable problem. On top of these disappointing results, Federal taxpayers and, unfortunately, future generations of American workers, have been left with an enormous bill. The ACA’s Medicaid expansion and subsidies for the individual market are projected by the Congressional Budget Office to cost more than \$1.8 trillion over the next decade.

The ACA is neither the best nor the only way to ensure that Americans who suffer from pre-existing conditions have access to health-insurance coverage. I have agreed with the States challenging the ACA, who have won in the Federal district court and court of appeals, that the ACA, as amended, exceeds the power of the Congress. The ACA was flawed from its inception and should be struck down. However, access to health insurance despite underlying health conditions should be maintained, even if the Supreme Court invalidates the unconstitutional, and largely harmful, ACA.

My Administration has always been committed to ensuring that patients with pre-existing conditions can obtain affordable healthcare, to lowering healthcare costs, to improving quality of care, and to enabling individuals to choose the healthcare that meets their needs. For example, when the COVID-19 pandemic hit, my Administration implemented a program to provide any individual without health-insurance coverage access to necessary COVID-19-related testing and treatment.

My commitment to improving care across our country expands vastly beyond the rules governing health insurance. On July 10, 2019, I signed Executive Order 13879 (Advancing American Kidney Health) [42 U.S.C. 280g-6 note] to improve care for the hundreds of thousands of Americans suffering from end-stage renal disease. Pursuant to that order, my Administration launched a program to encourage home dialysis and promote transplants for patients, and expects to enroll

approximately 120,000 Medicare beneficiaries with end-stage renal disease in the program. We also have removed financial barriers to living organ donation by adding additional financial support for living donors, such as by reimbursing expenses for lost wages, child care, and elder care. HHS, together with the American Society of Nephrology, issued two phases of awards through KidneyX's Redesign Dialysis Price Competition to work toward the creation of an artificial kidney.

My Administration has taken unprecedented action to improve the quality of and access to care for individuals with HIV, as part of our goal of ending the epidemic of HIV in the United States by 2030. HHS has awarded at least \$226 million to expand access to HIV care, treatment, medication, and prevention services, focused on 48 counties, Washington, DC, and San Juan, Puerto Rico, where more than 50 percent of new HIV diagnoses occurred in 2016 and 2017, as well as seven States with a substantial rural HIV rate. We secured a historic donation of a groundbreaking HIV preventive medication that is available at no cost to eligible patients.

My Administration has started a transformation in healthcare in rural America. This includes a new effort, pursuant to my directive in Executive Order 13941, to support small hospitals and health clinics in rural communities in transitioning from volume-based Medicare and Medicaid reimbursement, which has failed rural communities that struggle with a lack of patient volume, and toward value-based payment mechanisms that are tailored to meet the needs of their communities. We updated Medicare payment policies to address a problem in the program's payment calculation that has historically disadvantaged rural hospitals, and released a Rural Action Plan to incorporate recommendations from experts and leaders across the Federal Government. We have also dedicated a special focus on improving care offered through the Indian Health Service (IHS) within HHS, including by creating the Office of Quality, implementing an increase in annual funding for IHS by \$243 million from 2019 to 2020, and expanding nationwide IHS's successful Alaska Community Health Aide Program.

My Administration has additionally demonstrated an incredible dedication to protecting and improving care for those most in need, including senior citizens, those with substance use disorders, and those to whom our Nation owes the greatest debt: our veterans.

I have protected the viability of the Medicare program. For example, on February 9, 2018, I signed into law the repeal of the Independent Payment Advisory Board, which would have been a group of unelected bureaucrats created by the ACA, designed to be insulated from the will of America's elected leaders for the purpose of cutting the spending of this important program. On October 3, 2019, I signed Executive Order 13890 (Protecting and Improving Medicare for Our Nation's Seniors) [42 U.S.C. 1395 note prec.], to modernize the Medicare program and continue its viability. According to CMS estimates, seniors have saved \$2.65 billion in lower Medicare premiums under my Administration while benefiting from more choices. For example, the average monthly Medicare Advantage premium has declined an estimated 28 percent since 2017, and Medicare Advantage has included about 1,200 more plan options since 2018. New Medicare Advantage supplemental benefits have helped seniors stay safe in their homes, improved respite care for caregivers, and provided transportation, more in-home support services and assistance, and non-opioid pain management alternatives like therapeutic massages. Medicare Part D premiums are at their lowest level in their history, with the average basic premium declining 13.5 percent since 2016.

My Administration has directed unprecedented attention on the substance use disorder epidemic, with a focus on reducing overdose deaths from prescription opioids and the deadly synthetic opioid fentanyl. On October 24, 2018, I signed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treat-

ment for Patients and Communities Act [Pub. L. 115-271], enabling the expenditure of billions of dollars of funding for important programs to support prevention and recovery. My Administration has provided approximately \$22.5 billion from 2017 to 2020 to address the opioid crisis and improve access to prevention, treatment, and recovery services. We saw a 34 percent decrease in total opioids dispensed monthly by pharmacies between 2017 and 2019, an approximate increase of 64 percent in the number of Americans who receive medication-assisted treatment for opioid use disorder since 2016, and a 484 percent increase in naloxone prescriptions since 2017. Data show that drug overdose deaths fell nationwide for the first time in decades between 2017 and 2018, with many of the hardest-hit States leading the way.

Improving care for our Nation's veterans has been a priority since the beginning of my Administration. On June 6, 2018, I signed the [John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 [Pub. L. 115-182], which authorized billions of dollars to improve options for veterans to receive care outside of Department of Veterans Affairs (VA) healthcare providers. Since taking effect, the VA estimates that more than 2.4 million veterans have benefited from more than 6.5 million referrals to the 725,000 private healthcare providers with which the VA is now working. On June 23, 2017, I signed the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 [Pub. L. 115-41] to hold our civil servants accountable for maintaining the best quality of care possible for our Nation's veterans by giving the Secretary of Veterans Affairs more power to discipline employees and shorten an appeals process that can last years. On March 5, 2019, I signed Executive Order 13861 (National Roadmap to Empower Veterans and End Suicide) [Mar. 5, 2019, 84 F.R. 8585] to ensure that the Federal Government leads a collective effort to prevent suicide among our veterans.

I have used scientific research to focus on areas most pressing for the health of Americans. On September 19, 2019, I signed Executive Order 13887 (Modernizing Influenza Vaccines in the United States to Promote National Security and Public Health) [42 U.S.C. 247d-7e note], recognizing the threat that pandemic influenza continues to represent and putting forward a plan to prepare for future influenza pandemics. To modernize influenza vaccines and promote national security and public health, HHS issued a 6-year, \$226 million contract to retain and increase capacity to produce recombinant influenza vaccine domestically, and the National Institute of Allergy and Infectious Diseases, part of the National Institutes of Health within HHS, initiated the Collaborative Influenza Vaccine Innovation Centers program.

Investments my Administration has made in scientific research will help tackle some of our most pressing medical challenges and pay dividends for generations to come. This includes working to increase funding for Alzheimer's disease research by billions of dollars since 2017 and a plan to invest more than \$500 million over the next decade to improve pediatric cancer research. On December 18, 2018, I signed the Sickle Cell Disease and Other Heritable Blood Disorders Research, Surveillance, Prevention, and Treatment Act of 2018 [Pub. L. 115-327, see 42 U.S.C. 300b-5] to provide support for research into sickle cell disease, which disproportionately impacts African Americans and Hispanics, and to authorize programs relating to sickle cell disease surveillance, prevention, and treatment.

On May 30, 2018, I signed the Trickett Wendler, Frank Mongiello, Jordan McLinn, and Matthew Bellina Right to Try Act of 2017 [Pub. L. 115-176, see 21 U.S.C. 360bbb-0a], which gives terminally ill patients the right to access certain treatments without being blocked by onerous Federal regulations.

In response to the COVID-19 pandemic, my Administration launched Operation Warp Speed, a groundbreaking effort of the Federal Government to

engage with the private sector to quickly develop and deliver safe and effective vaccines, therapeutics, and diagnostics for COVID-19. On August 6, 2020, I signed Executive Order 13944 (Combating Public Health Emergencies and Strengthening National Security by Ensuring Essential Medicines, Medical Countermeasures, and Critical Inputs Are Made in the United States) [42 U.S.C. 247d-6b note], to protect Americans through reduced dependence on foreign manufacturers for essential medicines and other items and to strengthen the Nation's Public Health Industrial Base.

Taken together, these extraordinary reforms constitute an ongoing effort to improve American healthcare by putting patients first and delivering continuous innovation. And this effort will continue to succeed because of my Administration's commitment to delivering great healthcare with more choices, better care, and lower costs for all Americans.

SEC. 2. Policy. It has been and will continue to be the policy of the United States to give Americans seeking healthcare more choice, lower costs, and better care and to ensure that Americans with pre-existing conditions can obtain the insurance of their choice at affordable rates.

SEC. 3. Giving Americans More Choice in Healthcare. The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services shall maintain and build upon existing actions to expand access to and options for affordable healthcare.

SEC. 4. Lowering Healthcare Costs for Americans. (a) The Secretary of Health and Human Services, in coordination with the Commissioner of Food and Drugs, shall maintain and build upon existing actions to expand access to affordable medicines, including accelerating the approvals of new generic and biosimilar drugs and facilitating the safe importation of affordable prescription drugs from abroad.

(b) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services shall maintain and build upon existing actions to ensure consumers have access to meaningful price and quality information prior to the delivery of care.

(i) Recognizing that both chambers of the Congress have made substantial progress towards a solution to end surprise billing, the Secretary of Health and Human Services shall work with the Congress to reach a legislative solution by December 31, 2020.

(ii) In the event a legislative solution is not reached by December 31, 2020, the Secretary of Health and Human Services shall take administrative action to prevent a patient from receiving a bill for out-of-pocket expenses that the patient could not have reasonably foreseen.

(iii) Within 180 days of the date of this order [Sept. 24, 2020], the Secretary of Health and Human Services shall update the Medicare.gov Hospital Compare website to inform beneficiaries of hospital billing quality, including:

(A) whether the hospital is in compliance with the Hospital Price Transparency Final Rule, as amended (84 Fed. Reg. 65524), effective January 1, 2021;

(B) whether, upon discharge, the hospital provides patients with a receipt that includes a list of itemized services received during a hospital stay; and

(C) how often the hospital pursues legal action against patients, including to garnish wages, to place a lien on a patient's home, or to withdraw money from a patient's income tax refund.

(c) The Secretary of Health and Human Services, in coordination with the Administrator of CMS, shall maintain and build upon existing actions to reduce waste, fraud, and abuse in the healthcare system.

SEC. 5. Providing Better Care to Americans. (a) The Secretary of Health and Human Services and the Secretary of Veterans Affairs shall maintain and build upon existing actions to improve quality in the delivery of care for veterans.

(b) The Secretary of Health and Human Services shall continue to promote medical innovations to find novel and improved treatments for COVID-19, Alzheimer's

disease, sickle cell disease, pediatric cancer, and other conditions threatening the well-being of Americans.

SEC. 6. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

§ 18002. Reinsurance for early retirees

(a) Administration

(1) In general

Not later than 90 days after March 23, 2010, the Secretary shall establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees) during the period beginning on the date on which such program is established and ending on January 1, 2014.

(2) Reference

In this section:

(A) Health benefits

The term "health benefits" means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary, whether self-funded, or delivered through the purchase of insurance or otherwise.

(B) Employment-based plan

The term "employment-based plan" means a group benefits plan providing health benefits that—

(i) is—

(I) maintained by one or more current or former employers (including without limitation any State or local government or political subdivision thereof or any agency or instrumentality of any of the foregoing), employee organization, a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or

(II) a multiemployer plan (as defined in section 1002(37) of title 29); and

(ii) provides health benefits to early retirees.

(C) Early retirees

The term "early retirees" means individuals who are age 55 and older but are not eligible for coverage under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and who are not active employees of an employer maintaining, or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such plan.

(b) Participation**(1) Employment-based plan eligibility**

A participating employment-based plan is an employment-based plan that—

(A) meets the requirements of paragraph (2) with respect to health benefits provided under the plan; and

(B) submits to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.

(2) Employment-based health benefits

An employment-based plan meets the requirements of this paragraph if the plan—

(A) implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions;

(B) provides documentation of the actual cost of medical claims involved; and

(C) is certified by the Secretary.

(c) Payments**(1) Submission of claims****(A) In general**

A participating employment-based plan shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted.

(B) Basis for claims

Claims submitted under subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the health benefits provided to an early retiree or the spouse, surviving spouse, or dependent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the early retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles, co-payments, or co-insurance shall be included in the amounts paid by the participating employment-based plan.

(2) Program payments

If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceed \$15,000, subject to the limits contained in paragraph (3).

(3) Limit

To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan shall not be less than \$15,000 nor greater than \$90,000. Such amounts

shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of \$1,000) for the year involved.

(4) Use of payments

Amounts paid to a participating employment-based plan under this subsection shall be used to lower costs for the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. Such payments shall not be used as general revenues for an entity described in subsection (a)(2)(B)(i). The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such entities.

(5) Payments not treated as income

Payments received under this subsection shall not be included in determining the gross income of an entity described in subsection (a)(2)(B)(i) that is maintaining or currently contributing to a participating employment-based plan.

(6) Appeals

The Secretary shall establish—

(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and

(B) procedures to protect against fraud, waste, and abuse under the program.

(d) Audits

The Secretary shall conduct annual audits of claims data submitted by participating employment-based plans under this section to ensure that such plans are in compliance with the requirements of this section.

(e) Funding

There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, \$5,000,000,000 to carry out the program under this section. Such funds shall be available without fiscal year limitation.

(f) Limitation

The Secretary has the authority to stop taking applications for participation in the program based on the availability of funding under subsection (e).

(Pub. L. 111-148, title I, §1102, title X, §10102(a), Mar. 23, 2010, 124 Stat. 143, 892.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (a)(2)(C), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to subchapter XVIII (§1395 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.

AMENDMENTS

2010—Subsec. (a)(2)(B). Pub. L. 111-148, §10102(a)(1), substituted “group benefits plan providing health benefits” for “group health benefits plan” in introductory provisions.

Subsec. (a)(2)(B)(i)(I). Pub. L. 111-148, §10102(a)(2), inserted “or any agency or instrumentality of any of the foregoing” after “political subdivision thereof”.

§ 18003. Immediate information that allows consumers to identify affordable coverage options

(a) Internet portal to affordable coverage options

(1) Immediate establishment

Not later than July 1, 2010, the Secretary, in consultation with the States, shall establish a mechanism, including an Internet website, through which a resident of, or small business in, any State may identify affordable health insurance coverage options in that State.

(2) Connecting to affordable coverage

An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of, and small businesses in, any State to receive information on at least the following coverage options:

(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

- (i) a single disease or condition; or
- (ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary).

(B) Medicaid coverage under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

(C) Coverage under title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.].

(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

(E) Coverage under a high risk pool under section 18001 of this title.

(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 18002 of this title, tax credits available under section 45R of title 26 (as added by section 1421), and other information specifically for small businesses regarding affordable health care options.

(b) Enhancing comparative purchasing options

(1) In general

Not later than 60 days after March 23, 2010, the Secretary shall develop a standardized format to be used for the presentation of information relating to the coverage options described in subsection (a)(2). Such format shall, at a minimum, require the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (as reported under section 300gg-18(a) of this title), eligibility, availability, premium rates, and cost sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in section 300gg-15 of this title.

(2) Use of format

The Secretary shall utilize the format developed under paragraph (1) in compiling information concerning coverage options on the Internet website established under subsection (a).

(c) Authority to contract

The Secretary may carry out this section through contracts entered into with qualified entities.

(Pub. L. 111-148, title I, § 1103, title X, § 10102(b), Mar. 23, 2010, 124 Stat. 146, 892.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (a)(2)(B), (C), 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.

Section 1421, referred to in subsec. (a)(2)(F), means section 1421 of Pub. L. 111-148.

AMENDMENTS

2010—Subsec. (a)(1). Pub. L. 111-148, §10102(b)(1), which directed insertion of “, or small business in,” after “residents of any”, was executed by making the insertion after “resident of” to reflect the probable intent of Congress.

Subsec. (a)(2). Pub. L. 111-148, §10102(b)(2), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows:

“An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of any State to receive information on at least the following coverage options:

“(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

- “(i) a single disease or condition; or
- “(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary);

“(B) Medicaid coverage under title XIX of the Social Security Act.

“(C) Coverage under title XXI of the Social Security Act.

“(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

“(E) Coverage under a high risk pool under section 18001 of this title.”

SUBCHAPTER II—OTHER PROVISIONS

§ 18011. Preservation of right to maintain existing coverage

(a) No changes to existing coverage

(1) In general

Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on March 23, 2010.

(2) Continuation of coverage

Except as provided in paragraph (3), with respect to a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after March 23, 2010.

(3) Application of certain provisions

The provisions of sections 2715 [42 U.S.C. 300gg-15] and 2718 [42 U.S.C. 300gg-18] of the

Public Health Service Act (as added by subtitle A) shall apply to grandfathered health plans for plan years beginning on or after March 23, 2010.

(4) Application of certain provisions

(A) In general

The following provisions of the Public Health Service Act [42 U.S.C. 201 et seq.] (as added by this title)¹ shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply:

(i) Section 2708 [42 U.S.C. 300gg-7] (relating to excessive waiting periods).

(ii) Those provisions of section 2711 [42 U.S.C. 300gg-11] relating to lifetime limits.

(iii) Section 2712 [42 U.S.C. 300gg-12] (relating to rescissions).

(iv) Section 2714 [42 U.S.C. 300gg-14] (relating to extension of dependent coverage).

(B) Provisions applicable only to group health plans

(i) Provisions described

Those provisions of section 2711 [42 U.S.C. 300gg-11] relating to annual limits and the provisions of section 2704 [42 U.S.C. 300gg-3] (relating to pre-existing condition exclusions) of the Public Health Service Act (as added by this subtitle) shall apply to grandfathered health plans that are group health plans for plan years beginning with the first plan year to which such provisions otherwise apply.

(ii) Adult child coverage

For plan years beginning before January 1, 2014, the provisions of section 2714 of the Public Health Service Act [42 U.S.C. 300gg-14] (as added by this subtitle) shall apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if such adult child is not eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of title 26) other than such grandfathered health plan.

(5) Application of additional provisions

Sections 300gg-111, 300gg-112, and 300gg-117 of this title shall apply to grandfathered health plans for plan years beginning on or after January 1, 2022.

(b) Allowance for family members to join current coverage

With respect to a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010, and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of March 23, 2010.

(c) Allowance for new employees to join current plan

A group health plan that provides coverage on March 23, 2010, may provide for the enrolling of

new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) Effect on collective bargaining agreements

In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) Definition

In this title,¹ the term “grandfathered health plan” means any group health plan or health insurance coverage to which this section applies.

(Pub. L. 111-148, title I, § 1251, title X, § 10103(d), Mar. 23, 2010, 124 Stat. 161, 895; Pub. L. 111-152, title II, § 2301(a), Mar. 30, 2010, 124 Stat. 1081; Pub. L. 116-260, div. BB, title I, § 102(d)(2), Dec. 27, 2020, 134 Stat. 2797.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 102(d)(2) of div. BB of Pub. L. 116-260 applicable with respect to plan years beginning on or after Jan. 1, 2022. See 2020 Amendment note below.

REFERENCES IN TEXT

This Act, referred to in subsec. (a)(1), 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.

This subtitle, referred to in subsecs. (a)(2), (4)(B), (c), and (d), is subtitle C (§§1201-1255) of title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 154, which enacted this subchapter and sections 300gg-2 and 300gg-4 to 300gg-7 of this title, transferred section 300gg of this title to section 300gg-3 of this title, amended sections 300gg-1 and 300gg-4 of this title, and enacted provisions set out as a note under section 300gg of this title. For complete classification of subtitle C to the Code, see Tables.

Subtitle A, referred to in subsecs. (a)(2), (3), (c), and (d), is subtitle A (§§1001-1004) of title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 130, which enacted sections 300gg-11 to 300gg-19, 300gg-93, and 300gg-94 of this title, transferred sections 300gg-4 to 300gg-7 and 300gg-13 of this title to sections 300gg-25 to 300gg-28 and 300gg-9 of this title, respectively, amended sections 300gg-11, 300gg-12, and 300gg-21 to 300gg-23 of this title, and enacted provisions set out as a note under section 300gg-11 of this title. For complete classification of subtitle A to the Code, see Tables.

The Public Health Service Act, referred to in subsec. (a)(4)(A), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) 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. (a)(4)(A) and (e), is title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 130,

¹ See References in Text note below.

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

2020—Subsec. (a)(5). Pub. L. 116–260 added par. (5).

2010—Subsec. (a)(2). Pub. L. 111–148, §10103(d)(1), substituted “Except as provided in paragraph (3), with” for “With”.

Subsec. (a)(3). Pub. L. 111–148, §10103(d)(2), added par. (3).

Subsec. (a)(4). Pub. L. 111–152 added par. (4).

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116–260 applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB of Pub. L. 116–260, set out as a note under section 8902 of Title 5, Government Organization and Employees.

EFFECTIVE DATE

Section effective Mar. 23, 2010, see section 1255(1) of Pub. L. 111–148, set out as a note under section 300gg of this title.

§ 18012. Rating reforms must apply uniformly to all health insurance issuers and group health plans

Any standard or requirement adopted by a State pursuant to this title,¹ or any amendment made by this title,¹ shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title¹ (or any such amendment) that is not the same as the standard or requirement but that is not preempted under section 18041(d) of this title.

(Pub. L. 111–148, title I, §1252, Mar. 23, 2010, 124 Stat. 162.)

REFERENCES IN TEXT

This title, referred to in text, 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.

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

§ 18013. Annual report on self-insured plans

Not later than 1 year after March 23, 2010, and annually thereafter, the Secretary of Labor shall prepare an aggregate annual report, using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500), that shall include general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements) as well as data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments, and expenses). The Secretary shall submit such reports to the appropriate committees of Congress.

¹ See References in Text note below.

(Pub. L. 111–148, title I, §1253, as added Pub. L. 111–148, title X, §10103(f)(2), Mar. 23, 2010, 124 Stat. 895.)

PRIOR PROVISIONS

A prior section 1253 of Pub. L. 111–148 was renumbered section 1255 and is set out as a note under section 300gg of this title.

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

§ 18014. Treatment of expatriate health plans under ACA

(a) In general

Subject to subsection (b), the provisions of (including any amendment made by) the Patient Protection and Affordable Care Act (Public Law 111–148) and of title I and subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152) shall not apply with respect to—

- (1) expatriate health plans;
- (2) employers with respect to such plans, solely in their capacity as plan sponsors for such plans; or
- (3) expatriate health insurance issuers with respect to coverage offered by such issuers under such plans.

(b) Minimum essential coverage and reporting requirements

(1) In general

For the purpose of section 5000A(f) of title 26, and any other section of title 26 that incorporates the definition of minimum essential coverage under such section 5000A(f) by reference:

(A) An expatriate health plan offered to primary enrollees who are described in subsections (d)(3)(A) and (d)(3)(B) of this section shall be treated as an eligible employer sponsored plan under 5000A(f)(2) of such title.

(B) An expatriate health plan offered to primary enrollees who are described in subsection (d)(3)(C) of this section shall be treated as a plan in the individual market under section 5000A(f)(1)(C) of such title. This subparagraph shall apply solely for the purposes of sections 36B, 5000A, and 6055 of such title.

(2) Exception

Subsection (a) shall not apply with respect to section 6055 of title 26, or sections 4980H and 6056 of such title in the case of an applicable large employer (as defined in section 4980H of such title), except that statements furnished to individuals may be provided through electronic media and the primary insured shall be deemed to have consented to receive the statements under such sections in electronic form, unless the individual explicitly refuses such consent. Notwithstanding subsection (a), section 4980I¹ of title 26 shall continue to apply with respect to applicable employer-sponsored

¹ See References in Text note below.

coverage (as defined in such section) of a qualified expatriate described in subsection (d)(3)(A)(i) who is assigned (rather than transferred) to work in the United States.

(c) Qualified expatriates, spouses, and dependents not United States health risk

(1) In general

For purposes of section 9010¹ of the Patient Protection and Affordable Care Act (26 U.S.C. 4001 note prec.), for calendar years after 2015, a qualified expatriate (and any spouse, dependent, or any other individual enrolled in the plan) enrolled in an expatriate health plan shall not be considered a United States health risk.

(2) Special rule

Notwithstanding paragraph (1), the fee under section 9010¹ of such Act for each of calendar years 2014 and 2015 with respect to any expatriate health insurance issuer shall be the amount which bears the same ratio to the fee amount determined by the Secretary of the Treasury with respect to such issuer under such section for each such year (determined without regard to this paragraph) as—

(A) the amount of premiums taken into account under such section with respect to such issuer for each such year, less the amount of premiums for expatriate health plans taken into account under such section with respect to such issuer for each such year, bears to

(B) the amount of premiums taken into account under such section with respect to such issuer for each such year.

(d) Definitions

In this section:

(1) Expatriate health insurance issuer

The term “expatriate health insurance issuer” means a health insurance issuer that issues expatriate health plans.

(2) Expatriate health plan

The term “expatriate health plan” means a group health plan, health insurance coverage offered in connection with a group health plan, or health insurance coverage offered to a group of individuals described in paragraph (3)(C) (which may include spouses, dependents, and other individuals enrolled in the plan) that meets each of the following standards:

(A) Substantially all of the primary enrollees in such plan or coverage are qualified expatriates with respect to such plan or coverage. In applying the previous sentence, an individual shall not be considered a primary enrollee if the individual is not a national of the United States and the individual resides in the country of which the individual is a citizen.

(B) Substantially all of the benefits provided under the plan or coverage are not excepted benefits described in section 9832(c) of title 26.

(C) The plan or coverage provides coverage for inpatient hospital services, outpatient facility services, physician services, and emergency services (comparable to such

emergency services coverage described in and offered under section 8903(1) of title 5 for plan year 2009)—

(i) in the case of individuals described in paragraph (3)(A), both in the United States and in the country or countries from which the individual was transferred or assigned (accounting for flexibility needed with existing coverage), and such other country or countries as the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, may designate (after taking into account the barriers and prohibitions to providing health care services in the countries as designated);

(ii) in the case of individuals described in paragraph (3)(B), in the country or countries in which the individual is present in connection with the individual’s employment, and such other country or countries as the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, may designate; or

(iii) in the case of individuals described in paragraph (3)(C), in the country or countries as the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, may designate.

(D) The plan sponsor reasonably believes that the benefits provided by the expatriate health plan satisfy a standard at least actuarially equivalent to the level provided for in section 36B(c)(2)(C)(ii) of title 26.

(E) If the plan or coverage provides dependent coverage of children, the plan or coverage makes such dependent coverage available for adult children until the adult child turns 26 years of age, unless such individual is the child of a child receiving dependent coverage.

(F) The plan or coverage—

(i) is issued by an expatriate health plan issuer, or administered by an administrator, that together with any other person in the expatriate health plan issuer’s or administrator’s controlled group (as described in section 9010¹ of the Patient Protection and Affordable Care Act (and the regulations promulgated thereunder)), has licenses to sell insurance in more than two countries, and, with respect to such plan, coverage, or company in the controlled group—

(I) maintains network provider agreements that provide for direct claims payments, directly or through third party contracts, with health care providers in eight or more countries;

(II) maintains call centers, directly or through third party contracts, in three or more countries and accepts calls from customers in eight or more languages;

(III) processes (in the aggregate together with other plans or coverage it issues or administers) at least \$1,000,000 in claims in foreign currency equivalents each year;

(IV) makes available (directly or through third party contracts) global evacuation/repatriation coverage; and

(V) maintains legal and compliance resources in three or more countries; and

(ii) offers reimbursements for items or services under such plan or coverage in the local currency in eight or more countries.

(G) The plan or coverage, and the plan sponsor or expatriate health insurance issuer with respect to such plan or coverage, satisfies the provisions of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), chapter 100 of title 26, and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.), which would otherwise apply to such a plan or coverage, and sponsor or issuer, if not for the enactment of the Patient Protection and Affordable Care Act and title I and subtitle B of title II of the Health Care and Education Reconciliation Act of 2010.

(3) Qualified expatriate

The term “qualified expatriate” means a primary insured, or individual otherwise described in subparagraph (C)—

(A)(i) whose skills, qualifications, job duties, or expertise is of a type that has caused his or her employer to transfer or assign him or her to the United States for a specific and temporary purpose or assignment tied to his or her employment; and

(ii) in connection with such transfer or assignment, is reasonably determined by the plan sponsor to require access to health insurance and other related services and support in multiple countries, and is offered other multinational benefits on a periodic basis (such as tax equalization, compensation for cross border moving expenses, or compensation to enable the expatriate to return to their home country);

(B) who is working outside of the United States for a period of at least 180 days in a consecutive 12-month period that overlaps with the plan year; or

(C) who is a member of a group of similarly situated individuals—

(i) that is formed for the purpose of traveling or relocating internationally in service of one or more of the purposes listed in section 501(c)(3) or 501(c)(4) of title 26, or similarly situated organizations or groups (such as students or religious missionaries);

(ii) that is not formed primarily for the sale of health insurance coverage; and

(iii) that the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines requires access to health insurance and other related services and support in multiple countries.

(4) United States

The term “United States” means the 50 States, the District of Columbia, and Puerto Rico.

(5) Miscellaneous terms

(A) Group health plan; health insurance coverage; health insurance issuer; plan sponsor

The terms “group health plan”, “health insurance coverage”, “health insurance issuer”, and “plan sponsor” have the meanings given those terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91).

(B) Transfer

The term “transfer” means an employer has transferred an employee to perform services for a branch of the same employer or a parent, affiliate, franchise, or subsidiary thereof.

(e) Regulations

The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor may promulgate regulations necessary to carry out this Act, including such rules as may be necessary to prevent inappropriate expansion of the application of the exclusions under this Act from applicable laws and regulations, and to amend existing annual reporting requirements or procedures to include applicable qualified expatriate health insurers’ total number of expatriate plan enrollees.

(f) Effective date

Unless otherwise specified, this Act shall take effect on December 16, 2014, and shall apply only to expatriate health plans issued or renewed on or after July 1, 2015.

(Pub. L. 113-235, div. M, §3, Dec. 16, 2014, 128 Stat. 2768.)

REFERENCES IN TEXT

The Patient Protection and Affordable Care Act, referred to in subsecs. (a), (c), and (d)(2)(F)(i), (G), is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. Section 9010 of the Act was set out as a note preceding section 4001 of Title 26, Internal Revenue Code, prior to repeal by Pub. L. 116-94, div. N, title I, §502(a), Dec. 20, 2019, 133 Stat. 3119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The Health Care and Education Reconciliation Act of 2010, referred to in subsecs. (a) and (d)(2)(G), is Pub. L. 111-152, Mar. 30, 2010, 124 Stat. 1029. For complete classification of this Act to the Code, see Short Title of 2010 Amendment note set out under section 1305 of this title and Tables.

Section 4980I of title 26, referred to in subsec. (b)(2), was repealed by Pub. L. 116-94, div. N, title I, §503(a), Dec. 20, 2019, 133 Stat. 3119.

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

The Employee Retirement Income Security Act of 1974, referred to in subsec. (d)(2)(G), is Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 832. Part 7 of subtitle B of title I of the Act is classified generally to part 7 (§1181 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

This Act, referred to in subsecs. (e) and (f), is div. M of Pub. L. 113-235, Dec. 16, 2014, 128 Stat. 2767, known as

the Expatriate Health Coverage Clarification Act of 2014. For complete classification of this Act to the Code, see Short Title of 2014 Amendment note set out under section 18001 of this title and Tables.

CODIFICATION

Section was enacted as part of the Expatriate Health Coverage Clarification Act of 2014, and also as part of the Consolidated and Further Continuing Appropriations Act, 2015, and not as part of title I of the Patient Protection and Affordable Care Act which enacted this chapter.

SUBCHAPTER III—AVAILABLE COVERAGE
CHOICES FOR ALL AMERICANS

PART A—ESTABLISHMENT OF QUALIFIED HEALTH
PLANS

§ 18021. Qualified health plan defined

(a) Qualified health plan

In this title:¹

(1) In general

The term “qualified health plan” means a health plan that—

(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 18031(c) of this title issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 18022(a) of this title; and

(C) is offered by a health insurance issuer that—

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;¹

(ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 18031(d) of this title and such other requirements as an applicable Exchange may establish.

(2) Inclusion of CO-OP plans and multi-State qualified health plans

Any reference in this title¹ to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 18042 of this title, and a multi-State plan under section 18054 of this title, unless specifically provided for otherwise.

(3) Treatment of qualified direct primary care medical home plans

The Secretary of Health and Human Services shall permit a qualified health plan to

provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

(4) Variation based on rating area

A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 300gg(a)(2) of this title).

(b) Terms relating to health plans

In this title:¹

(1) Health plan

(A) In general

The term “health plan” means health insurance coverage and a group health plan.

(B) Exception for self-insured plans and MEWAs

Except to the extent specifically provided by this title,¹ the term “health plan” shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 1144 of title 29.

(2) Health insurance coverage and issuer

The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms by section 300gg-91(b) of this title.

(3) Group health plan

The term “group health plan” has the meaning given such term by section 300gg-91(a) of this title.

(Pub. L. 111-148, title I, §1301, title X, §10104(a), Mar. 23, 2010, 124 Stat. 162, 896.)

REFERENCES IN TEXT

This title, where footnoted in text, 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. (a)(2) to (4). Pub. L. 111-148, §10104(a), added pars. (2) to (4) and struck out former par. (2). Prior to amendment, text of par. (2) read as follows: “Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 18042 of this title or a community health insurance option under section 18043 of this title, unless specifically provided for otherwise.”

§ 18022. Essential health benefits requirements

(a) Essential health benefits package

In this title,¹ the term “essential health benefits package” means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

¹ See References in Text note below.

¹ See References in Text note below.

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) Essential health benefits

(1) In general

Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventive and wellness services and chronic disease management.
- (J) Pediatric services, including oral and vision care.

(2) Limitation

(A) In general

The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) Certification

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) Notice and hearing

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) Required elements for consideration

In defining the essential health benefits under paragraph (1), the Secretary shall—

- (A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection,² so that benefits are not unduly weighted toward any category;
- (B) not make coverage decisions, determine reimbursement rates, establish incen-

tive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

- (i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and
- (ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 18031(b)(2)(B)(ii)³ of this title (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and⁴

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

- (i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;
- (ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;
- (iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;
- (iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

³ So in original. Probably should be “18031(d)(2)(B)(ii)”.

⁴ So in original. The word “and” probably should not appear.

² So in original. Probably should be “paragraph.”.

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) Rule of construction

Nothing in this title¹ shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) Requirements relating to cost-sharing

(1) Annual limitation on cost-sharing

(A) 2014

The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of title 26 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 and later

In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(2) Repealed. Pub. L. 113–93, title II, § 213(a)(1), Apr. 1, 2014, 128 Stat. 1047

(3) Cost-sharing

In this title—¹

(A) In general

The term “cost-sharing” includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of title 26) with respect to essential health benefits covered under the plan.

(B) Exceptions

Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) Premium adjustment percentage

For purposes of paragraph (1)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the pre-

ceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) Levels of coverage

(1) Levels of coverage defined

The levels of coverage described in this subsection are as follows:

(A) Bronze level

A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) Silver level

A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) Gold level

A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) Platinum level

A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) Actuarial value

(A) In general

Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) Employer contributions

The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of title 26) may be taken into account in determining the level of coverage for a plan of the employer.

(C) Application

In determining under this title,¹ the Public Health Service Act [42 U.S.C. 201 et seq.], or title 26 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) Allowable variance

The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) Plan reference

In this title,¹ any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) Catastrophic plan**(1) In general**

A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713);¹ and

(ii) coverage for at least three primary care visits.

(2) Individuals eligible for enrollment

An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title¹ that the individual is exempt from the requirement under section 5000A of title 26 by reason of—

(i) section 5000A(e)(1) of such title (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such title (relating to individuals with hardships).

(3) Restriction to individual market

If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) Child-only plans

If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) Payments to Federally-qualified health centers

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1396d(l)(2)(B) of this title) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1396a(bb) of this title) for such item or service.

(Pub. L. 111-148, title I, §1302, title X, §10104(b), Mar. 23, 2010, 124 Stat. 163, 896; Pub. L. 113-93, title II, §213(a), Apr. 1, 2014, 128 Stat. 1047.)

REFERENCES IN TEXT

This title, referred to in subsecs. (a), (b)(5), (d)(2)(C), (4), and (e)(2)(B), 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 Public Health Service Act, referred to in subsec. (d)(2)(C), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) 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.

Section 2713, referred to in subsec. (e)(1)(B)(i), probably means section 2713 of act July 1, 1944, which is classified to section 300gg-13 of this title.

AMENDMENTS

2014—Subsec. (c)(2). Pub. L. 113-93, §213(a)(1), struck out par. (2) which related to annual limitation on deductibles for employer-sponsored plans.

Subsec. (c)(4). Pub. L. 113-93, §213(a)(2), which directed amendment of par. (4)(A) by substituting “paragraph (1)(B)(i)” for “paragraphs (1)(B)(i) and (2)(B)(i)”, was executed by making the substitution in par. (4) to reflect the probable intent of Congress.

2010—Subsec. (d)(2)(B). Pub. L. 111-148, §10104(b)(1), substituted “shall issue” for “may issue”.

Subsec. (g). Pub. L. 111-148, §10104(b)(2), added subsec. (g).

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113-93 effective as if included in the enactment of Pub. L. 111-148, see section 213(c) of Pub. L. 113-93, set out as a note under section 300gg-6 of this title.

§ 18023. Special rules**(a) State opt-out of abortion coverage****(1) In general**

A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

(2) Termination of opt out

A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

(b) Special rules relating to coverage of abortion services**(1) Voluntary choice of coverage of abortion services****(A) In general**

Notwithstanding any other provision of this title¹ (or any amendment made by this title)—¹

(i) nothing in this title¹ (or any amendment made by this title),¹ shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) subject to subsection (a), the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

¹ See References in Text note below.

(B) Abortion services**(i) Abortions for which public funding is prohibited**

The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(ii) Abortions for which public funding is allowed

The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(2) Prohibition on the use of Federal funds**(A) In general**

If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

(i) The credit under section 36B of title 26 (and the amount (if any) of the advance payment of the credit under section 18082 of this title).

(ii) Any cost-sharing reduction under section 18071 of this title (and the amount (if any) of the advance payment of the reduction under section 18082 of this title).

(B) Establishment of allocation accounts

In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

(i) collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

(ii) shall² deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

(C) Segregation of funds**(i) In general**

The issuer of a plan to which subparagraph (A) applies shall establish allocation

accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

(ii) Allocation accounts

The issuer of a plan to which subparagraph (A) applies shall deposit—

(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

(II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

(D) Actuarial value**(i) In general**

The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i).

(ii) Considerations

In making such estimate, the issuer—

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(II) shall estimate such costs as if such coverage were included for the entire population covered; and

(III) may not estimate such a cost at less than \$1 per enrollee, per month.

(E) Ensuring compliance with segregation requirements**(i) In general**

Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subsection through the segregation of plan funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office.

(ii) Clarification

Nothing in clause (i) shall prohibit the right of an individual or health plan to appeal such action in courts of competent jurisdiction.

(3) Rules relating to notice**(A) Notice**

A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

(B) Rules relating to payments

The notice described in subparagraph (A), any advertising used by the issuer with re-

²So in original. The word "shall" probably should not appear.

spect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for services described in paragraph (1)(B)(i) and other services covered by the plan.

(4) No discrimination on basis of provision of abortion

No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions³

(c) Application of State and Federal laws regarding abortion

(1) No preemption of State laws regarding abortion

Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) No effect on Federal laws regarding abortion

(A)⁴ In general

Nothing in this Act shall be construed to have any effect on Federal laws regarding—

- (i) conscience protection;
- (ii) willingness or refusal to provide abortion; and
- (iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) No effect on Federal civil rights law

Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964 [42 U.S.C. 2000e et seq.].

(d) Application of emergency services laws

Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1395dd of this title (popularly known as “EMTALA”).

(Pub. L. 111-148, title I, §1303, title X, §10104(c), Mar. 23, 2010, 124 Stat. 168, 896.)

REFERENCES IN TEXT

This title, referred to in subsec. (b)(1)(A), 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.

This Act, referred to in subsecs. (c)(1), (2)(A) and (d), 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.

³ So in original. Probably should be followed by a period.

⁴ So in original. There is no subpar. (B).

The Civil Rights Act of 1964, referred to in subsec. (c)(3), is Pub. L. 88-352, July 2, 1964, 78 Stat. 241. Title VII of the Act is classified generally to subchapter VI (§2000e et seq.) of chapter 21 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 2000a of this title and Tables.

AMENDMENTS

2010—Pub. L. 111-148, §10104(c), amended section generally. Prior to amendment, section consisted of subsecs. (a) to (c) relating to special rules relating to coverage of abortion services, application of State and Federal laws regarding abortion, and application of emergency services laws.

EX. ORD. NO. 13535. ENSURING ENFORCEMENT AND IMPLEMENTATION OF ABORTION RESTRICTIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Ex. Ord. No. 13535, Mar. 24, 2010, 75 F.R. 15599, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the “Patient Protection and Affordable Care Act” (Public Law 111-148), I hereby order as follows:

SECTION. 1. *Policy.* Following the recent enactment of the Patient Protection and Affordable Care Act (the “Act”), it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment. The purpose of this order is to establish a comprehensive, Government-wide set of policies and procedures to achieve this goal and to make certain that all relevant actors—Federal officials, State officials (including insurance regulators) and health care providers—are aware of their responsibilities, new and old.

The Act maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly created health insurance exchanges. Under the Act, longstanding Federal laws to protect conscience (such as the Church Amendment, 42 U.S.C. 300a-7, and the Weldon Amendment, section 508(d)(1) of Public Law 111-8) remain intact and new protections prohibit discrimination against health care facilities and health care providers because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Numerous executive agencies have a role in ensuring that these restrictions are enforced, including the Department of Health and Human Services (HHS), the Office of Management and Budget (OMB), and the Office of Personnel Management.

SEC. 2. *Strict Compliance with Prohibitions on Abortion Funding in Health Insurance Exchanges.* The Act specifically prohibits the use of tax credits and cost-sharing reduction payments to pay for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered) in the health insurance exchanges that will be operational in 2014. The Act also imposes strict payment and accounting requirements to ensure that Federal funds are not used for abortion services in exchange plans (except in cases of rape or incest, or when the life of the woman would be endangered) and requires State health insurance commissioners to ensure that exchange plan funds are segregated by insurance companies in accordance with generally accepted accounting principles, OMB funds management circulars, and accounting guidance provided by the Government Accountability Office.

I hereby direct the Director of the OMB and the Secretary of HHS to develop, within 180 days of the date of this order, a model set of segregation guidelines for State health insurance commissioners to use when determining whether exchange plans are complying with the Act’s segregation requirements, established in sec-

tion 1303 of the Act, for enrollees receiving Federal financial assistance. The guidelines shall also offer technical information that States should follow to conduct independent regular audits of insurance companies that participate in the health insurance exchanges. In developing these model guidelines, the Director of the OMB and the Secretary of HHS shall consult with executive agencies and offices that have relevant expertise in accounting principles, including, but not limited to, the Department of the Treasury, and with the Government Accountability Office. Upon completion of those model guidelines, the Secretary of HHS should promptly initiate a rulemaking to issue regulations, which will have the force of law, to interpret the Act's segregation requirements, and shall provide guidance to State health insurance commissioners on how to comply with the model guidelines.

SEC. 3. Community Health Center Program. The Act establishes a new Community Health Center (CHC) Fund within HHS, which provides additional Federal funds for the community health center program. Existing law prohibits these centers from using Federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), as a result of both the Hyde Amendment and longstanding regulations containing the Hyde language. Under the Act, the Hyde language shall apply to the authorization and appropriations of funds for Community Health Centers under section 10503 and all other relevant provisions. I hereby direct the Secretary of HHS to ensure that program administrators and recipients of Federal funds are aware of and comply with the limitations on abortion services imposed on CHCs by existing law. Such actions should include, but are not limited to, updating Grant Policy Statements that accompany CHC grants and issuing new interpretive rules.

SEC. 4. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect: (i) authority granted by law or Presidential directive to an agency, or the head thereof; or (ii) functions of the Director of the OMB relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees or agents, or any other person.

BARACK OBAMA.

§ 18024. Related definitions

(a) Definitions relating to markets

In this title:¹

(1) Group market

The term “group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

(2) Individual market

The term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) Large and small group markets

The terms “large group market” and “small group market” mean the health insurance market under which individuals obtain health insurance coverage (directly or through any

arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

(b) Employers

In this title:¹

(1) Large employer

The term “large employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) Small employer

The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(3) State option to extend definition of small employer

Notwithstanding paragraphs (1) and (2), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(4) Rules for determining employer size

For purposes of this subsection—

(A) Application of aggregation rule for employers

All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of title 26 shall be treated as 1 employer.

(B) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) Predecessors

Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) Continuation of participation for growing small employers

If—

(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and

¹ See References in Text note below.

(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this subchapter for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

(c) Secretary

In this title,¹ the term “Secretary” means the Secretary of Health and Human Services.

(d) State

In this title,¹ the term “State” means each of the 50 States and the District of Columbia.

(e) Educated health care consumers

The term “educated health care consumer” means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(Pub. L. 111-148, title I, §1304, title X, §10104(d), Mar. 23, 2010, 124 Stat. 171, 900; Pub. L. 114-60, §2(a), Oct. 7, 2015, 129 Stat. 543.)

REFERENCES IN TEXT

This title, referred to in subsecs. (a) to (d), 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

2015—Subsec. (b)(1). Pub. L. 114-60, §2(a)(1), substituted “51” for “101”.

Subsec. (b)(2). Pub. L. 114-60, §2(a)(2), substituted “50” for “100”.

Subsec. (b)(3). Pub. L. 114-60, §2(a)(3), amended par. (3) generally. Prior to amendment, text read as follows: “In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting ‘51 employees’ for ‘101 employees’ in paragraph (1) and by substituting ‘50 employees’ for ‘100 employees’ in paragraph (2).”

2010—Subsec. (e). Pub. L. 111-148, §10104(d), added subsec. (e).

PART B—CONSUMER CHOICES AND INSURANCE
COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

§ 18031. Affordable choices of health benefit plans

(a) Assistance to States to establish American Health Benefit Exchanges

(1) Planning and establishment grants

There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after March 23, 2010, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) Amount specified

For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) Use of funds

A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) Renewability of grant

(A) In general

Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

(i) is making progress, as determined by the Secretary, toward—

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) Limitation

No grant shall be awarded under this subsection after January 1, 2015.

(5) Technical assistance to facilitate participation in SHOP Exchanges

The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) American Health Benefit Exchanges

(1) In general

Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title¹ as an “Exchange”) for the State that—

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title¹ referred to as a “SHOP Exchange”) that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) Merger of individual and SHOP Exchanges

A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) Responsibilities of the Secretary

(1) In general

The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

¹ See References in Text note below.

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act [42 U.S.C. 300gg-1(c)]), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 U.S.C. 1396r-8(c)(1)(D)(i)(IV)] as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options;

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act [42 U.S.C. 280j-2], as applicable; and

(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric qual-

ity reporting measures established under section 1139A of the Social Security Act [42 U.S.C. 1320b-9a].

(2) Rule of construction

Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) Rating system

The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) Enrollee satisfaction system

The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

(5) Internet portals

The Secretary shall—

(A) continue to operate, maintain, and update the Internet portal developed under section 18003(a) of this title and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716¹ of the Public Health Service Act and to a copy of the plan's written policy.

(6) Enrollment periods

The Secretary shall require an Exchange to provide for—

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of title 26 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w-101 et seq.]; and

(D) special monthly enrollment periods for Indians (as defined in section 1603 of title 25).

(7) Reenrollment of certain individuals in qualified health plans in certain exchanges

(A) In general

In the case of an Exchange that the Secretary operates pursuant to section 18041(c)(1) of this title, the Secretary shall establish a process under which an individual described in subparagraph (B) is reenrolled for plan year 2021 in a qualified health plan offered through such Exchange. Such qualified health plan under which such individual is so reenrolled shall be—

(i) if available for plan year 2021, the qualified health plan under which such individual is enrolled during the annual open enrollment period for such plan year; and

(ii) if such qualified health plan is not available for plan year 2021, a qualified health plan offered through such Exchange determined appropriate by the Secretary.

(B) Individual described

An individual described in this subsection is an individual who, with respect to plan year 2020—

(i) resides in a State with an Exchange described in subparagraph (A);

(ii) is enrolled in a qualified health plan during such plan year and does not enroll in a qualified health plan for plan year 2021 during the annual open enrollment period for such plan year 2021; and

(iii) does not elect to disenroll under a qualified health plan for plan year 2021 during such annual open enrollment period.

(d) Requirements

(1) In general

An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) Offering of coverage

(A) In general

An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) Limitation

(i) In general

An Exchange may not make available any health plan that is not a qualified health plan.

(ii) Offering of stand-alone dental benefits

Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of title 26 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the

plan provides pediatric dental benefits meeting the requirements of section 18022(b)(1)(J) of this title).

(3) Rules relating to additional required benefits

(A) In general

Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 18022(b) of this title.

(B) States may require additional benefits

(i) In general

Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 18022(b) of this title.

(ii) State must assume cost

A State shall make payments—

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

(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (i).

(4) Functions

An Exchange shall, at a minimum—

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act [42 U.S.C. 300gg-15];

(F) in accordance with section 18083 of this title, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], the CHIP program under title XXI of such Act [42 U.S.C. 1397aa et seq.], or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the

actual cost of coverage after the application of any premium tax credit under section 36B of title 26 and any cost-sharing reduction under section 18071 of this title;

(H) subject to section 18081 of this title, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of title 26, an individual is exempt from the individual requirement or from the penalty imposed by such section because—

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury—

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of title 26 because—

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such title to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 18081(b)(4) of this title that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) Funding limitations

(A) No Federal funds for continued operations

In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) Prohibiting wasteful use of funds

In carrying out activities under this subsection, an Exchange shall not utilize any

funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) Consultation

An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—

(A) educated health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) Publication of costs

An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) Certification

(1) In general

An Exchange may certify a health plan as a qualified health plan if—

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) Premium considerations

The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1)¹ of the Public Health Service Act [42 U.S.C. 300gg-94(b)(1)] (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as com-

pared to the rate of such growth inside the Exchange, including information reported by the States.

(3) Transparency in coverage

(A) In general

The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

- (i) Claims payment policies and practices.
- (ii) Periodic financial disclosures.
- (iii) Data on enrollment.
- (iv) Data on disenrollment.
- (v) Data on the number of claims that are denied.
- (vi) Data on rating practices.
- (vii) Information on cost-sharing and payments with respect to any out-of-network coverage.
- (viii) Information on enrollee and participant rights under this title.¹
- (ix) Other information as determined appropriate by the Secretary.

(B) Use of plain language

The information required to be submitted under subparagraph (A) shall be provided in plain language. The term “plain language” means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(C) Cost sharing transparency

The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual’s plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

(D) Group health plans

The Secretary of Labor shall update and harmonize the Secretary’s rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).

(f) Flexibility

(1) Regional or other interstate exchanges

An Exchange may operate in more than one State if—

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) Subsidiary Exchanges

A State may establish one or more subsidiary Exchanges if—

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act [42 U.S.C. 300gg(a)].

(3) Authority to contract

(A) In general

A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) Eligible entity

In this paragraph, the term “eligible entity” means—

(i) a person—

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of title 26 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State Medicaid agency under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

(g) Rewarding quality through market-based incentives

(1) Strategy described

A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities; and

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) Guidelines

The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) Requirements

The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) Quality improvement

(1) Enhancing patient safety

Beginning on January 1, 2015, a qualified health plan may contract with—

(A) a hospital with greater than 50 beds only if such hospital—

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act [42 U.S.C. 299b-21 et seq.]; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) Exceptions

The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) Adjustment

The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

(i) Navigators

(1) In general

An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) Eligibility

(A) In general

To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) Types

Entities described in subparagraph (A) may include trade, industry, and profes-

sional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities that—

(i) are capable of carrying out the duties described in paragraph (3);

(ii) meet the standards described in paragraph (4); and

(iii) provide information consistent with the standards developed under paragraph (5).

(3) Duties

An entity that serves as a navigator under a grant under this subsection shall—

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of title 26 and cost-sharing reductions under section 18071 of this title;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act [42 U.S.C. 300gg-93], or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) Standards

(A) In general

The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not—

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) Fair and impartial information and services

The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) Funding

Grants under this subsection shall be made from the operational funds of the Exchange

and not Federal funds received by the State to establish the Exchange.

(j) Applicability of mental health parity

Section 2726 of the Public Health Service Act [42 U.S.C. 300gg-26] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) Conflict

An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subchapter.

(Pub. L. 111-148, title I, §1311, title X, §§10104(e)-(h), 10203(a), Mar. 23, 2010, 124 Stat. 173, 900, 901, 927; Pub. L. 116-94, div. N, title I, §608, Dec. 20, 2019, 133 Stat. 3130.)

REFERENCES IN TEXT

Subtitles A and C, referred to in subsec. (a)(4)(A)(i)(II), are subtitles A (§§1001-1004) and C (§§1201-1255), respectively, of title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 130, 154. Subtitle A enacted sections 300gg-11 to 300gg-19, 300gg-93, and 300gg-94 of this title, transferred sections 300gg-4 to 300gg-7 and 300gg-13 of this title to sections 300gg-25 to 300gg-28 and 300gg-9 of this title, respectively, amended sections 300gg-11, 300gg-12, and 300gg-21 to 300gg-23 of this title, and enacted provisions set out as a note under section 300gg-11 of this title. Subtitle C enacted subchapter II of this chapter and sections 300gg to 300gg-2 and 300gg-4 to 300gg-7 of this title, transferred section 300gg of this title to section 300gg-3 of this title, amended sections 300gg-1 and 300gg-4 of this title, and enacted provisions set out as a note under section 300gg of this title. For complete classification of subtitles A and C to the Code, see Tables.

This title, referred to in subsecs. (b)(1) and (e)(3)(A)(viii), 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.

Section 2716 of the Public Health Service Act, referred to in subsec. (c)(5), probably should be section 2715 of the Public Health Service Act, act July 1, 1944, which is classified to section 300gg-15 of this title and requires the Secretary to develop a uniform explanation of coverage documents and standardized definitions. Section 2716 of act July 1, 1944, which is classified to section 300gg-16 of this title, relates to prohibition on discrimination in favor of highly compensated individuals.

The Social Security Act, referred to in subsecs. (c)(6)(C), (d)(4)(F), and (f)(3)(B)(ii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part D of title XVIII of the Act is classified generally to part D (§1395w-101 et seq.) of subchapter XVIII of chapter 7 of this title. 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.

Section 2794 of the Public Health Service Act, referred to in subsec. (e)(2), probably means section 2794 of act July 1, 1944, as added by section 1003 of Pub. L. 111-148, which relates to premium increases for consumers and is classified to section 300gg-94 of this title. Another section 2794 of act July 1, 1944, relates to uniform fraud and abuse referral format and is classified to section 300gg-95 of this title.

The Public Health Service Act, referred to in subsec. (h)(1)(A)(i), is act July 1, 1944, ch. 373, 58 Stat. 682. Part C of title IX of the Act is classified generally to part C (§299b-21 et seq.) of subchapter VII 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 subchapter, referred to in subsec. (k), was in the original “this subtitle”, meaning subtitle D of title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 162, which enacted this subchapter and amended sections 501, 4958, and 6033 of Title 26, Internal Revenue Code.

AMENDMENTS

2019—Subsec. (c)(7). Pub. L. 116-94 added par. (7).

2010—Subsec. (c)(1)(I). Pub. L. 111-148, §10203(a), added subpar. (I).

Subsec. (d)(3)(B)(ii). Pub. L. 111-148, §10104(e)(1), added cl. (ii) and struck out former cl. (ii). Prior to amendment, text read as follows: “A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of title 26 and any cost-sharing reduction under section 18071 of this title to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of title 26 and section 18071(c)(4) of this title.”

Subsec. (d)(6)(A). Pub. L. 111-148, §10104(e)(2), inserted “educated” before “health care”.

Subsec. (e)(2). Pub. L. 111-148, §10104(f)(1), which directed substitution of “shall” for “may” in second sentence, was executed by making the substitution in third sentence before “take” to reflect the probable intent of Congress because the word “shall” already appeared in second sentence.

Subsec. (e)(3). Pub. L. 111-148, §10104(f)(2), added par. (3).

Subsec. (g)(1)(E). Pub. L. 111-148, §10104(g), added subpar. (E).

Subsec. (i)(2)(B). Pub. L. 111-148, §10104(h), substituted “resource partners of the Small Business Administration” for “small business development centers”.

§ 18032. Consumer choice

(a) Choice

(1) Qualified individuals

A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.

(2) Qualified employers

(A) Employer may specify level

A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 18022(d) of this title to be made available to employees through an Exchange.

(B) Employee may choose plans within a level

Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) Payment of premiums by qualified individuals

A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) Single risk pool

(1) Individual market

A health insurance issuer shall consider all enrollees in all health plans (other than grand-

fathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) Small group market

A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) Merger of markets

A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

(4) State law

A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(d) Empowering consumer choice

(1) Continued operation of market outside Exchanges

Nothing in this title¹ shall be construed to prohibit—

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) Continued operation of State benefit requirements

Nothing in this title¹ shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) Voluntary nature of an Exchange

(A) Choice to enroll or not to enroll

Nothing in this title¹ shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) Prohibition against compelled enrollment

Nothing in this title¹ shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) Individuals allowed to enroll in any plan

A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 18022(e) of this title, a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 18022(e)(2) of this title.

(D) Members of Congress in the Exchange

(i) Requirement

Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) Definitions

In this section:

(I) Member of Congress

The term “Member of Congress” means any member of the House of Representatives or the Senate.

(II) Congressional staff

The term “congressional staff” means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) No penalty for transferring to minimum essential coverage outside Exchange

An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of title 26 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such title).

(e) Enrollment through agents or brokers

The Secretary shall establish procedures under which a State may allow agents or brokers—

(1) to enroll individuals and employers in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

(f) Qualified individuals and employers; access limited to citizens and lawful residents

(1) Qualified individuals

In this title:¹

(A) In general

The term “qualified individual” means, with respect to an Exchange, an individual who—

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange.

(B) Incarcerated individuals excluded

An individual shall not be treated as a qualified individual if, at the time of enroll-

¹ See References in Text note below.

ment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) Qualified employer

In this title:¹

(A) In general

The term “qualified employer” means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) Extension to large groups

(i) In general

Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) Large employers eligible

If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term “qualified employer” shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) Access limited to lawful residents

If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

(Pub. L. 111–148, title I, § 1312, title X, § 10104(i), Mar. 23, 2010, 124 Stat. 182, 901.)

REFERENCES IN TEXT

This title, referred to in subsecs. (d)(1), (2), (3)(A), (B) and (f)(1), (2), 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 effective date of this subtitle, referred to in subsec. (d)(3)(D)(i), is the effective date of subtitle D of title I of Pub. L. 111–148, which is Mar. 23, 2010.

This Act, referred to in subsec. (d)(3)(D)(i), 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. (a)(1). Pub. L. 111–148, § 10104(i)(1), inserted “and for which such individual is eligible” before period at end.

Subsec. (e). Pub. L. 111–148, § 10104(i)(2)(B), struck out concluding provisions which read as follows: “Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.”

Subsec. (e)(1). Pub. L. 111–148, § 10104(i)(2)(A), inserted “and employers” after “enroll individuals”.

Subsec. (f)(1)(A)(ii). Pub. L. 111–148, § 10104(i)(3), struck out “(except with respect to territorial agreements under this subsection)” before period at end.

§ 18033. Financial integrity

(a) Accounting for expenditures

(1) In general

An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

(2) Investigations

The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) Audits

An Exchange shall be subject to annual audits by the Secretary.

(4) Pattern of abuse

If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title,¹ the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

(5) Protections against fraud and abuse

With respect to activities carried out under this title,¹ the Secretary shall provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that—

(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title;¹ and

(B) the Secretary has authority to implement under this title¹ or any other Act.

(6) Application of the False Claims Act

(A) In general

Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer’s entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

¹ See References in Text note below.

(B)² Damages

Notwithstanding paragraph (1) of section 3729(a) of title 31, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(b) GAO oversight

Not later than 5 years after the first date on which Exchanges are required to be operational under this title,¹ the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review—

(1) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;

(2) any significant observations regarding the utilization and adoption of Exchanges;

(3) where appropriate, recommendations for improvements in the operations or policies of Exchanges;

(4) a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns (as defined under section 632 of title 15), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and

(5) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care programs.

(Pub. L. 111–148, title I, §1313, title X, §10104(k), Mar. 23, 2010, 124 Stat. 184, 902.)

REFERENCES IN TEXT

This title, referred to in subsecs. (a)(4), (5) and (b), 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.

This Act, referred to in subsec. (a)(4), (6)(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.

The False Claims Act, referred to in subsec. (a)(6), was the popular name for sections 231, 232, 233, and 235 of former Title 31, Money and Finance. Sections 231, 232, 233, and 235 were repealed by Pub. L. 97–258, §5(b), Sept. 13, 1982, 96 Stat. 1084, and reenacted by the first section thereof as sections 3729 to 3731 of Title 31, Money and Finance.

² See Termination of Provision note below.

AMENDMENTS

2010—Subsec. (b)(4), (5). Pub. L. 111–148, §10104(k), added par. (4) and redesignated former par. (4) as (5).

TERMINATION OF PROVISION

Pub. L. 111–148, title X, §10104(j)(1), Mar. 23, 2010, 124 Stat. 901, provided that: “Subparagraph (B) of section 1313(a)(6) of this Act [42 U.S.C. 18033(a)(6)(B)] is hereby deemed null, void, and of no effect.”

PART C—STATE FLEXIBILITY RELATING TO EXCHANGES

§ 18041. State flexibility in operation and enforcement of Exchanges and related requirements**(a) Establishment of standards****(1) In general**

The Secretary shall, as soon as practicable after March 23, 2010, issue regulations setting standards for meeting the requirements under this title,¹ and the amendments made by this title,¹ with respect to—

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part E; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act [42 U.S.C. 201 et seq.].

(2) Consultation

In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) State action

Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) Failure to establish Exchange or implement requirements**(1) In general**

If—

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State—

¹ See References in Text note below.

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement—

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) Enforcement authority

The provisions of section 2736(b)¹ of the Public Health Services² Act [42 U.S.C. 300gg–22(b)] shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) No interference with State regulatory authority

Nothing in this title¹ shall be construed to preempt any State law that does not prevent the application of the provisions of this title.¹

(e) Presumption for certain State-operated Exchanges

(1) In general

In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) Process

The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

(Pub. L. 111–148, title I, §1321, Mar. 23, 2010, 124 Stat. 186.)

REFERENCES IN TEXT

This title, referred to in subsecs. (a)(1) and (d), 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.

Subtitles A and C, referred to in subsecs. (a)(1) and (c)(1)(B)(ii)(II), are subtitles A (§§1001–1004) and C (§§1201–1255), respectively, of title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, 154. Subtitle A enacted sections 300gg–11 to 300gg–19, 300gg–93, and 300gg–94 of this

title, transferred sections 300gg–4 to 300gg–7 and 300gg–13 of this title to sections 300gg–25 to 300gg–28 and 300gg–9 of this title, respectively, amended sections 300gg–11, 300gg–12, and 300gg–21 to 300gg–23 of this title, and enacted provisions set out as a note under section 300gg–11 of this title. Subtitle C enacted subchapter II of this chapter and sections 300gg to 300gg–2 and 300gg–4 to 300gg–7 of this title, transferred section 300gg of this title to section 300gg–3 of this title, amended sections 300gg–1 and 300gg–4 of this title, and enacted provisions set out as a note under section 300gg of this title. For complete classification of subtitles A and C to the Code, see Tables.

The Public Health Service Act, referred to in subsec. (a)(1), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) 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.

Section 2736 of the Public Health Service Act, referred to in subsec. (c)(2), was renumbered section 2723 of that Act by Pub. L. 111–148, §1563(c)(13)(C) (formerly §1562(c)(13)(C)), Mar. 23, 2010, 124 Stat. 269, and is classified to section 300gg–22 of this title.

This Act, referred to in subsec. (e)(1), 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.

§ 18042. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers

(a) Establishment of program

(1) In general

The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO–OP) program.

(2) Purpose

It is the purpose of the CO–OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

(b) Loans and grants under the CO–OP program

(1) In general

The Secretary shall provide through the CO–OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of—

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

(2) Requirements for awarding loans and grants

(A) In general

In awarding loans and grants under the CO–OP program, the Secretary shall—

(i) take into account the recommendations of the advisory board established under paragraph (3);

(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and

(iii) ensure that there is sufficient funding to establish at least 1 qualified non-

²So in original. Probably should be “Service”.

profit health insurance issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

(B) States without issuers in program

If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

(C) Agreement

(i) In general

The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)—

(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

(II) any requirements contained in the agreement for such person to receive such loan or grant.

(ii) Restrictions on use of Federal funds

The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used—

(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II) for marketing.

Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of title 26.

(iii) Failure to meet requirements

If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

(I) 110 percent of the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such title.

(D) Time for awarding loans and grants

The Secretary shall not later than July 1, 2013, award the loans and grants under the

CO-OP program and begin the distribution of amounts awarded under such loans and grants.

(3) Repayment of loans and grants

Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants.

(4) Advisory board

(A) In general

The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1395b-6(c)(2) of this title.

(B) Rules relating to appointments

(i) Standards

Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.

(ii) Original appointments

The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after March 23, 2010.

(C) Vacancy

Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

(D) Pay and reimbursement

(i) No compensation for members of advisory board

Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.

(ii) Travel expenses

Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5.

(E) Application of FACA

The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

(F) Termination

The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

(c) Qualified nonprofit health insurance issuer

For purposes of this section—

(1) In general

The term “qualified nonprofit health insurance issuer” means a health insurance issuer that is an organization—

(A) that is organized under State law as a nonprofit, member corporation;

(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and

(C) that meets the other requirements of this subsection.

(2) Certain organizations prohibited

An organization shall not be treated as a qualified nonprofit health insurance issuer if—

(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or

(B) the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

(3) Governance requirements

An organization shall not be treated as a qualified nonprofit health insurance issuer unless—

(A) the governance of the organization is subject to a majority vote of its members;

(B) its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and

(C) as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(4) Profits inure to benefit of members

An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

(5) Compliance with State insurance laws

An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, and any applicable State premium assessments and any other State law described in section 18044(b) of this title.

(6) Coordination with State insurance reforms

An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the

State) the market reforms required by part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as amended by subtitles A and C of this Act).

(d) Establishment of private purchasing council**(1) In general**

Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

(2) Council may not set payment rates

The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

(3) Continued application of antitrust laws**(A) In general**

Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.

(B) Antitrust laws

For purposes of this subparagraph, the term “antitrust laws” has the meaning given the term in subsection (a) of section 12 of title 15. Such term also includes section 45 of title 15 to the extent that such section 45 applies to unfair methods of competition.

(e) Limitation on participation

No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(f) Limitations on Secretary**(1) In general**

The Secretary shall not—

(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) Competition

Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(g) Appropriations

There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, \$6,000,000,000 to carry out this section.

(h) Omitted**(i) GAO study and report****(1) Study**

The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) Report

The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

(Pub. L. 111-148, title I, §1322, title X, §10104(l), Mar. 23, 2010, 124 Stat. 187, 902.)

REFERENCES IN TEXT

The Federal Advisory Committee Act, referred to in subsec. (b)(4)(E), is Pub. L. 92-463, Oct. 6, 1972, 86 Stat. 770, which is set out in the Appendix to Title 5, Government Organization and Employees.

The Public Health Service Act, referred to in subsec. (c)(6), 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.

Subtitles A and C of this Act, referred to in subsec. (c)(6), are subtitles A (§§1001-1004) and C (§§1201-1255), respectively, of title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 130, 154. Subtitle A enacted sections 300gg-11 to 300gg-19, 300gg-93, and 300gg-94 of this title, transferred sections 300gg-4 to 300gg-7 and 300gg-13 of this title to sections 300gg-25 to 300gg-28 and 300gg-9 of this title, respectively, amended sections 300gg-11, 300gg-12, and 300gg-21 to 300gg-23 of this title, and enacted provisions set out as a note under section 300gg-11 of this title. Subtitle C enacted subchapter II of this chapter and sections 300gg to 300gg-2 and 300gg-4 to 300gg-7 of this title, transferred section 300gg of this title to section 300gg-3 of this title, amended sections 300gg-1 and 300gg-4 of this title, and enacted provisions set out as a note under section 300gg of this title. For complete classification of subtitles A and C to the Code, see Tables.

This Act, referred to in subsec. (i)(1), 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.

CODIFICATION

Section is comprised of section 1322 of Pub. L. 111-148. Subsec. (h) of section 1322 of Pub. L. 111-148 amended sections 501, 4958, and 6033 of Title 26, Internal Revenue Code.

AMENDMENTS

2010—Subsec. (b)(3), (4). Pub. L. 111-148, §10104(l), added par. (3) and redesignated former par. (3) as (4).

CONSUMER OPERATED AND ORIENTED PLAN PROGRAM
CONTINGENCY FUND

Pub. L. 112-240, title VI, §644, Jan. 2, 2013, 126 Stat. 2362, provided that:

“(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a fund to be used to provide assistance and oversight to qualified nonprofit health insurance issuers that have been awarded loans or grants under section 1322 of the Patient Protection and Affordable Care Act (42 U.S.C. 18042) prior to the date of enactment of this Act [Jan. 2, 2013].

“(b) TRANSFER AND RESCISSION.—

“(1) TRANSFER.—From the unobligated balance of funds appropriated under section 1322(g) of the Patient Protection and Affordable Care Act (42 U.S.C. 18042(g)), 10 percent of such sums are hereby transferred to the fund established under subsection (a) to remain available until expended.

“(2) RESCISSION.—Except as provided for in paragraph (1), amounts appropriated under section 1322(g) of the Patient Protection and Affordable Care Act (42 U.S.C. 18042(g)) that are unobligated as of the date of enactment of this Act [Jan. 2, 2013] are rescinded.”

§ 18043. Funding for the territories**(a) In general**

A territory that—

(1) elects consistent with subsection (b) to establish an Exchange in accordance with part B of this subchapter and establishes such an Exchange in accordance with such part shall be treated as a State for purposes of such part and shall be entitled to payment from the amount allocated to the territory under subsection (c); or

(2) does not make such election shall be entitled to an increase in the dollar limitation applicable to the territory under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for such period in such amount for such territory and such increase shall not be taken into account in computing any other amount under such subsections.

(b) Terms and conditions

An election under subsection (a)(1) shall—

(1) not be effective unless the election is consistent with section 18041 of this title and is received not later than October 1, 2013; and

(2) be contingent upon entering into an agreement between the territory and the Secretary that requires that—

(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 health plan” means a health benefits plan that the State contracts with under this section—

¹ So in original. Probably should be “health”.

(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 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 a² 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.

² So in original. Probably should be preceded by “is”.

§ 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 sections¹ 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 title² 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 regula-

tions 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 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 title² as certified by Office³ of the Actuary

¹ So in original. Probably should be “section”.

² See References in Text note below.

³ So in original. Probably should be preceded by “the”.

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 title² would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title² 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 therefor.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 sub-

mission 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 ju-

⁴So in original. Probably should be “therefor.”

risdiction 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 title¹ would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title¹ 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 program¹ under chapter 89 of title 5, including (through negotiating with each multi-state² 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

¹So in original. The words “employees health benefit program” probably should be capitalized.

²So in original. Probably should be “multi-State”.

¹ See References in Text note below.

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 title³ 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.

(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

³ See References in Text note below.

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 purposes of the reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of—

(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or

(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

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

(B) Payment amount

The formula for determining the amount of payments that will be paid to health insurance issuers described in paragraph (1)(B) that insure high-risk individuals. Such formula shall provide for the equitable allocation of available funds through reconciliation and may be designed—

- (i) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or
- (ii) to use any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.

(3) Determination of required contributions**(A) In general**

The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) Specific requirements

The method under this paragraph shall be designed so that—

- (i) the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator;
- (ii) the contribution amount can include an additional amount to fund the administrative expenses of the applicable reinsurance entity;
- (iii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal \$10,000,000,000 for plan years beginning in 2014, \$6,000,000,000 for plan years beginning² 2015, and \$4,000,000,000 for plan years beginning in 2016; and
- (iv) in addition to the aggregate contribution amounts under clause (iii), each issuer's contribution amount for any calendar year under clause (iii) reflects its proportionate share of an additional \$2,000,000,000 for 2014, an additional \$2,000,000,000 for 2015, and an additional \$1,000,000,000 for 2016.

Nothing in this subparagraph shall be construed to preclude a State from collecting

additional amounts from issuers on a voluntary basis.

(4) Expenditure of funds

The provisions under paragraph (1) shall provide that—

- (A) the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and
- (B) amounts remaining unexpended as of December, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.

(c) Applicable reinsurance entity

For purposes of this section—

(1) In general

The term “applicable reinsurance entity” means a not-for-profit organization—

- (A) the purpose of which is to help stabilize premiums for coverage in the individual market in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest; and
- (B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.

(2) State discretion

A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

(3) Entities are tax-exempt

An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of title 26. The preceding sentence shall not apply to the tax imposed by section 511 such³ title (relating to tax on unrelated business taxable income of an exempt organization).

(d) Coordination with State high-risk pools

The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

² So in original. Probably should be followed by “in”.

³ So in original. Probably should be preceded by “of”.

(Pub. L. 111-148, title I, §1341, title X, §10104(r), Mar. 23, 2010, 124 Stat. 208, 906.)

AMENDMENTS

2010—Pub. L. 111-148, §10104(r)(1), substituted “market” for “and small group markets” in section catchline.

Subsec. (b)(2)(B). Pub. L. 111-148, §10104(r)(2), substituted “paragraph (1)(B)” for “paragraph (1)(A)” in introductory provisions.

Subsec. (c)(1)(A). Pub. L. 111-148, §10104(r)(3), substituted “individual market” for “individual and small group markets”.

§ 18062. Establishment of risk corridors for plans in individual and small group markets

(a) In general

The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan’s aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w-101 et seq.].

(b) Payment methodology

(1) Payments out

The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan’s allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan’s allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) Payments in

The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan’s allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan’s allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) Definitions

In this section:

(1) Allowable costs

(A) In general

The amount of allowable costs of a plan for any year is an amount equal to the total

costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) Reduction for risk adjustment and reinsurance payments

Allowable costs shall¹ reduced by any risk adjustment and reinsurance payments received under section² 18061 and 18063 of this title.

(2) Target amount

The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

(Pub. L. 111-148, title I, §1342, Mar. 23, 2010, 124 Stat. 211.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (a), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part D of title XVIII of the Act is classified generally to part D (§1395w-101 et seq.) of subchapter XVIII of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

§ 18063. Risk adjustment

(a) In general

(1) Low actuarial risk plans

Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.]).

(2) High actuarial risk plans

Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) Criteria and methods

The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq., 1395w-101 et seq.]. Such criteria and methods shall be included in the standards and re-

¹ So in original. Probably should be followed by “be”.

² So in original. Probably should be “sections”.

quirements the Secretary prescribes under section 18041 of this title.

(c) Scope

A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.

(Pub. L. 111-148, title I, §1343, Mar. 23, 2010, 124 Stat. 212.)

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in subsec. (a), is Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 829, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Social Security Act, referred to in subsec. (b), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Parts C and D of title XVIII of the Act are classified generally to parts C (§1395w-21 et seq.) and D (§1395w-101 et seq.), respectively, of subchapter XVIII of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

SUBCHAPTER IV—AFFORDABLE COVERAGE CHOICES FOR ALL AMERICANS

PART A—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

§ 18071. Reduced cost-sharing for individuals enrolling in qualified health plans

(a) In general

In the case of an eligible insured enrolled in a qualified health plan—

- (1) the Secretary shall notify the issuer of the plan of such eligibility; and
- (2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

(b) Eligible insured

In this section, the term “eligible insured” means an individual—

- (1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and
- (2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of title 26, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) Determination of reduction in cost-sharing

(1) Reduction in out-of-pocket limit

(A) In general

The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of-pocket¹ limit under section 18022(c)(1) of this title in the case of—

- (i) an eligible insured whose household income is more than 100 percent but not

more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) Coordination with actuarial value limits

(i) In general

The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan’s share of the total allowed costs of benefits provided under the plan above—

- (I) 94 percent in the case of an eligible insured described in paragraph (2)(A);
- (II) 87 percent in the case of an eligible insured described in paragraph (2)(B);
- (III) 73 percent in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved; and
- (IV) 70 percent in the case of an eligible insured whose household income is more than 250 percent but not more than 400 percent of the poverty line for a family of the size involved.

(ii) Adjustment

The Secretary shall adjust the out-of-pocket¹ limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(2) Additional reduction for lower income insureds

The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan’s share of the total allowed costs of benefits provided under the plan to 94 percent of such costs;

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan’s share of the total allowed costs of benefits provided under the plan to 87 percent of such costs; and

(C) in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved, increase the plan’s share of the total allowed costs of benefits provided under the plan to 73 percent of such costs.

¹ So in original. Probably should be “out-of-pocket”.

(3) Methods for reducing cost-sharing**(A) In general**

An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.

(B) Capitated payments

The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.

(4) Additional benefits

If a qualified health plan under section 18022(b)(5) of this title offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 18031(d)(3)(B) of this title to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) Special rule for pediatric dental plans

If an individual enrolls in both a qualified health plan and a plan described in section 18031(d)(2)(B)(ii)(I)² of this title for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 18022(b)(1)(J) of this title.

(d) Special rules for Indians**(1) Indians under 300 percent of poverty**

If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 5304(d) of title 25) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) Items or services furnished through Indian health providers

If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-

sharing that would be due from the Indian but for subparagraph (A).

(3) Payment

The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

(e) Rules for individuals not lawfully present**(1) In general**

If an individual who is an eligible insured is not lawfully present—

(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) Lawfully present

For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) Secretarial authority

The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) Definitions and special rules

In this section:

(1) In general

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) Limitations on reduction

No cost-sharing reduction shall be allowed under this section with respect to coverage for

² So in original. Probably should be "18031(d)(3)(B)(ii)(I)".

any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such title.

(3) Data used for eligibility

Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 18082 of this title and not the taxable year for which the credit under section 36B of title 26 is allowed.

(Pub. L. 111-148, title I, §1402, Mar. 23, 2010, 124 Stat. 220; Pub. L. 111-152, title I, §1001(b), Mar. 30, 2010, 124 Stat. 1031.)

AMENDMENTS

2010—Subsec. (c)(1)(B)(i)(I), Pub. L. 111-152, §1001(b)(1)(A), substituted “94” for “90”.

Subsec. (c)(1)(B)(i)(II), Pub. L. 111-152, §1001(b)(1)(B)(i), substituted “87” for “80”.

Subsec. (c)(1)(B)(i)(III), (IV), Pub. L. 111-152, §1001(b)(1)(B)(ii), (C), added subcls. (III) and (IV) and struck out former subcl. (III). Prior to amendment, subcl. (III) read as follows: “70 percent in the case of an eligible insured described in clause (i) or (iii) of subparagraph (A).”

Subsec. (c)(2)(A), Pub. L. 111-152, §1001(b)(2)(A)(i), substituted “94” for “90”.

Subsec. (c)(2)(B), Pub. L. 111-152, §1001(b)(2)(B)(i), substituted “87” for “80”.

Subsec. (c)(2)(C), Pub. L. 111-152, §1001(b)(2)(A)(ii), (B)(ii), (C), added subpar. (C).

PART B—ELIGIBILITY DETERMINATIONS

§ 18081. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions

(a) Establishment of program

The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 18032(f)(3), 18071(e), and 18082(d) of this title and section 36B(e) of title 26 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of title 26 or section 18071 of this title—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual’s coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2) of title 26;¹ and

(4) whether to grant a certification under section 18031(d)(4)(H) of this title attesting

that, for purposes of the individual responsibility requirement under section 5000A of title 26, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) Information required to be provided by applicants

(1) In general

An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an “enrollee”); and

(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) Citizenship or immigration status

The following information shall be provided with respect to every enrollee:

(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee’s social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee’s immigration status, the enrollee’s social security number (if applicable) and such identifying information with respect to the enrollee’s immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) Eligibility and amount of tax credit or reduced cost-sharing

In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of title 26 or section 18071 of this title is being claimed, the following information:

(A) Information regarding income and family size

The information described in section 6103(l)(21) of title 26¹ for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

(B) Certain individual health insurance policies obtained through small employers

The amount of the enrollee’s permitted benefit (as defined in section 9831(d)(3)(C) of title 26) under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of such title).

(C) Changes in circumstances

The information described in section 18082(b)(2) of this title, including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) Employer-sponsored coverage

In the case of an enrollee with respect to whom eligibility for a premium tax credit

¹ See References in Text note below.

under section 36B of title 26 or cost-sharing reduction under section 18071 of this title is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of title 26 as providing minimum essential coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of title 26) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) Exemptions from individual responsibility requirements

In the case of an individual who is seeking an exemption certificate under section 18031(d)(4)(H) of this title from any requirement or penalty imposed by section 5000A of title 26,¹ the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

(c) Verification of information contained in records of specific Federal officials

(1) Information transferred to Secretary

An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).

(2) Citizenship or immigration status

(A) Commissioner of Social Security

The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is con-

sistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) Secretary of Homeland Security

(i) In general

In the case of an individual—

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) Information

The information described in clause (ii) is the following:

(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) Eligibility for tax credit and cost-sharing reduction

The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

(4) Methods

(A) In general

The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done—

(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such

other method as is approved by the Secretary.

(B) Flexibility

The Secretary may modify the methods used under the program established by this section for the Exchange² and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of title 26 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) Verification by Secretary

In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) Actions relating to verification

(1) In general

Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) Verification

(A) Eligibility for enrollment and premium tax credits and cost-sharing reductions

If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 18082(c) of this title of the amount of any advance payment to be made.

(B) Exemption from individual responsibility

If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 18031(d)(4)(H) of this title.

(3) Inconsistencies involving attestation of citizenship or lawful presence

If the information provided by any applicant under subsection (b)(2) is inconsistent with in-

formation in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the medicaid program is determined under section 1396a(ee) of this title (as in effect on January 1, 2010).

(4) Inconsistencies involving other information

(A) In general

If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) Reasonable effort

The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

(ii) Notice and opportunity to correct

In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) Specific actions not involving citizenship or lawful presence

(i) In general

Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.

(ii) Eligibility or amount of credit or reduction

If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

²So in original. Probably should not be capitalized.

(iii) Employer affordability

If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of title 26 or cost-sharing reduction under section 18071 of this title because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of title 26.

(iv) Exemption

In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such title will be issued.

(C) Appeals process

The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(f) Appeals and redeterminations**(1) In general**

The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) Employer liability**(A) In general**

The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of title 26 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to—

(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such title.

(B) Confidentiality

Notwithstanding any provision of this title¹ (or the amendments made by this title)¹ or section 6103 of title 26, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of title 26 with respect to the employee, except that—

(i) the employer may be notified as to the name of an employee and whether or not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) Confidentiality of applicant information**(1) In general**

An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(2) Receipt of information

Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall—

(A) use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and

(B) not disclose the information to any other person except as provided in this section.

(h) Penalties**(1) False or fraudulent information****(A) Civil penalty****(i) In general**

If—

(I) any person fails to provide³ correct information under subsection (b); and

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than

³ So in original. Probably should be "provide".

\$25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms “negligence” and “disregard” shall have the same meanings as when used in section 6662 of title 26.

(ii) Reasonable cause exception

No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) Knowing and willful violations

Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$250,000.

(2) Improper use or disclosure of information

Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$25,000.

(3) Limitations on liens and levies

The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or

(B) levy on any such property with respect to such failure.

(i) Study of administration of employer responsibility

(1) In general

The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title¹ and section 4980H of title 26 (as added by section 1513)¹ that the following rights are protected:

(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.

(B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(2) Report

Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of⁴ Education and Labor and Ways and Means of the House of Representatives.

(Pub. L. 111–148, title I, §1411, Mar. 23, 2010, 124 Stat. 224; Pub. L. 114–255, div. C, title XVIII, §18001(a)(6)(B), Dec. 13, 2016, 130 Stat. 1342.)

⁴So in original. Probably should be “on”.

REFERENCES IN TEXT

Sections 36B(c)(2)(C) and 5000A(e)(2) of title 26, section 6103(l)(21) of title 26, and section 5000A of title 26, referred to in subsecs. (a)(3) and (b)(3)(A), (5), were in the original “sections 36B(c)(2)(C) and 5000A(e)(2)”, “section 6103(l)(21)”, and “section 5000A”, respectively, and were translated as if they had been followed by “of the Internal Revenue Code of 1986”, to reflect the probable intent of Congress.

This title, referred to in subsecs. (f)(2)(B) and (i)(1), 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.

Section 1513, referred to in subsec. (i)(1), means section 1513 of Pub. L. 111–148.

AMENDMENTS

2016—Subsec. (b)(3)(B), (C). Pub. L. 114–255 added subpar. (B) and redesignated former subpar. (B) as (C).

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable to applications for enrollment made after Dec. 31, 2016, see section 18001(a)(7)(F) of Pub. L. 114–255, set out in a note under section 36B of Title 26, Internal Revenue Code.

VERIFICATION OF HOUSEHOLD INCOME AND OTHER QUALIFICATIONS FOR THE PROVISION OF ACA PREMIUM AND COST-SHARING SUBSIDIES

Pub. L. 113–46, div. B, §1001, Oct. 17, 2013, 127 Stat. 566, provided that:

“(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall ensure that American Health Benefit Exchanges verify that individuals applying for premium tax credits under section 36B of the Internal Revenue Code of 1986 [26 U.S.C. 36B] and reductions in cost-sharing under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) are eligible for such credits and cost sharing reductions consistent with the requirements of section 1411 of such Act (42 U.S.C. 18081), and, prior to making such credits and reductions available, the Secretary shall certify to the Congress that the Exchanges verify such eligibility consistent with the requirements of such Act [Pub. L. 111–148, see Tables for classification].

“(b) REPORT BY SECRETARY.—Not later than January 1, 2014, the Secretary shall submit a report to the Congress that details the procedures employed by American Health Benefit Exchanges to verify eligibility for credits and cost-sharing reductions described in subsection (a).

“(c) REPORT BY INSPECTOR GENERAL.—Not later than July 1, 2014, the Inspector General of the Department of Health and Human Services shall submit to the Congress a report regarding the effectiveness of the procedures and safeguards provided under the Patient Protection and Affordable Care Act for preventing the submission of inaccurate or fraudulent information by applicants for enrollment in a qualified health plan offered through an American Health Benefit Exchange.”

§ 18082. Advance determination and payment of premium tax credits and cost-sharing reductions

(a) In general

The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which—

(1) upon request of an Exchange, advance determinations are made under section 18081 of this title with respect to the income eligibility of individuals enrolling in a qualified

health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of title 26 and the cost-sharing reductions under section 18071 of this title;

(2) the Secretary notifies—

(A) the Exchange and the Secretary of the Treasury of the advance determinations; and

(B) the Secretary of the Treasury of the name and employer identification number of each employer with respect to whom 1 or more employee¹ of the employer were determined to be eligible for the premium tax credit under section 36B of title 26 and the cost-sharing reductions under section 18071 of this title because—

(i) the employer did not provide minimum essential coverage; or

(ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of title 26 to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.

(b) Advance determinations

(1) In general

The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made—

(A) during the annual open enrollment period applicable to the individual (or such other enrollment period as may be specified by the Secretary); and

(B) on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available.

(2) Changes in circumstances

The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—

(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and

(B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

¹ So in original. Probably should be "employees".

(c) Payment of premium tax credits and cost-sharing reductions

(1) In general

The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 18081 of this title.

(2) Premium tax credit

(A) In general

The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of title 26 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).

(B) Issuer responsibilities

An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—

(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) in the case of any nonpayment of premiums by the insured—

(I) notify the Secretary of such nonpayment; and

(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

(3) Cost-sharing reductions

The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 18071 of this title is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.

(d) No Federal payments for individuals not lawfully present

Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.

(e) State flexibility

Nothing in this subtitle or the amendments made by this subtitle shall be construed to prohibit a State from making payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this subtitle and such amendments.

(Pub. L. 111-148, title I, §1412, Mar. 23, 2010, 124 Stat. 231.)

REFERENCES IN TEXT

This subtitle, referred to in subsecs. (d) and (e), is subtitle E (§§1401-1421) of title I of Pub. L. 111-148,

which enacted this subchapter and sections 36B and 45R of Title 26, Internal Revenue Code, amended section 405 of this title, sections 38, 196, 280C, 6103, and 7213 of Title 26, and section 1324 of Title 31, Money and Finance, and enacted provisions set out as notes under sections 36B and 38 of Title 26. For complete classification of subtitle E to the Code, see Tables.

§ 18083. Streamlining of procedures for enrollment through an Exchange and State medicaid, CHIP, and health subsidy programs

(a) In general

The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for medical assistance under the State medicaid plan under title XIX¹ [42 U.S.C. 1396 et seq.], or eligible for enrollment under a State children's health insurance program (CHIP) under title XXI of such Act [42 U.S.C. 1397aa et seq.], the individual is enrolled for assistance under such plan or program.

(b) Requirements relating to forms and notice

(1) Requirements relating to forms

(A) In general

The Secretary shall develop and provide to each State a single, streamlined form that—

- (i) may be used to apply for all applicable State health subsidy programs within the State;
- (ii) may be filed online, in person, by mail, or by telephone;
- (iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and
- (iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) State authority to establish form

A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) Supplemental eligibility forms

The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of title 26).

(2) Notice

The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any

need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) Requirements relating to eligibility based on data exchanges

(1) Development of secure interfaces

Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 18081(c)(4) of this title.

(2) Data matching program

Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

(A) provides access to data described in paragraph (3);

(B) applies only to individuals who—

- (i) receive assistance from an applicable State health subsidy program; or
- (ii) apply for such assistance—

(I) by filing a form described in subsection (b); or

(II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) consistent² with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act [42 U.S.C. 1396w-2] or that are otherwise applicable to such programs.

(3) Determination of eligibility

(A) In general

Each applicable State health subsidy program shall, to the maximum extent practicable—

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act [42 U.S.C. 1320b-7, 653(i), 1396w-2(a)], obtained through such arrangement.

(B) Exception

This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative

¹ So in original. Probably should be followed by "of the Social Security Act".

² So in original. Probably should be preceded by "is".

and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) Secretarial standards

The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) Administrative authority

(1) Agreements

Subject to section 18081 of this title and section 6103(l)(21) of title 26 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and enter into agreements, for the sharing of data under this section.

(2) Authority of exchange to contract out

Nothing in this section shall be construed to—

(A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) change any requirement under title XIX¹ that eligibility for participation in a State's medicaid program must be determined by a public agency.

(e) Applicable State health subsidy program

In this section, the term "applicable State health subsidy program" means—

(1) the program under this title³ for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of title 26 and cost-sharing reductions under section 18071 of this title;

(2) a State medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.];

(3) a State children's health insurance program (CHIP) under title XXI of such Act [42 U.S.C. 1397aa et seq.]; and

(4) a State program under section 18051 of this title establishing qualified basic health plans.

(Pub. L. 111-148, title I, §1413, Mar. 23, 2010, 124 Stat. 233.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (a), (d)(2)(B), and (e)(2), (3), 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.

³ See References in Text note below.

For complete classification of this Act to the Code, see section 1305 of this title and Tables.

This title, where footnoted in subsec. (e)(1), 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.

§ 18084. Premium tax credit and cost-sharing reduction payments disregarded for Federal and federally-assisted programs

For purposes of determining the eligibility of any individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds—

(1) any credit or refund allowed or made to any individual by reason of section 36B of title 26 (as added by section 1401)¹ shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 18071 or 18082 of this title shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

(Pub. L. 111-148, title I, §1415, Mar. 23, 2010, 124 Stat. 237.)

REFERENCES IN TEXT

Section 1401, referred to in par. (1), means section 1401 of Pub. L. 111-148.

SUBCHAPTER V—SHARED RESPONSIBILITY FOR HEALTH CARE

PART A—INDIVIDUAL RESPONSIBILITY

§ 18091. Requirement to maintain minimum essential coverage; findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this section referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

¹ See References in Text note below.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from \$2,500,000,000, or 17.6 percent of the economy, in 2009 to \$4,700,000,000 in 2019. Private health insurance spending is projected to be \$854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to \$207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was \$43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over \$1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act [42 U.S.C. 300gg-3, 300gg-4] (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health in-

surance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were \$90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In *United States v. South-Eastern Underwriters Association* (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(Pub. L. 111-148, title I, §1501(a), title X, §10106(a), Mar. 23, 2010, 124 Stat. 242, 907.)

REFERENCES IN TEXT

This Act, referred to in par. (2)(C), (E) to (J), 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.

The Employee Retirement Income Security Act of 1974, referred to in par. (2)(H), is Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 829, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Public Health Service Act, referred to in par. (2)(H), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) 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.

AMENDMENTS

2010—Par. (2). Pub. L. 111-148, §10106(a), amended par. (2) generally. Prior to amendment, par. (2) described effects of the individual responsibility requirement on the national economy and interstate commerce.

§ 18092. Notification of nonenrollment

Not later than June 30 of each year, the Secretary of the Treasury, acting through the Internal Revenue Service and in consultation with the Secretary of Health and Human Services, shall send a notification to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage (as defined in section 5000A of title 26). Such notification shall contain information on the services

available through the Exchange operating in the State in which such individual resides.

(Pub. L. 111-148, title I, § 1502(c), Mar. 23, 2010, 124 Stat. 251.)

PART B—EMPLOYER RESPONSIBILITIES

§ 18101. Repealed. Pub. L. 112-10, div. B, title VIII, § 1858(a), Apr. 15, 2011, 125 Stat. 168

Section, Pub. L. 111-148, title X, § 10108(a)–(e), Mar. 23, 2010, 124 Stat. 912, 913, related to free choice vouchers.

EFFECTIVE DATE OF REPEAL

Repeal by Pub. L. 112-10 effective as if included in the provisions of, and the amendments made by, the provisions of Pub. L. 111-148 to which it relates, see section 1858(d) of Pub. L. 112-10, set out as an Effective Date of 2011 Amendment note under section 36B of Title 26, Internal Revenue Code.

SUBCHAPTER VI—MISCELLANEOUS PROVISIONS

§ 18111. Definitions

Unless specifically provided for otherwise, the definitions contained in section 300gg-91 of this title shall apply with respect to this title.¹

(Pub. L. 111-148, title I, § 1551, Mar. 23, 2010, 124 Stat. 258.)

REFERENCES IN TEXT

This title, where footnoted in text, 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.

§ 18112. Transparency in Government

Not later than 30 days after March 23, 2010, the Secretary of Health and Human Services shall publish on the Internet website of the Department of Health and Human Services, a list of all of the authorities provided to the Secretary under this Act (and the amendments made by this Act).

(Pub. L. 111-148, title I, § 1552, Mar. 23, 2010, 124 Stat. 258.)

REFERENCES IN TEXT

This Act, referred to in text, 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.

§ 18113. Prohibition against discrimination on assisted suicide

(a) In general

The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing,

or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

(b) Definition

In this section, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(c) Construction and treatment of certain services

Nothing in subsection (a) shall be construed to apply to, or to affect, any limitation relating to—

- (1) the withholding or withdrawing of medical treatment or medical care;
- (2) the withholding or withdrawing of nutrition or hydration;
- (3) abortion; or
- (4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(d) Administration

The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section.

(Pub. L. 111-148, title I, § 1553, Mar. 23, 2010, 124 Stat. 259.)

REFERENCES IN TEXT

This Act, referred to in subsec. (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.

§ 18114. Access to therapies

Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

- (1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;
- (2) impedes timely access to health care services;
- (3) interferes with communications regarding a full range of treatment options between the patient and the provider;
- (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;
- (5) violates the principles of informed consent and the ethical standards of health care professionals; or
- (6) limits the availability of health care treatment for the full duration of a patient’s medical needs.

(Pub. L. 111-148, title I, § 1554, Mar. 23, 2010, 124 Stat. 259.)

REFERENCES IN TEXT

This Act, referred to in text, is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119, known as the Patient Protection

¹ See References in Text note below.

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.

§ 18115. Freedom not to participate in Federal health insurance programs

No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any Federal health insurance program created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any such amendments), and there shall be no penalty or fine imposed upon any such issuer for choosing not to participate in such programs.

(Pub. L. 111-148, title I, §1555, Mar. 23, 2010, 124 Stat. 260.)

REFERENCES IN TEXT

This Act, referred to in text, 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.

§ 18116. Nondiscrimination

(a) In general

Except as otherwise provided for in this title¹ (or an amendment made by this title),¹ an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title¹ (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Continued application of laws

Nothing in this title¹ (or an amendment made by this title)¹ shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 794 of title 29, or the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.], or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) Regulations

The Secretary may promulgate regulations to implement this section.

(Pub. L. 111-148, title I, §1557, Mar. 23, 2010, 124 Stat. 260.)

¹ See References in Text note below.

REFERENCES IN TEXT

This title, referred to in subsecs. (a) and (b), 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 Civil Rights Act of 1964, referred to in subsecs. (a) and (b), is Pub. L. 88-352, July 2, 1964, 78 Stat. 241. Titles VI and VII of the Act are classified generally to subchapters V (§2000d et seq.) and VI (§2000e et seq.), respectively, of chapter 21 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 2000a of this title and Tables.

The Education Amendments of 1972, referred to in subsecs. (a) and (b), is Pub. L. 92-318, June 23, 1972, 86 Stat. 235. Title IX of the Act, known as the Patsy Takemoto Mink Equal Opportunity in Education Act, is classified principally to chapter 38 (§1681 et seq.) of Title 20, Education. For complete classification of title IX to the Code, see Short Title note set out under section 1681 of Title 20 and Tables.

The Age Discrimination Act of 1975, referred to in subsecs. (a) and (b), is title III of Pub. L. 94-135, Nov. 28, 1975, 89 Stat. 728, which is classified generally to chapter 76 (§6101 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 6101 of this title and Tables.

§ 18117. Oversight

The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title¹ as it relates to such Department.

(Pub. L. 111-148, title I, §1559, Mar. 23, 2010, 124 Stat. 261.)

REFERENCES IN TEXT

This title, referred to in text, 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.

§ 18118. Rules of construction

(a) No effect on antitrust laws

Nothing in this title¹ (or an amendment made by this title)¹ shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For the purposes of this section, the term “antitrust laws” has the meaning given such term in subsection (a) of section 12 of title 15, except that such term includes section 45 of title 15 to the extent that such section 45 applies to unfair methods of competition.

(b) Rule of construction regarding Hawaii’s Prepaid Health Care Act

Nothing in this title¹ (or an amendment made by this title)¹ shall be construed to modify or limit the application of the exemption for Hawaii’s Prepaid Health Care Act (Haw. Rev. Stat. §§393-1 et seq.) as provided for under section 1144(b)(5) of title 29.

(c) Student health insurance plans

Nothing in this title¹ (or an amendment made by this title)¹ shall be construed to prohibit an institution of higher education (as such term is

¹ See References in Text note below.

¹ See References in Text note below.

defined for purposes of the Higher Education Act of 1965 [20 U.S.C. 1001 et seq.] from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.

(d) No effect on existing requirements

Nothing in this title¹ (or an amendment made by this title,¹ unless specified by direct statutory reference) shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for programs identified in section 18083 of this title.

(Pub. L. 111-148, title I, §1560, Mar. 23, 2010, 124 Stat. 261.)

REFERENCES IN TEXT

This title, where footnoted in text, 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 Higher Education Act of 1965, referred to in subsec. (c), is Pub. L. 89-329, Nov. 8, 1965, 79 Stat. 1219, which is classified generally to chapter 28 (§1001 et seq.) of Title 20, Education. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 20 and Tables.

§ 18119. Small business procurement

Part 19 of the Federal Acquisition Regulation, section 644 of title 15, and any other applicable laws or regulations establishing procurement requirements relating to small business concerns (as defined in section 632 of title 15) may not be waived with respect to any contract awarded under any program or other authority under this Act or an amendment made by this Act.

(Pub. L. 111-148, title I, §1563, as added Pub. L. 111-148, title X, §10107(b)(2), Mar. 23, 2010, 124 Stat. 912.)

REFERENCES IN TEXT

This Act, referred to in text, 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.

CODIFICATION

Another section 1563 of Pub. L. 111-148 enacted section 18120 of this title, section 9815 of Title 26, Internal Revenue Code, and section 1185d of Title 29, Labor, and amended sections 300gg-1 to 300gg-3, 300gg-9, 300gg-11, 300gg-12, 300gg-21 to 300gg-23, 300gg-25 to 300gg-28, 300gg-62, and 300gg-91 of this title.

§ 18120. Application

Notwithstanding any other provision of the Patient Protection and Affordable Care Act, nothing in such Act (or an amendment made by such Act) shall be construed to—

(1) prohibit (or authorize the Secretary of Health and Human Services to promulgate regulations that prohibit) a group health plan or health insurance issuer from carrying out utilization management techniques that are commonly used as of March 23, 2010; or

(2) restrict the application of the amendments made by this subtitle.

(Pub. L. 111-148, title I, §1563(d), formerly §1562(d), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 269, 911.)

REFERENCES IN TEXT

The Patient Protection and Affordable Care Act, referred to in text, is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The amendments made by this subtitle, referred to in par. (2), mean the amendments made by subtitle G (§§1551-1563) of title I of Pub. L. 111-148, which enacted section 300jj-51 of this title, sections 4980H, 5000A, 6055, 6056, and 9815 of Title 26, Internal Revenue Code, and sections 218a to 218c and 1185d of Title 29, Labor, amended sections 300gg-1 to 300gg-3, 300gg-9, 300gg-11, 300gg-12, 300gg-21 to 300gg-23, 300gg-25 to 300gg-28, 300gg-62, and 300gg-91 of this title, sections 125 and 6724 of Title 26, and sections 921 and 932 of Title 30, Mineral Lands and Mining.

CODIFICATION

Another section 1563 of Pub. L. 111-148 is classified to section 18119 of this title.

§ 18121. Implementation funding

(a) In general

There is hereby established a Health Insurance Reform Implementation Fund (referred to in this section as the “Fund”) within the Department of Health and Human Services to carry out the Patient Protection and Affordable Care Act and this Act (and the amendments made by such Acts).

(b) Funding

There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, \$1,000,000,000 for Federal administrative expenses to carry out such Act¹ (and the amendments made by such Acts).

(Pub. L. 111-152, title I, §1005, Mar. 30, 2010, 124 Stat. 1036.)

REFERENCES IN TEXT

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

This Act, referred to in subsec. (a), is Pub. L. 111-152, Mar. 30, 2010, 124 Stat. 1029, known as the Health Care and Education Reconciliation Act of 2010. For complete classification of this Act to the Code, see Short Title of 2010 Amendment note under section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Health Care and Education Reconciliation Act of 2010, and not as part of the Patient Protection and Affordable Care Act which comprises this chapter.

§ 18122. Rule of construction regarding health care providers

(1) In general

Subject to paragraph (3), the development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

¹ So in original. Probably should be “Acts”.

(2) Definitions

For purposes of this section:

(A) Federal health care provision

The term “Federal health care provision” means any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), or title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq., 42 U.S.C. 1396 et seq.).

(B) Health care provider

The term “health care provider” means any individual, group practice, corporation of health care professionals, or hospital—

- (i) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or
- (ii) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(C) Medical malpractice or medical product liability action or claim

The term “medical malpractice or medical product liability action or claim” means a medical malpractice action or claim (as defined in section 11151(7) of this title) and includes a liability action or claim relating to a health care provider’s prescription or provision of a drug, device, or biological product (as such terms are defined in section 321 of title 21 or section 262 of this title).

(D) State

The term “State” includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) No preemption

Nothing in paragraph (1) or any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), or title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq., 42 U.S.C. 1396 et seq.) shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

(Pub. L. 114-10, title I, §106(d), Apr. 16, 2015, 129 Stat. 142.)

REFERENCES IN TEXT

The Patient Protection and Affordable Care Act, referred to in pars. (2)(A) and (3), is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The Health Care and Education Reconciliation Act of 2010, referred to in pars. (2)(A) and (3), is Pub. L. 111-152, Mar. 30, 2010, 124 Stat. 1029. For complete classification of this Act to the Code, see Short Title of 2010 Amendment note set out under section 1305 of this title and Tables.

The Social Security Act, referred to in pars. (2)(A) and (3), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII and XIX of the Act are classified generally to subchapters XVIII (§1395 et seq.) and XIX (§1396 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.

CODIFICATION

Section was enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015, and not as part of the Patient Protection and Affordable Care Act which comprises this chapter.

CHAPTER 158—SUPPORT FOR PREGNANT AND PARENTING TEENS AND WOMEN

Sec.	Definitions.
18201.	Establishment of Pregnancy Assistance Fund.
18203.	Permissible uses of Fund.
18204.	Appropriations.

§ 18201. Definitions

In this chapter:

(1) Accompaniment

The term “accompaniment” means assisting, representing, and accompanying a woman in seeking judicial relief for child support, child custody, restraining orders, and restitution for harm to persons and property, and in filing criminal charges, and may include the payment of court costs and reasonable attorney and witness fees associated therewith.

(2) Eligible institution of higher education

The term “eligible institution of higher education” means an institution of higher education (as such term is defined in section 1001 of title 20) that has established and operates, or agrees to establish and operate upon the receipt of a grant under this chapter, a pregnant and parenting student services office.

(3) Community service center

The term “community service center” means a non-profit organization that provides social services to residents of a specific geographical area via direct service or by contract with a local governmental agency.

(4) High school

The term “high school” means any public or private school that operates grades 10 through 12, inclusive, grades 9 through 12, inclusive or grades 7 through 12, inclusive.

(5) Intervention services

The term “intervention services” means, with respect to domestic violence, sexual violence, sexual assault, or stalking, 24-hour telephone hotline services for police protection and referral to shelters.

(6) Secretary

The term “Secretary” means the Secretary of Health and Human Services.

(7) State

The term “State” includes the District of Columbia, any commonwealth, possession, or other territory of the United States, and any Indian tribe or reservation.

(8) Supportive social services

The term “supportive social services” means transitional and permanent housing, vocational counseling, and individual and group counseling aimed at preventing domestic violence, sexual violence, sexual assault, or stalking.

(9) Violence

The term “violence” means actual violence and the risk or threat of violence.