advisory board, except that section 14 of such Act'' in text.

2010—Subsec. (b)(3), (4). Pub. L. 111–148, §10104(*l*), added par. (3) and redesignated former par. (3) as (4).

Statutory Notes and Related Subsidiaries

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Care Act (42 U.S.C. 18042(g)) that are unobligated as of the date of enactment of this Act [Jan. 2, 2013] are rescinded.''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.)

Editorial Notes

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.)

Editorial Notes

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, §10104(n), substituted '', or a multi-State qualified health plan under

section 18054 of this title'' for '', a community health insurance option under section 18043 of this title, or a nationwide qualified health plan under section 18053(b) of this title''.

PART D—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

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

(a) Establishment of program

(1) In general

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

(2) Certifications as to benefit coverage and costs

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

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

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

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

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

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

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

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

(b) Standard health plan

In this section, the term ''standard heath[1] plan'' means a health benefits plan that the State contracts with under this section—

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

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

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

(c) Contracting process

(1) In general

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

(2) Specific items to be considered

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

(A) Innovation

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

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

(ii) incentives for use of preventive services; and

(iii) the establishment of relationships between providers and patients that 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.

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