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

AMENDMENTS

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

§ 18054. Multi-State plans

(a) Oversight by the Office of Personnel Management

(1) In general

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

(2) Terms

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

(3) Non-profit entities

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

(4) Administration

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

(A) a medical loss ratio;

(B) a profit margin;

(C) the premiums to be charged; and

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

(5) Authority to protect consumers

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

(6) Assured availability of varied coverage

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

(7) Withdrawal

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

(b) Eligibility

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

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

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

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

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

(c) Requirements for multi-State qualified health plan

(1) In general

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

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

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

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

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

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

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

[3] See References in Text note below.

(2) States may offer additional benefits

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

(3) Credits

(A) In general

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

(B) No additional Federal cost

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

(4) State must assume cost

A State shall make payments—

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

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

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

(5) Application of certain State rating requirements

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

(d) Plans deemed to be certified

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

(e) Phase-in

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

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

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

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

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

(f) Applicability

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

(g) Continued support for FEHBP

(1) Maintenance of effort

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

(2) Separate risk pool

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

(3) Authority to establish separate entities

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

(4) Effective oversight

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

(5) Assurance of separate program

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

(6) FEHBP plans not required to participate

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

(h) Advisory board

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

(i) Authorization of appropriations

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

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

REFERENCES IN TEXT

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

This title, referred to in subsecs. (b)(2), (3), (c)(1)(B), and (f), is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

CODIFICATION

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

PART E—REINSURANCE AND RISK ADJUSTMENT

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

(a) In general

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

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

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

(b) Model regulation

(1) In general

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

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

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

(2) High-risk individual; payment amounts

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

(A) Determination of high-risk individuals

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

(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

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