gram 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.

(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.)

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 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 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.

[1] See References in Text note below.

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, 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). 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

Subchapter effective for plan years beginning on or after Jan. 1, 2014, except that section 18011 of this title effective Mar. 23, 2010, see section 1255 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 title[1] (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.

§ 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.

(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.

[1] See References in Text note below.

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 title[1] 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 appro-

[1] See References in Text note below.