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.

priate 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);

(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 incentive 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

[1] See References in Text note below.

[2] So in original. Probably should be ''paragraph,''.