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 2014, $6,000,000,000 for plan years beginning[2] 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] So in original. A second closing parenthesis probably should precede the semicolon.

[2] So in original. Probably should be followed by ''in''.

(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 such[3] 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.

(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 shall[1] reduced by any risk adjustment and reinsurance payments received under section[2] 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

[3] So in original. Probably should be preceded by ''of''.

[1] So in original. Probably should be followed by ''be''.

[2] So in original. Probably should be ''sections''.