

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 title¹ 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-

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:

¹ See References in Text note below.

¹ See References in Text note below.