

**(e) Educated health care consumers**

The term “educated health care consumer” means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(Pub. L. 111–148, title I, §1304, title X, §10104(d), Mar. 23, 2010, 124 Stat. 171, 900.)

## REFERENCES IN TEXT

This title, referred to in subsecs. (a) to (d), 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. (e). Pub. L. 111–148, §10104(d), added subsec. (e).

PART B—CONSUMER CHOICES AND INSURANCE  
COMPETITION THROUGH HEALTH BENEFIT EX-  
CHANGES**§ 18031. Affordable choices of health benefit plans****(a) Assistance to States to establish American Health Benefit Exchanges****(1) Planning and establishment grants**

There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after March 23, 2010, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

**(2) Amount specified**

For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

**(3) Use of funds**

A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

**(4) Renewability of grant****(A) In general**

Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

(i) is making progress, as determined by the Secretary, toward—

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

**(B) Limitation**

No grant shall be awarded under this subsection after January 1, 2015.

**(5) Technical assistance to facilitate participation in SHOP Exchanges**

The Secretary shall provide technical assistance to States to facilitate the participation

of qualified small businesses in such States in SHOP Exchanges.

**(b) American Health Benefit Exchanges****(1) In general**

Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title<sup>1</sup> as an “Exchange”) for the State that—

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title<sup>1</sup> referred to as a “SHOP Exchange”) that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

**(2) Merger of individual and SHOP Exchanges**

A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

**(c) Responsibilities of the Secretary****(1) In general**

The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act [42 U.S.C. 300gg–1(c)]), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 U.S.C. 1396r–8(c)(1)(D)(i)(IV)] as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures

<sup>1</sup> See References in Text note below.

such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options;

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act [42 U.S.C. 280j-2], as applicable; and

(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act [42 U.S.C. 1320b-9a].

## **(2) Rule of construction**

Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

## **(3) Rating system**

The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

## **(4) Enrollee satisfaction system**

The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet

portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

## **(5) Internet portals**

The Secretary shall—

(A) continue to operate, maintain, and update the Internet portal developed under section 18003(a) of this title and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716<sup>1</sup> of the Public Health Service Act and to a copy of the plan's written policy.

## **(6) Enrollment periods**

The Secretary shall require an Exchange to provide for—

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of title 26 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w-101 et seq.]; and

(D) special monthly enrollment periods for Indians (as defined in section 1603 of title 25).

## **(d) Requirements**

### **(1) In general**

An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

### **(2) Offering of coverage**

#### **(A) In general**

An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

#### **(B) Limitation**

##### **(i) In general**

An Exchange may not make available any health plan that is not a qualified health plan.

##### **(ii) Offering of stand-alone dental benefits**

Each Exchange within a State shall allow an issuer of a plan that only provides

limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of title 26 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 18022(b)(1)(J) of this title.

**(3) Rules relating to additional required benefits**

**(A) In general**

Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 18022(b) of this title.

**(B) States may require additional benefits**

**(i) In general**

Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 18022(b) of this title.

**(ii) State must assume cost**

A State shall make payments—

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

(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (i).

**(4) Functions**

An Exchange shall, at a minimum—

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act [42 U.S.C. 300gg–15];

(F) in accordance with section 18083 of this title, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], the CHIP program under title XXI of such Act [42 U.S.C. 1397aa et seq.], or any applicable State or local public program and if through screening of the ap-

plication by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of title 26 and any cost-sharing reduction under section 18071 of this title;

(H) subject to section 18081 of this title, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of title 26, an individual is exempt from the individual requirement or from the penalty imposed by such section because—

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury—

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of title 26 because—

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such title to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 18081(b)(4) of this title that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

**(5) Funding limitations**

**(A) No Federal funds for continued operations**

In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to partici-

pating health insurance issuers, or to otherwise generate funding, to support its operations.

**(B) Prohibiting wasteful use of funds**

In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

**(6) Consultation**

An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—

- (A) educated health care consumers who are enrollees in qualified health plans;
- (B) individuals and entities with experience in facilitating enrollment in qualified health plans;
- (C) representatives of small businesses and self-employed individuals;
- (D) State Medicaid offices; and
- (E) advocates for enrolling hard to reach populations.

**(7) Publication of costs**

An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

**(e) Certification**

**(1) In general**

An Exchange may certify a health plan as a qualified health plan if—

- (A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and
- (B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—
  - (i) on the basis that such plan is a fee-for-service plan;
  - (ii) through the imposition of premium price controls; or
  - (iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

**(2) Premium considerations**

The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1)<sup>1</sup> of the Public Health Service Act [42

U.S.C. 300gg-94(b)(1)] (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

**(3) Transparency in coverage**

**(A) In general**

The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

- (i) Claims payment policies and practices.
- (ii) Periodic financial disclosures.
- (iii) Data on enrollment.
- (iv) Data on disenrollment.
- (v) Data on the number of claims that are denied.
- (vi) Data on rating practices.
- (vii) Information on cost-sharing and payments with respect to any out-of-network coverage.
- (viii) Information on enrollee and participant rights under this title.<sup>1</sup>
- (ix) Other information as determined appropriate by the Secretary.

**(B) Use of plain language**

The information required to be submitted under subparagraph (A) shall be provided in plain language. The term “plain language” means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

**(C) Cost sharing transparency**

The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

**(D) Group health plans**

The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and peri-

odic financial disclosure with the standards established by the Secretary under subparagraph (A).

**(f) Flexibility**

**(1) Regional or other interstate exchanges**

An Exchange may operate in more than one State if—

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

**(2) Subsidiary Exchanges**

A State may establish one or more subsidiary Exchanges if—

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act [42 U.S.C. 300gg(a)].

**(3) Authority to contract**

**(A) In general**

A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

**(B) Eligible entity**

In this paragraph, the term “eligible entity” means—

(i) a person—

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of title 26 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

**(g) Rewarding quality through market-based incentives**

**(1) Strategy described**

A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge rein-

forcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities; and

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

**(2) Guidelines**

The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

**(3) Requirements**

The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

**(h) Quality improvement**

**(1) Enhancing patient safety**

Beginning on January 1, 2015, a qualified health plan may contract with—

(A) a hospital with greater than 50 beds only if such hospital—

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act [42 U.S.C. 299b-21 et seq.]; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

**(2) Exceptions**

The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

**(3) Adjustment**

The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

**(i) Navigators**

**(1) In general**

An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

**(2) Eligibility**

**(A) In general**

To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has

existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

**(B) Types**

Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities that—

- (i) are capable of carrying out the duties described in paragraph (3);
- (ii) meet the standards described in paragraph (4); and
- (iii) provide information consistent with the standards developed under paragraph (5).

**(3) Duties**

An entity that serves as a navigator under a grant under this subsection shall—

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of title 26 and cost-sharing reductions under section 18071 of this title;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act [42 U.S.C. 300gg-93], or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

**(4) Standards**

**(A) In general**

The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not—

- (i) be a health insurance issuer; or
- (ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

**(5) Fair and impartial information and services**

The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

**(6) Funding**

Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

**(j) Applicability of mental health parity**

Section 2726 of the Public Health Service Act [42 U.S.C. 300gg-26] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

**(k) Conflict**

An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subchapter.

(Pub. L. 111-148, title I, §1311, title X, §§10104(e)–(h), 10203(a), Mar. 23, 2010, 124 Stat. 173, 900, 901, 927.)

REFERENCES IN TEXT

Subtitles A and C, referred to in subsec. (a)(4)(A)(i)(II), are subtitles A (§§1001-1004) and C (§§1201-1255), respectively, of title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 130, 154. Subtitle A 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. Subtitle C enacted subchapter II of this chapter 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 subtitles A and C to the Code, see Tables.

This title, referred to in subsecs. (b)(1) and (e)(3)(A)(viii), 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.

Section 2716 of the Public Health Service Act, referred to in subsec. (c)(5), probably should be section 2715 of the Public Health Service Act, act July 1, 1944, which is classified to section 300gg-15 of this title and requires the Secretary to develop a uniform explanation of coverage documents and standardized definitions. Section 2716 of act July 1, 1944, which is classified to section 300gg-16 of this title, relates to prohibition on discrimination in favor of highly compensated individuals.

The Social Security Act, referred to in subsecs. (c)(6)(C), (d)(4)(F), and (f)(3)(B)(ii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part D of title XVIII of the Act is classified generally to part D (§1395w-101 et seq.) of subchapter XVIII of chapter 7 of this title. 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 2794 of the Public Health Service Act, referred to in subsec. (e)(2), probably means section 2794 of act July 1, 1944, as added by section 1003 of Pub. L.

111-148, which relates to premium increases for consumers and is classified to section 300gg-94 of this title. Another section 2794 of act July 1, 1944, relates to uniform fraud and abuse referral format and is classified to section 300gg-95 of this title.

The Public Health Service Act, referred to in subsec. (h)(1)(A)(i), is act July 1, 1944, ch. 373, 58 Stat. 682. Part C of title IX of the Act is classified generally to part C (§299b-21 et seq.) of subchapter VII 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 subchapter, referred to in subsec. (k), was in the original “this subtitle”, meaning subtitle D of title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 162, which enacted this subchapter and amended sections 501, 4958, and 6033 of Title 26, Internal Revenue Code.

#### AMENDMENTS

2010—Subsec. (c)(1)(I). Pub. L. 111-148, §10203(a), added subpar. (I).

Subsec. (d)(3)(B)(ii). Pub. L. 111-148, §10104(e)(1), added cl. (ii) and struck out former cl. (ii). Prior to amendment, text read as follows: “A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of title 26 and any cost-sharing reduction under section 18071 of this title to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of title 26 and section 18071(c)(4) of this title.”

Subsec. (d)(6)(A). Pub. L. 111-148, §10104(e)(2), inserted “educated” before “health care”.

Subsec. (e)(2). Pub. L. 111-148, §10104(f)(1), which directed substitution of “shall” for “may” in second sentence, was executed by making the substitution in third sentence before “take” to reflect the probable intent of Congress because the word “shall” already appeared in second sentence.

Subsec. (e)(3). Pub. L. 111-148, §10104(f)(2), added par. (3).

Subsec. (g)(1)(E). Pub. L. 111-148, §10104(g), added subpar. (E).

Subsec. (i)(2)(B). Pub. L. 111-148, §10104(h), substituted “resource partners of the Small Business Administration” for “small business development centers”.

### § 18032. Consumer choice

#### (a) Choice

##### (1) Qualified individuals

A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.

##### (2) Qualified employers

###### (A) Employer may specify level

A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 18022(d) of this title to be made available to employees through an Exchange.

###### (B) Employee may choose plans within a level

Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

#### (b) Payment of premiums by qualified individuals

A qualified individual enrolled in any qualified health plan may pay any applicable premium

owed by such individual to the health insurance issuer issuing such qualified health plan.

#### (c) Single risk pool

##### (1) Individual market

A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

##### (2) Small group market

A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

##### (3) Merger of markets

A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

##### (4) State law

A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

#### (d) Empowering consumer choice

##### (1) Continued operation of market outside Exchanges

Nothing in this title<sup>1</sup> shall be construed to prohibit—

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

##### (2) Continued operation of State benefit requirements

Nothing in this title<sup>1</sup> shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

##### (3) Voluntary nature of an Exchange

###### (A) Choice to enroll or not to enroll

Nothing in this title<sup>1</sup> shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

###### (B) Prohibition against compelled enrollment

Nothing in this title<sup>1</sup> shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

###### (C) Individuals allowed to enroll in any plan

A qualified individual may enroll in any qualified health plan, except that in the case

<sup>1</sup> See References in Text note below.