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.

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

Section effective Mar. 23, 2010, see section 1255(1) 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.

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

§ 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

[1] See References in Text note below.

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.

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

§ 18014. Treatment of expatriate health plans under ACA

(a) In general

Subject to subsection (b), the provisions of (including any amendment made by) the Patient Protection and Affordable Care Act (Public Law 111–148) and of title I and subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152) shall not apply with respect to—

(1) expatriate health plans;

(2) employers with respect to such plans, solely in their capacity as plan sponsors for such plans; or

(3) expatriate health insurance issuers with respect to coverage offered by such issuers under such plans.

(b) Minimum essential coverage and reporting requirements

(1) In general

For the purpose of section 5000A(f) of title 26, and any other section of title 26 that incorporates the definition of minimum essential coverage under such section 5000A(f) by reference:

(A) An expatriate health plan offered to primary enrollees who are described in subsections (d)(3)(A) and (d)(3)(B) of this section shall be treated as an eligible employer sponsored plan under 5000A(f)(2) of such title.

(B) An expatriate health plan offered to primary enrollees who are described in subsection (d)(3)(C) of this section shall be treated as a plan in the individual market under section 5000A(f)(1)(C) of such title. This subparagraph shall apply solely for the purposes of sections 36B, 5000A, and 6055 of such title.

(2) Exception

Subsection (a) shall not apply with respect to section 6055 of title 26, or sections 4980H and 6056 of such title in the case of an applicable large employer (as defined in section 4980H of such title), except that statements furnished to individuals may be provided through electronic media and the primary insured shall be deemed to have consented to receive the statements under such sections in electronic form, unless the individual explicitly refuses such consent. Notwithstanding subsection (a), section 4980I of title 26 shall continue to apply with respect to applicable employer-sponsored coverage (as defined in such section) of a qualified expatriate described in subsection (d)(3)(A)(i) who is assigned (rather than transferred) to work in the United States.

(c) Qualified expatriates, spouses, and dependents not United States health risk

(1) In general

For purposes of section 9010 of the Patient Protection and Affordable Care Act (26 U.S.C. 4001 note prec.), for calendar years after 2015, a qualified expatriate (and any spouse, dependent, or any other individual enrolled in the plan) enrolled in an expatriate health plan shall not be considered a United States health risk.

(2) Special rule

Notwithstanding paragraph (1), the fee under section 9010 of such Act for each of calendar years 2014 and 2015 with respect to any expatriate health insurance issuer shall be the amount which bears the same ratio to the fee amount determined by the Secretary of the Treasury with respect to such issuer under such section for each such year (determined without regard to this paragraph) as—

(A) the amount of premiums taken into account under such section with respect to such issuer for each such year, less the amount of premiums for expatriate health plans taken into account under such section with respect to such issuer for each such year, bears to

(B) the amount of premiums taken into account under such section with respect to such issuer for each such year.

(d) Definitions

In this section:

(1) Expatriate health insurance issuer

The term ''expatriate health insurance issuer'' means a health insurance issuer that issues expatriate health plans.

(2) Expatriate health plan

The term ''expatriate health plan'' means a group health plan, health insurance coverage offered in connection with a group health plan, or health insurance coverage offered to a group of individuals described in paragraph (3)(C) (which may include spouses, dependents, and other individuals enrolled in the plan) that meets each of the following standards:

(A) Substantially all of the primary enrollees in such plan or coverage are qualified expatriates with respect to such plan or coverage. In applying the previous sentence, an individual shall not be considered a primary enrollee if the individual is not a national of the United States and the individual resides in the country of which the individual is a citizen.

(B) Substantially all of the benefits provided under the plan or coverage are not excepted benefits described in section 9832(c) of title 26.

(C) The plan or coverage provides coverage for inpatient hospital services, outpatient