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

2020—Subsec. (a)(5). Pub. L. 116–260 added par. (5).

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 OF 2020 AMENDMENT

Amendment by Pub. L. 116–260 applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB of Pub. L. 116–260, set out as a note under section 8902 of Title 5, Government Organization and Employees.

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 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[1] of title 26 shall continue to apply with respect to applicable employer-sponsored

[1] See References in Text note below.

[1] See References in Text note below.

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[1] 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[1] 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 facility services, physician services, and emergency services (comparable to such emergency services coverage described in and offered under section 8903(1) of title 5 for plan year 2009)—

(i) in the case of individuals described in paragraph (3)(A), both in the United States and in the country or countries from which the individual was transferred or assigned (accounting for flexibility needed with existing coverage), and such other country or countries as the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, may designate (after taking into account the barriers and prohibitions to providing health care services in the countries as designated);

(ii) in the case of individuals described in paragraph (3)(B), in the country or countries in which the individual is present in connection with the individual's employment, and such other country or countries as the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, may designate; or

(iii) in the case of individuals described in paragraph (3)(C), in the country or countries as the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, may designate.

(D) The plan sponsor reasonably believes that the benefits provided by the expatriate health plan satisfy a standard at least actuarially equivalent to the level provided for in section 36B(c)(2)(C)(ii) of title 26.

(E) If the plan or coverage provides dependent coverage of children, the plan or coverage makes such dependent coverage available for adult children until the adult child turns 26 years of age, unless such individual is the child of a child receiving dependent coverage.

(F) The plan or coverage—

(i) is issued by an expatriate health plan issuer, or administered by an administrator, that together with any other person in the expatriate health plan issuer's or administrator's controlled group (as described in section 9010[1] of the Patient Protection and Affordable Care Act (and the regulations promulgated thereunder)), has licenses to sell insurance in more than two countries, and, with respect to such plan, coverage, or company in the controlled group—

(I) maintains network provider agreements that provide for direct claims payments, directly or through third party contracts, with health care providers in eight or more countries;

(II) maintains call centers, directly or through third party contracts, in three or more countries and accepts calls from customers in eight or more languages;

(III) processes (in the aggregate together with other plans or coverage it issues or administers) at least $1,000,000 in claims in foreign currency equivalents each year;

(IV) makes available (directly or through third party contracts) global evacuation/repatriation coverage; and

(V) maintains legal and compliance resources in three or more countries; and

(ii) offers reimbursements for items or services under such plan or coverage in the local currency in eight or more countries.

(G) The plan or coverage, and the plan sponsor or expatriate health insurance issuer with respect to such plan or coverage, satisfies the provisions of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), chapter 100 of title 26, and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.), which would otherwise apply to such a plan or coverage, and sponsor or issuer, if not for the enactment of the Patient Protection and Affordable Care Act and title I and subtitle B of title II of the Health Care and Education Reconciliation Act of 2010.

(3) Qualified expatriate

The term ''qualified expatriate'' means a primary insured, or individual otherwise described in subparagraph (C)—

(A)(i) whose skills, qualifications, job duties, or expertise is of a type that has caused his or her employer to transfer or assign him or her to the United States for a specific and temporary purpose or assignment tied to his or her employment; and

(ii) in connection with such transfer or assignment, is reasonably determined by the plan sponsor to require access to health insurance and other related services and support in multiple countries, and is offered other multinational benefits on a periodic basis (such as tax equalization, compensation for cross border moving expenses, or compensation to enable the expatriate to return to their home country);

(B) who is working outside of the United States for a period of at least 180 days in a consecutive 12-month period that overlaps with the plan year; or

(C) who is a member of a group of similarly situated individuals—

(i) that is formed for the purpose of traveling or relocating internationally in service of one or more of the purposes listed in section 501(c)(3) or 501(c)(4) of title 26, or similarly situated organizations or groups (such as students or religious missionaries);

(ii) that is not formed primarily for the sale of health insurance coverage; and

(iii) that the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines requires access to health insurance and other related services and support in multiple countries.

(4) United States

The term ''United States'' means the 50 States, the District of Columbia, and Puerto Rico.

(5) Miscellaneous terms

(A) Group health plan; health insurance coverage; health insurance issuer; plan sponsor

The terms ''group health plan'', ''health insurance coverage'', ''health insurance issuer'', and ''plan sponsor'' have the meanings given those terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(B) Transfer

The term ''transfer'' means an employer has transferred an employee to perform services for a branch of the same employer or a parent, affiliate, franchise, or subsidiary thereof.

(e) Regulations

The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor may promulgate regulations necessary to carry out this Act, including such rules as may be necessary to prevent inappropriate expansion of the application of the exclusions under this Act from applicable laws and regulations, and to amend existing annual reporting requirements or procedures to include applicable qualified expatriate health insurers' total number of expatriate plan enrollees.

(f) Effective date

Unless otherwise specified, this Act shall take effect on December 16, 2014, and shall apply only to expatriate health plans issued or renewed on or after July 1, 2015.

(Pub. L. 113–235, div. M, §3, Dec. 16, 2014, 128 Stat. 2768.)

REFERENCES IN TEXT

The Patient Protection and Affordable Care Act, referred to in subsecs. (a), (c), and (d)(2)(F)(i), (G), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. Section 9010 of the Act was set out as a note preceding section 4001 of Title 26, Internal Revenue Code, prior to repeal by Pub. L. 116–94, div. N, title I, §502(a), Dec. 20, 2019, 133 Stat. 3119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The Health Care and Education Reconciliation Act of 2010, referred to in subsecs. (a) and (d)(2)(G), is Pub. L. 111–152, Mar. 30, 2010, 124 Stat. 1029. For complete classification of this Act to the Code, see Short Title of 2010 Amendment note set out under section 1305 of this title and Tables.

Section 4980I of title 26, referred to in subsec. (b)(2), was repealed by Pub. L. 116–94, div. N, title I, §503(a), Dec. 20, 2019, 133 Stat. 3119.

The Public Health Service Act, referred to in subsec. (d)(2)(G), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) of this title. Title XXVII of the Act is classified generally to subchapter XXV (§300gg et seq.) of chapter 6A. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (d)(2)(G), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832. Part 7 of subtitle B of title I of the Act is classified generally to part 7 (§1181 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

This Act, referred to in subsecs. (e) and (f), is div. M of Pub. L. 113–235, Dec. 16, 2014, 128 Stat. 2767, known as

the Expatriate Health Coverage Clarification Act of 2014. For complete classification of this Act to the Code, see Short Title of 2014 Amendment note set out under section 18001 of this title and Tables.

CODIFICATION

Section was enacted as part of the Expatriate Health Coverage Clarification Act of 2014, and also as part of the Consolidated and Further Continuing Appropriations Act, 2015, and not as part of title I of the Patient Protection and Affordable Care Act which enacted this chapter.

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 appropriate 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);

[1] See References in Text note below.

[1] See References in Text note below.