

(c) Appropriation and allocation**(1) Appropriation**

Out of any funds in the Treasury not otherwise appropriated, there is appropriated for purposes of payment pursuant to subsection (a) \$1,000,000,000, to be available during the period beginning with 2014 and ending with 2019.

(2) Allocation

The Secretary shall allocate the amount appropriated under paragraph (1) among the territories for purposes of carrying out this section as follows:

(A) For Puerto Rico, \$925,000,000.

(B) For another territory, the portion of \$75,000,000 specified by the Secretary.

(Pub. L. 111-148, title I, §1323, as added Pub. L. 111-152, title I, §1204(a), Mar. 30, 2010, 124 Stat. 1055.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (b)(2)(B), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XIX of the Act is classified generally to subchapter XIX (§1396 et seq.) of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

PRIOR PROVISIONS

A prior section 18043, Pub. L. 111-148, title I, §1323, Mar. 23, 2010, 124 Stat. 192, which related to establishment of community health insurance option, was repealed by Pub. L. 111-148, title X, §10104(m), Mar. 23, 2010, 124 Stat. 902.

§ 18044. Level playing field**(a) In general**

Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 18042 of this title, or a multi-State qualified health plan under section 18054 of this title, is not subject to such law.

(b) Laws described

The Federal and State laws described in this subsection are those Federal and State laws relating to—

- (1) guaranteed renewal;
- (2) rating;
- (3) preexisting conditions;
- (4) non-discrimination;
- (5) quality improvement and reporting;
- (6) fraud and abuse;
- (7) solvency and financial requirements;
- (8) market conduct;
- (9) prompt payment;
- (10) appeals and grievances;
- (11) privacy and confidentiality;
- (12) licensure; and
- (13) benefit plan material or information.

(Pub. L. 111-148, title I, §1324, title X, §10104(n), Mar. 23, 2010, 124 Stat. 199, 902.)

Editorial Notes

AMENDMENTS

2010—Subsec. (a). Pub. L. 111-148, §10104(n), substituted “, or a multi-State qualified health plan under

section 18054 of this title” for “, a community health insurance option under section 18043 of this title, or a nationwide qualified health plan under section 18053(b) of this title”.

PART D—STATE FLEXIBILITY TO ESTABLISH
ALTERNATIVE PROGRAMS**§ 18051. State flexibility to establish basic health programs for low-income individuals not eligible for medicaid****(a) Establishment of program****(1) In general**

The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 18022(b) of this title to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) Certifications as to benefit coverage and costs

Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—

(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of title 26) offered to the individual through an Exchange; and

(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—

(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and

(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and

(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 18022(b) of this title.

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax credits and cost-sharing reductions allowable with respect to either plan.