(i) *Account-based group health plan.* An account-based group health plan is an employer-provided group health plan that provides reimbursements of medical care expenses with the reimbursement subject to a maximum fixed dollar amount for a period. An HRA is a type of account-based group health plan. An account-based group health plan does not include a qualified small employer health reimbursement arrangement, as defined in section 9831(d)(2) of the Code.

(ii) *Medical care expenses.* Medical care expenses means expenses for medical care as defined under section 213(d) of the Code.

(e) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. Until the applicability date for this section, plans and issuers are required to continue to comply with the corresponding sections of this subchapter B, contained in the 45 CFR, subtitle A, parts 1–199, revised as of October 1, 2018.

[80 FR 72276, Nov. 18, 2015, as amended at 81 FR 75326, Oct. 31, 2016; 84 FR 29025, June 20, 2019]

§ 147.128 Rules regarding rescissions.

(a) *Prohibition on rescissions*—(1) A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)

(2) For purposes of this section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if —

(i) The cancellation or discontinuance of coverage has only a prospective effect;

(ii) The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRA premiums) towards the cost of coverage;

(iii) The cancellation or discontinuance of coverage is initiated by the individual (or by the individual's authorized representative) and the sponsor, employer, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual; or

(iv) The cancellation or discontinuance of coverage is initiated by the Exchange pursuant to § 155.430 of this subchapter (other than under paragraph (b)(2)(iii) of this section).

(3) The rules of this paragraph (a) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires *A* to complete a questionnaire regarding *A*'s prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire

complies with the other requirements of this part and part 146 of this subchapter. The questionnaire includes the following question: ''Is there anything else relevant to your health that we should know?'' *A* inadvertently fails to list that *A* visited a psychologist on two occasions, six years previously. *A* is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about *A*'s visits to the psychologist, which was not disclosed in the questionnaire.

(ii) *Conclusion.* In this *Example 1,* the plan cannot rescind *A*'s coverage because *A*'s failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

Example 2. (i) *Facts.* An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual *B* has coverage under the plan as a full-time employee. The employer reassigns *B* to a part-time position. Under the terms of the plan, *B* is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from *B* and paying claims submitted by *B*. After a routine audit, the plan discovers that *B* no longer works at least 30 hours per week. The plan rescinds *B*'s coverage effective as of the date that *B* changed from a full-time employee to a part-time employee.

(ii) *Conclusion.* In this *Example 2,* the plan cannot rescind *B*'s coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for *B* prospectively, subject to other applicable Federal and State laws.

(b) *Compliance with other requirements.* Other requirements of Federal or State law may apply in connection with a rescission of coverage.

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years (in the individual market, policy years) beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 45 CFR parts 144, 146 and 147, contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2015.

[80 FR 72277, Nov. 18, 2015]

§ 147.130 Coverage of preventive health services.

(a) *Services*—(1) *In general.* Beginning at the time described in paragraph (b) of this section and subject to §§ 147.131, 147.132, and 147.133, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for and must not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) for—

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, such additional preventive care and screenings not described in paragraph (a)(1)(i) of this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of section 2713(a)(4) of the Public Health Service Act, subject to §§ 147.131, 147.132, and 147.133.

(2) *Office visits.* (i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.