

“(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

“(2) unreasonable annual limits (within the meaning of section 223 of title 26) on the dollar value of benefits for any participant or beneficiary.

“(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 18022(b) of this title from placing annual or lifetime per beneficiary limits on specific covered benefits to the extent that such limits are otherwise permitted under Federal or State law.”

#### EFFECTIVE DATE

Pub. L. 111-148, title I, §1004, Mar. 23, 2010, 124 Stat. 140, provided that:

“(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle [subtitle A (§§1001-1004) of title I of Pub. L. 111-148, enacting this section and sections 300gg-12 to 300gg-15, 300gg-16 to 300gg-19, 300gg-93, and 300gg-94 of this title, amending former sections 300gg-11 and 300gg-12 of this title and sections 300gg-21 to 300gg-23 of this title, and transferring section 300gg-13 of this title to section 300gg-9 of this title and sections 300gg-4 to 300gg-7 of this title to sections 300gg-25 to 300gg-28 of this title, respectively] (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act [Mar. 23, 2010], except that the amendments made by sections 1002 and 1003 [enacting sections 300gg-93 and 300gg-94 of this title] shall become effective for fiscal years beginning with fiscal year 2010.

“(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 [enacting sections 300gg-93 and 300gg-94 of this title] shall take effect on the date of enactment of this Act [Mar. 23, 2010].”

#### § 300gg-12. Prohibition on rescissions

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 300gg-2(b)<sup>1</sup> or 300gg-42(b) of this title.

(July 1, 1944, ch. 373, title XXVII, §2712, as added Pub. L. 111-148, title I, §1001(5), Mar. 23, 2010, 124 Stat. 131.)

#### REFERENCES IN TEXT

Section 300gg-2(b) of this title, referred to in text, was in the original a reference to section “2702(c)” of act July 1, 1944, which was translated as meaning section 2703(b) of act July 1, 1944, to reflect the probable intent of Congress. Section 2702(c), which is classified to section 300gg-1 of this title, relates to special rules for network plans, while section 2703(b) specifies the reasons for which a health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offering in the group or individual market. Section 300gg-2(b) also parallels section 300gg-42(b) which appears in the same context in this section as the reference to section 300gg-2(b).

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

#### PRIOR PROVISIONS

A prior section 300gg-12, act July 1, 1944, ch. 373, title XXVII, §2712, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1964, was renumbered section 2732 of act July 1, 1944, amended, and transferred to subsecs. (b) to (e) of section 300gg-2 of this title, by Pub. L. 111-148, title I, §§1001(3), 1563(c)(9), formerly §1562(c)(9), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 267, 911. Prior to amendment and transfer, text of section 300gg-12 read as follows:

“(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage at the option of the plan sponsor of the plan.

“(b) GENERAL EXCEPTIONS.—A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:

“(1) NONPAYMENT OF PREMIUMS.—The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

“(2) FRAUD.—The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

“(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RULES.—The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 300gg-11(e) of this title in the case of the small group market or pursuant to applicable State law in the case of the large group market.

“(4) TERMINATION OF COVERAGE.—The issuer is ceasing to offer coverage in such market in accordance with subsection (c) and applicable State law.

“(5) MOVEMENT OUTSIDE SERVICE AREA.—In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 300gg-11(c)(1)(A) of this title.

“(6) ASSOCIATION MEMBERSHIP CEASES.—In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

“(c) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.—

“(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if—

“(A) the issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

“(B) the issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance cov-

erage currently being offered by the issuer to a group health plan in such market; and

“(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

“(2) DISCONTINUANCE OF ALL COVERAGE.—

“(A) IN GENERAL.—In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in a State, health insurance coverage may be discontinued by the issuer only in accordance with applicable State law and if—

“(i) the issuer provides notice to the applicable State authority and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

“(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

“(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

“(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan—

“(1) in the large group market; or

“(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

“(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.—In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to ‘plan sponsor’ is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.”

Another prior section 2712 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238k of this title.

#### EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

### § 300gg-13. Coverage of preventive health services

#### (a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

(1) 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;

(2) immunizations 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; and<sup>1</sup>

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.<sup>2</sup>

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.<sup>2</sup>

(5) for the purposes of this chapter, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

#### (b) Interval

##### (1) In general

The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

##### (2) Minimum

The interval described in paragraph (1) shall not be less than 1 year.

#### (c) Value-based insurance design

The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

(July 1, 1944, ch. 373, title XXVII, §2713, as added Pub. L. 111-148, title I, §1001(5), Mar. 23, 2010, 124 Stat. 131.)

#### PRIOR PROVISIONS

A prior section 300gg-13, act July 1, 1944, ch. 373, title XXVII, §2713, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1966, was renumbered section 2709 of act July 1, 1944, and transferred to section 300gg-9 of this title by Pub. L. 111-148, title I, §§1001(3), 1563(c)(10)(C), formerly §1562(c)(10)(C), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 268, 911.

Another prior section 2713 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238l of this title.

#### EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section

<sup>1</sup> So in original. The word “and” probably should not appear.

<sup>2</sup> So in original. The period probably should be a semicolon.