service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-day suspension upon denial of coverage

A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

(July 1, 1944, ch. 373, title XXVII, §2702, as added and amended Pub. L. 111–148, title I, §§1201(4), 1563(c)(8), formerly §1562(c)(8), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 156, 266, 911.)

Editorial Notes

CODIFICATION

The text of section 300gg–11 of this title, which was amended and transferred to subsecs. (c) and (d) of this section by Pub. L. 111–148, §1563(c)(8), formerly §1562(c)(8), as renumbered by Pub. L. 111–148, §10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, §2731, formerly §2711, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1962; renumbered §2731, Pub. L. 111–148, title I, §1001(3), Mar. 23, 2010, 124 Stat. 130.

PRIOR PROVISIONS

A prior section 300gg–1, act July 1, 1944, ch. 373, title XXVII, §2702, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1961; Pub. L. 110–233, title I, §102(a)(1)–(3), May 21, 2008, 122 Stat. 888, 890, which related to prohibition on discrimination against individual participants and beneficiaries based on health status, was amended by Pub. L. 111–148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, effective for plan years beginning on or after Jan. 1, 2014, and was transferred to subsecs. (b) to (f) of section 300gg–4 of this title.

Another prior section 2702 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238a of this title.

AMENDMENTS

2010—Pub. L. 111–148, §1563(c)(8), formerly §1562(c)(8), as renumbered by Pub. L. 111–148, §10107(b)(1), transferred section 300gg–11 of this title to the end of this section after amending it by striking out the section catchline ''Guaranteed availability of coverage for employers in group market'', by striking out subsec. (a) which related to issuance of coverage in small group market, subsec. (b) which related to assurance of access in large group market, subsec. (e) which related to exception to requirement for failure to meet certain minimum participation or contribution rules, and subsec. (f) which related to exception for coverage offered only to bona fide association members, by amending subsec. (c) by substituting ''group and individual'' for ''small group'' in introductory provisions of par. (1), inserting ''and individuals'' after ''employers'' in introductory provisions of par. (1)(B), inserting ''or any additional individuals'' after ''additional groups'' in par. (1)(B)(i), substituting ''and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals'' for ''without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such'' in par. (1)(B)(ii), and substituting ''group or individual'' for ''small group'' in par. (2), and by amending subsec. (d) by substituting ''group or individual'' for ''small group'' wherever appearing and substituting ''all employers and individuals'' for ''all employers'', ''those individuals, employers'' for ''those employers'', and ''such individuals, employees'' for ''such employees'' in par. (1)(B).

Statutory Notes and Related Subsidiaries

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.

§ 300gg–2. Guaranteed renewability of coverage

(a) In general

Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

(b) General exceptions

A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) Nonpayment of premiums

The plan sponsor, or individual, as applicable, 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, or individual, as applicable, 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 rates

In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.

(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 2711(c)(1)(A).[1]

(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 or individual health insurance coverage, 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 or individual, as applicable, 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 or individual, as applicable, 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 coverage currently being offered by the issuer to a group health plan or individual health insurance coverage 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 individuals, as applicable, 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 individual or group market, or all 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 or individual, as applicable,[2] (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.

(July 1, 1944, ch. 373, title XXVII, § 2703, as added and amended Pub. L. 111–148, title I, §§ 1201(4), 1563(c)(9), formerly § 1562(c)(9), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 156, 267, 911.)

Editorial Notes

REFERENCES IN TEXT

Section 2711, referred to in subsec. (b)(5), is a reference to section 2711 of act July 1, 1944. Section 2711, which was classified to section 300gg–11 of this title, was renumbered section 2731 and amended and transferred by Pub. L. 111–148, title I, §§ 1001(3), 1563(c)(8), formerly § 1562(c)(8), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911, to the end of section 2702 of act July 1, 1944, as added by Pub. L. 111–148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 156, and classified to section 300gg–1 of this title. A new section 2711 of act July 1, 1944, related to no lifetime or annual limits, was added by Pub.

[1] See References in Text note below.

[2] So in original.

L. 111–148, title I, §1001(5), Mar. 23, 2010, 124 Stat. 131, effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, and is classified to section 300gg–11 of this title.

CODIFICATION

The text of section 300gg–12 of this title, which was amended and transferred to subsecs. (b) to (e) of this section by Pub. L. 111–148, §1563(c)(9), formerly §1562(c)(9), as renumbered by Pub. L. 111–148, §10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, §2732, formerly §2712, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1964; renumbered §2732, Pub. L. 111–148, title I, §1001(3), Mar. 23, 2010, 124 Stat. 130.

PRIOR PROVISIONS

A prior section 2703 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238b of this title.

AMENDMENTS

2010—Pub. L. 111–148, §1563(c)(9), formerly §1562(c)(9), as renumbered by Pub. L. 111–148, §10107(b)(1), transferred section 300gg–12 of this title to the end of this section after amending it by striking out the section catchline ''Guaranteed renewability of coverage for employers in group market'', by striking subsec. (a) which required a health insurance issuer offering coverage in connection with a group health plan to renew such coverage at the option of the plan sponsor, by amending subsec. (b) by substituting ''health insurance coverage offered in the group or individual market'' for ''group health plan in the small or large group market'' in introductory provisions, inserting '', or individual, as applicable,'' after ''plan sponsor'' in pars. (1) and (2), adding par. (3), and striking out former par. (3) which related to violation of participation or contribution rules, and by amending subsec. (c) by substituting ''group or individual health insurance coverage'' for ''group health insurance coverage offered in the small or large group market'' in introductory provisions of par. (1), inserting ''or individual, as applicable,'' after ''plan sponsor'' in par. (1)(A) and (B), inserting ''or individual health insurance coverage'' in par. (1)(B), inserting ''or individuals, as applicable,'' after ''those sponsors'' in par. (1)(C), substituting ''individual or group market, or all markets,'' for ''small group market or the large group market, or both markets,'' in introductory provisions of par. (2)(A), and inserting ''or individual, as applicable,'' after ''plan sponsor'' in par. (2)(A)(i). Amendment inserting ''or individual health insurance coverage'' in subsec. (c)(1)(B) was executed by making the insertion after ''group health plan'' as the probable intent of Congress, notwithstanding that the directory language did not specify where in subsec. (c)(1)(B) to make the insertion.

Statutory Notes and Related Subsidiaries

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.

§ 300gg–3. Prohibition of preexisting condition exclusions or other discrimination based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) Definitions

For purposes of this part—

(1) Preexisting condition exclusion

(A) In general

The term ''preexisting condition exclusion'' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1)[1] in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term ''enrollment date'' means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term ''late enrollee'' means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f).

(4) Waiting period

The term ''waiting period'' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) "Creditable coverage" defined

For purposes of this subchapter, the term ''creditable coverage'' means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C. 1396s].

(E) Chapter 55 of title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504(e) of title 22.

[1] See References in Text note below.