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(3) Geographic rating areas, pursuant to § 147.102(b).

(4) In states that do not permit rating based on age or tobacco use, uniform family tiers and corresponding multipliers, pursuant to § 147.102(c)(2).

(5) A requirement that that issuers in the small group market offer to a group premiums that are based on average enrollee amounts, pursuant to paragraph § 147.102(c)(3).

(6) A uniform age rating curve, pursuant to § 147.102(e).

(b) *Updates.* If a state adopts a standard or requirement described in paragraph (a) of this section for any plan or policy year beginning after the 2014 plan or policy year (or updates a standard or requirement that applies for the 2014 plan or policy year), the state must submit to CMS information about such standard in a form and manner specified in guidance by the Secretary.

(c) *Applicability date.* The provisions of this section apply on March 29, 2013.

[78 FR 13437, Feb. 27, 2013]

§ 147.104 Guaranteed availability of coverage.

(a) *Guaranteed availability of coverage in the individual and group market.* Subject to paragraphs (b) through (d) of this section, a health insurance issuer that offers health insurance coverage in the individual, small group, or large group market in a State must offer to any individual or employer in the State all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products.

(b) *Enrollment periods.* A health insurance issuer may restrict enrollment in health insurance coverage to open or special enrollment periods.

(1) *Open enrollment periods—(i) Group market.* (A) Subject to paragraph (b)(1)(i)(B) of this section, a health insurance issuer in the group market must allow an employer to purchase health insurance coverage for a group health plan at any point during the year.

(B) In the case of a group health plan in the small group market that cannot comply with employer contribution or group participation rules for the offering of health insurance coverage, as al-

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lowed under applicable State law, and in the case of a QHP offered in the SHOP, as permitted by § 156.285(e) or § 156.286(e) of this subchapter, a health insurance issuer may restrict the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each calendar year.

(C) With respect to coverage in the small group market, and in the large group market if such coverage is offered through a SHOP in a State, for a group enrollment received on the first through the fifteenth day of any month, the coverage effective date must be no later than the first day of the following month. For a group enrollment received on the 16th through last day of any month, the coverage effective date must be no later than the first day of the second following month. In either such case, a small employer may instead opt for a later effective date within a quarter for which small group market rates are available.

(ii) *Individual market.* A health insurance issuer in the individual market must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods described in § 155.410(b) and (e) of this subchapter. Coverage must become effective consistent with the dates described in § 155.410(c) and (f) of this subchapter.

(2) *Limited open enrollment periods.* (i) A health insurance issuer in the individual market must provide a limited open enrollment period for the triggering events described in § 155.420(d) of this subchapter, excluding, with respect to coverage offered outside of an Exchange, the following:

(A) Section 155.420(d)(3) of this subchapter (concerning Exchange eligibility standards);

(B) Section 155.420(d)(6) of this subchapter (to the extent concerning eligibility for advance payments of the premium tax credit or change in eligibility for cost-sharing reductions other than ineligibility);

(C) Section 155.420(d)(8) of this subchapter (concerning Indians);

(D) Section 155.420(d)(9) of this subchapter (concerning exceptional circumstances);

(E) Section 155.420(d)(12) of this subchapter (concerning plan and benefit display errors); and

(F) Section 155.420(d)(13) of this subchapter (concerning eligibility for insurance affordability programs or enrollment in the Exchange).

(ii) In applying this paragraph (b)(2), a reference in §155.420 (other than in §155.420(a)(5)) of this subchapter to a “QHP” is deemed to refer to a plan, a reference to “the Exchange” is deemed to refer to the applicable State authority, and a reference to a “qualified individual” is deemed to refer to an individual in the individual market.

(iii) Notwithstanding anything to the contrary in §155.420(d) of this subchapter, §155.420(a)(4) of this subchapter does not apply to limited open enrollment periods under paragraph (b)(2) of this section.

(3) *Special enrollment periods.* A health insurance issuer in the group and individual market must establish special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

(4) *Length of enrollment periods.* (i) In the group market, enrollees must be provided 30 calendar days after the date of the qualifying event described in paragraph (b)(3) of this section to elect coverage.

(ii) In the individual market, enrollees must be provided 60 calendar days after the date of an event described in paragraph (b)(2) and (3) of this section to elect coverage, as well as 60 calendar days before certain triggering events as provided for in §155.420(c)(2) of this subchapter.

(5) *Effective date of coverage for limited open and special enrollment periods.* With respect to an election made under paragraph (b)(2) or (b)(3) of this section, coverage must become effective consistent with the dates described in §155.420(b) of this subchapter.

(c) *Special rules for network plans.* (1) In the case of a health insurance issuer that offers health insurance coverage in the group and individual market

through a network plan, the issuer may do the following:

(i) Limit the employers that may apply for the coverage to those with eligible individuals in the group market who live, work, or reside in the service area for the network plan, and limit the individuals who may apply for the coverage in the individual market to those who live or reside in the service area for the network plan.

(ii) Within the service area of the plan, deny coverage to employers and individuals if the issuer has demonstrated to the applicable state authority (if required by the state authority) the following:

(A) It will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees.

(B) It is applying paragraph (c)(1) of this section uniformly to all employers 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, employees, and dependents.

(2) An issuer that denies health insurance coverage to an individual or an employer in any service area, in accordance with paragraph (c)(1)(ii) of this section, may not offer coverage in the individual, small group, or large group market, as applicable, for a period of 180 calendar days after the date the coverage is denied. This paragraph (c)(2) does not limit the issuer’s ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) *Application of financial capacity limits.* (1) A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated to the applicable state authority (if required by the state authority) the following:

(i) It does not have the financial reserves necessary to offer additional coverage.

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(ii) It is applying this paragraph (d)(1) uniformly to all employers or individual in the large group, small group, or individual market, as applicable, 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) An issuer that denies health insurance coverage to any employer or individual in a state under paragraph (d)(1) of this section may not offer coverage in the large group, small group, or individual market, as applicable, in the State before the later of either of the following dates:

(i) The 181st day after the date the issuer denies coverage.

(ii) The date the issuer demonstrates to the applicable state authority, if required under applicable state law, that the issuer has sufficient financial reserves to underwrite additional coverage.

(3) Paragraph (d)(2) of this section does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(4) Coverage offered after the 180-day period specified in paragraph (d)(2) of this section is subject to the requirements of this section.

(5) An applicable state authority may provide for the application of this paragraph (d) on a service-area-specific basis.

(e) *Marketing.* A health insurance issuer and its officials, employees, agents and representatives must comply with any applicable State laws and regulations regarding marketing by health insurance issuers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health conditions.

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(f) *Calendar year plans.* An issuer that offers coverage in the individual market, or in a merged market in a State that has elected to merge the individual market and small group market risk pools in accordance with section 1312(c)(3) of the Affordable Care Act, must ensure that such coverage is offered on a calendar year basis with a policy year ending on December 31 of each calendar year.

(g) *Applicability date.* The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

(h) *Grandfathered health plans.* This section does not apply to grandfathered health plans in accordance with § 147.140.

(i) *Construction.* Nothing in this section should be construed to require an issuer to offer coverage otherwise prohibited under applicable Federal law.

[78 FR 13437, Feb. 27, 2013, as amended at 78 FR 65092, Oct. 30, 2013; 78 FR 76217, Dec. 17, 2013; 79 FR 30339, May 27, 2014; 79 FR 59138, Oct. 1, 2014; 80 FR 10862, Feb. 27, 2015; 81 FR 94173, Dec. 22, 2016; 82 FR 18381, Apr. 18, 2017; 83 FR 17058, Apr. 17, 2018; 85 FR 37247, June 19, 2020]

§ 147.106 Guaranteed renewability of coverage.

(a) *General rule.* Subject to paragraphs (b) through (e) of this section, a health insurance issuer offering health insurance coverage in the individual, small group, or large group market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable.

(b) *Exceptions.* An issuer may nonrenew or discontinue 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, including any timeliness requirements.

(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 in connection with the coverage.