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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.

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### §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.

(3) *Violation of participation or contribution rules.* In the case of group health insurance coverage, 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. For purposes of this paragraph the following apply:

(i) The term “employer contribution rule” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

(ii) The term “group participation rule” means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(4) *Termination of product.* The issuer is ceasing to offer coverage in the market in accordance with paragraph (c) or (d) of this section and applicable State law.

(5) *Enrollees’ movement outside service area.* For network plans, there is no longer any enrollee under the 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 applies the same criteria it would apply in denying enrollment in the plan under §147.104(c)(1)(i); provided the issuer provides notice in accordance with the requirements of paragraph (c)(1) of this section.

(6) *Association membership ceases.* For coverage made available in the small or large group market only through one or more bona fide associations, if the employer’s membership in the bona fide association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(c) *Discontinuing a particular product.* In any case in which an issuer decides to discontinue offering a particular product offered in the group or individual market, that product may be discontinued by the issuer in accordance with applicable state law in the

applicable market only if the following occurs:

(1) The issuer provides notice in writing, in a form and manner specified by the Secretary, to each plan sponsor or individual, as applicable, provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 calendar days before the date the coverage will be discontinued.

(2) The issuer offers to each plan sponsor or individual, as applicable, provided that particular product the option, on a guaranteed availability basis, 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 that market.

(3) In exercising the option to discontinue that product and in offering the option of coverage under paragraph (c)(2) of this section, 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.

(d) *Discontinuing all coverage.* (1) An issuer may elect to discontinue offering all health insurance coverage in the individual, small group, or large group market, or all markets, in a State in accordance with applicable State law only if—

(i) The issuer provides notice in writing to the applicable state authority and to each plan sponsor or individual, as applicable, (and all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 calendar days prior to the date the coverage will be discontinued; and

(ii) All health insurance policies issued or delivered for issuance in the state in the applicable market (or markets) are discontinued and not renewed.

(2) An issuer that elects to discontinue offering all health insurance coverage in a market (or markets) in a state as described in this paragraph (d)

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may not issue coverage in the applicable market (or markets) and state involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

(3) For purposes of this paragraph (d), subject to applicable State law, an issuer will not be considered to have discontinued offering all health insurance coverage in a market in a State if—

(i) The issuer (in this paragraph referred to as the initial issuer) or, if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, offers and makes available in the applicable market in the State at least one product that is considered in accordance with §144.103 of this subchapter to be the same product as a product the initial issuer had been offering in such market in such State; or

(ii) The issuer—

(A) Offers and makes available at least one product (in paragraphs (d)(3)(ii)(A) through (C) of this section referred to as the new product) in the applicable market in the State, even if such product is not considered in accordance with §144.103 of this subchapter to be the same product as a product the issuer had been offering in the applicable market in the State (in paragraphs (d)(3)(ii)(A) through (C) of this section referred to as the discontinued product);

(B) Subjects such new product or products to the applicable process and requirements established under part 154 of this title as if such process and requirements applied with respect to that product or products, to the extent such process and requirements are otherwise applicable to coverage of the same type and in the same market; and

(C) Reasonably identifies the discontinued product or products that correspond to the new product or products for purposes of the process and requirements applied pursuant to paragraph (d)(3)(ii)(B) of this section.

(4) For purposes of this section, the term controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended, or a

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narrower group as may be provided by applicable State law.

(e) *Exception for uniform modification of coverage.* (1) Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan or an individual, as applicable, in the following:

(i) Large group market.

(ii) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with State law and is effective uniformly among group health plans with that product.

(iii) Individual market if the modification is consistent with State law and is effective uniformly for all individuals with that product.

(2) For purposes of paragraphs (e)(1)(ii) and (iii) of this section, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:

(i) The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and

(ii) The modification is directly related to the imposition or modification of the Federal or State requirement.

(3) Other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product in the individual or small group market meets all of the following criteria:

(i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act), or if the issuer is a member of a controlled group (as described in paragraph (d)(4) of this section), any other health insurance issuer that is a member of such controlled group);

(ii) The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);

(iii) The product continues to cover at least a majority of the same service area;

(iv) Within the product, each plan has the same cost-sharing structure as

before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and

(v) The product provides the same covered benefits, except for any changes in benefits that cumulatively impact the plan-adjusted index rate (as described in §156.80(d)(2) of this subchapter) for any plan within the product within an allowable variation of  $\pm 2$  percentage points (not including changes pursuant to applicable Federal or State requirements).

(4) A State may only broaden the standards in paragraphs (e)(3)(iii) and (iv) of this section.

(f) *Notice of renewal of coverage.* (1) If an issuer in the individual market is renewing non-grandfathered coverage as described in paragraph (a) of this section, or uniformly modifying non-grandfathered coverage as described in paragraph (e) of this section, the issuer must provide to each individual written notice of the renewal before the date of the first day of the next annual open enrollment period in a form and manner specified by the Secretary.

(2) If an issuer in the small group market is renewing coverage as described in paragraph (a) of this section, or uniformly modifying coverage as described in paragraph (e) of this section, the issuer must provide to each plan sponsor written notice of the renewal at least 60 calendar days before the date of the coverage will be renewed in a form and manner specified by the Secretary.

(g) *Notification of change of ownership.* If an issuer of a QHP, a plan otherwise subject to risk corridors, a risk adjustment covered plan, or a reinsurance-eligible plan experiences a change of ownership, as recognized by the State in which the plan is offered, the issuer must notify HHS in a manner specified by HHS, by the latest of—

(1) The date the transaction is entered into; or

(2) The 30th day prior to the effective date of the transaction.

(h) *Construction.* (1) Nothing in this section should be construed to require an issuer to renew or continue in force

coverage for which continued eligibility would otherwise be prohibited under applicable Federal law.

(2) Medicare entitlement or enrollment is not a basis to nonrenew an individual's health insurance coverage in the individual market under the same policy or contract of insurance.

(i) *Application to coverage offered only through associations.* 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, the reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer.

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

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

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#### § 147.108 Prohibition of preexisting condition exclusions.

(a) *In general.* A group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion (as defined in §144.103 of this subchapter).

(b) *Examples.* The rules of paragraph (a) of this section are illustrated by the following examples (for additional examples illustrating the definition of a preexisting condition exclusion, see §146.111(a)(2) of this subchapter):

*Example 1.* (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer P. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer N. N's policy excludes benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for oral surgery required as a result of a traumatic injury if the injury