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 ±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.

[78 FR 13437, Feb. 27, 2013, as amended at 78 FR 65092, Oct. 30, 2013; 79 FR 30339, May 27, 2014; 79 FR 42985, July 24, 2014; 79 FR 53004, Sept. 5, 2014; 80 FR 10862, Feb. 27, 2015; 81 FR 94173, Dec. 22, 2016; 84 FR 17561, Apr. 25, 2019]

§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

occurred before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. Therefore, such an exclusion is prohibited.

Example 2. (i) *Facts.* Individual *C* applies for individual health insurance coverage with Issuer *M*. *M* denies *C*'s application for coverage because a pre-enrollment physical revealed that *C* has type 2 diabetes.

(ii) *Conclusion. See Example 2* in §146.111(a)(2) of this subchapter for a conclusion that *M*'s denial of *C*'s application for coverage is a preexisting condition exclusion because a denial of an application for coverage based on the fact that a condition was present before the date of denial is an exclusion of benefits based on a preexisting condition.

(c) *Allowable screenings to determine eligibility for alternative coverage in the individual market*—(1) *In general.* (i) A health insurance issuer offering individual health insurance coverage may screen applicants for eligibility for alternative coverage options before offering a child-only policy if—

(A) The practice is permitted under State law;

(B) The screening applies to all child-only applicants, regardless of health status; and

(C) The alternative coverage options include options for which healthy children would potentially be eligible (*e.g.*, Children's Health Insurance Program (CHIP) or group health insurance).

(ii) An issuer must provide such coverage to an applicant effective on the first date that a child-only policy would have been effective had the applicant not been screened for an alternative coverage option, as provided by State law. A State may impose a reasonable time limit by when an issuer would have to enroll a child regardless of pending applications for other coverage.

(2) *Restrictions.* A health insurance issuer offering individual health insurance coverage may screen applicants for eligibility for alternative coverage provided that:

(i) The screening process does not by its operation significantly delay enrollment or artificially engineer eligibility of a child for a program targeted to individuals with a pre-existing condition;

(ii) The screening process is not applied to offers of dependent coverage for children; or

(ii) The issuer does not consider whether an applicant is eligible for, or is provided medical assistance under, Medicaid in making enrollment decisions, as provided under 42 U.S.C. 1396a (25)(G).

(d) *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 72274, Nov. 18, 2015]

EDITORIAL NOTE: At 80 FR 72284, Nov. 18, 2015, §147.108 was revised to include two paragraphs (c)(2)(ii).

§147.110 Prohibiting discrimination against participants, beneficiaries, and individuals based on a health factor.

(a) *In general.* A group health plan and a health insurance issuer offering group or individual health insurance coverage must comply with all the requirements under 45 CFR 146.121 applicable to a group health plan and a health insurance issuer offering group health insurance coverage. Accordingly, with respect to an issuer offering health insurance coverage in the individual market, the issuer is subject to the requirements of §146.121 to the same extent as an issuer offering group health insurance coverage, except the exception contained in §146.121(f) (concerning nondiscriminatory wellness programs) does not apply.

(b) *Applicability date.* This section is applicable to group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014. See §147.140, which provides that the rules of this section do not apply to grandfathered