

to an eligible individual 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 individuals in the individual market in the State consistent with applicable State law and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) 180-day suspension upon denial of coverage

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

(e)² Market requirements

(1) In general

The provisions of subsection (a) of this section shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

(2) Conversion policies

A health insurance issuer offering health insurance coverage in connection with group health plans under this subchapter shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

(f) Construction

Nothing in this section shall be construed—

(1) to restrict the amount of the premium rates that an issuer may charge an individual for health insurance coverage provided in the individual market under applicable State law; or

(2) to prevent a health insurance issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(July 1, 1944, ch. 373, title XXVII, § 2741, as added Pub. L. 104-191, title I, § 111(a), Aug. 21, 1996, 110 Stat. 1978.)

REFERENCES IN TEXT

Section 2701 of this Act, referred to in subsecs. (a)(1)(B) and (b)(1)(A), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1,

2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg-3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111-148, title I, § 1201(4), title X, § 10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

The Social Security Act, referred to in subsec. (b)(2), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Parts A and B of title XVIII of the Act are classified generally to parts A (§ 1395c et seq.) and B (§ 1395j et seq.) of subchapter XVIII of chapter 7 of this title. Title XIX of the Act is classified generally to subchapter XIX (§ 1396 et seq.) of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 2712, referred to in subsec. (b)(3), is a reference to section 2712 of act July 1, 1944. Section 2712, which was classified to section 300gg-12 of this title, was renumbered section 2732 and 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. A new section 2712 of act July 1, 1944, related to prohibition on rescissions, was added by Pub. 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-12 of this title.

EFFECTIVE DATE

Pub. L. 104-191, title I, § 111(b), Aug. 21, 1996, 110 Stat. 1987, provided that:

“(1) IN GENERAL.—Except as provided in this subsection, part B of title XXVII of the Public Health Service Act [42 U.S.C. 300gg-41 et seq.] (as inserted by subsection (a)) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

“(2) APPLICATION OF CERTIFICATION RULES.—The provisions of section 102(d)(2) [102(c)(2)] of this Act [set out as a note under section 300gg of this title] shall apply to section 2743 of the Public Health Service Act [42 U.S.C. 300gg-43] in the same manner as it applies to section 2701(e) [now 2704(e)] of such Act [42 U.S.C. 300gg-3(e)].”

§ 300gg-42. Guaranteed renewability of individual health insurance coverage

(a) In general

Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

(b) General exceptions

A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) Nonpayment of premiums

The individual 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 individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Termination of plan

The issuer is ceasing to offer coverage in the individual market in accordance with subsection (c) of this section and applicable State law.

(4) Movement outside service area

In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(5) Association membership ceases

In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual 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 of covered individuals.

(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 health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if—

(A) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals 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 any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(2) Discontinuance of all coverage**(A) In general**

Subject to subparagraph (C), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in a State, health insurance coverage may be discontinued by the issuer only if—

(i) the issuer provides notice to the applicable State authority and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

(ii) all health insurance issued or delivered for issuance in the State in such market are discontinued and coverage under

such health insurance coverage in such market is not renewed.

(B) Prohibition on market reentry

In the case of a discontinuation under subparagraph (A) in the individual 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 policy form offered to individuals in the individual market so long as such modification is consistent with State law and effective on a uniform basis among all individuals with that policy form.

(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 individual market to individuals only through one or more associations, a reference to an “individual” is deemed to include a reference to such an association (of which the individual is a member).

(July 1, 1944, ch. 373, title XXVII, §2742, as added Pub. L. 104-191, title I, §111(a), Aug. 21, 1996, 110 Stat. 1982.)

EFFECTIVE DATE

Section applicable with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs, see section 111(b) of Pub. L. 104-191, set out as a note under section 300gg-41 of this title.

§ 300gg-43. Certification of coverage

The provisions of section 2701(e)¹ shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(July 1, 1944, ch. 373, title XXVII, §2743, as added Pub. L. 104-191, title I, §111(a), Aug. 21, 1996, 110 Stat. 1983.)

REFERENCES IN TEXT

Section 2701 of this Act, referred to in text, is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg-3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111-148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

¹ See References in Text note below.