(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

(July 1, 1944, ch. 373, title XXVII, § 2728, formerly § 2707, as added Pub. L. 110–381, § 2(b)(1), Oct. 9, 2008, 122 Stat. 4083; renumbered § 2728 and amended Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(6), formerly § 1562(c)(6), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911.)

CODIFICATION

Section was formerly classified to section 300gg–7 of this title prior to renumbering by Pub. L. 111–148.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, § 1563(c)(6)(A), formerly § 1562(c)(6)(A), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''individual health insurance coverage'' for ''health insurance coverage offered in connection with such plan'' in introductory provisions.

Subsec. (b)(1). Pub. L. 111–148, § 1563(c)(6)(B)(i), formerly § 1562(c)(6)(B)(i), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''or a health insurance issuer that offers group or individual health insurance coverage'' for ''or a health insurance issuer that provides health insurance coverage in connection with a group health plan'' in introductory provisions.

Subsec. (b)(2). Pub. L. 111–148, § 1563(c)(6)(B)(ii), formerly § 1562(c)(6)(B)(ii), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''individual health insurance coverage'' for ''health insurance coverage offered in connection with the plan'' in introductory provisions.

Subsec. (b)(3). Pub. L. 111–148, § 1563(c)(6)(B)(iii), formerly § 1562(c)(6)(B)(iii), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''individual health insurance coverage'' for ''health insurance coverage offered by an issuer in connection with such plan''.

Subsec. (c). Pub. L. 111–148, § 1563(c)(6)(C), formerly § 1562(c)(6)(C), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''health insurance issuer that offers group or individual health insurance coverage'' for ''health insurance issuer providing health insurance coverage in connection with a group health plan''.

Subsec. (e)(1). Pub. L. 111–148, § 1563(c)(6)(D), formerly § 1562(c)(6)(D), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''individual health insurance coverage'' for ''health insurance coverage offered in connection with such a plan''.

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after the date that is one year after Oct. 9, 2008, and to medically necessary leaves of absence beginning during such plan years, see section 2(d) of Pub. L. 110–381, set out as a note under section 9813 of Title 26, Internal Revenue Code.

PART B—INDIVIDUAL MARKET RULES

SUBPART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

§ 300gg–41. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage

(a) Guaranteed availability

(1) In general

Subject to the succeeding subsections of this section and section 300gg–44 of this title, each health insurance issuer that offers health insurance coverage (as defined in section 300gg–91(b)(1) of this title) in the individual market in a State may not, with respect to an eligible individual (as defined in subsection (b)) desiring to enroll in individual health insurance coverage—

(A) decline to offer such coverage to, or deny enrollment of, such individual; or

(B) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A))[1] with respect to such coverage.

(2) Substitution by State of acceptable alternative mechanism

The requirement of paragraph (1) shall not apply to health insurance coverage offered in the individual market in a State in which the State is implementing an acceptable alternative mechanism under section 300gg–44 of this title.

(b) "Eligible individual" defined

In this part, the term ''eligible individual'' means an individual—

(1)(A) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage (as defined in section 2701(c))[1] is 18 or more months and (B) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(2) who is not eligible for coverage under (A) a group health plan, (B) part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.], or (C) a State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] (or any successor program), and does not have other health insurance coverage;

(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) was not terminated based on a factor described in paragraph (1) or (2) of section 2712(b)[1] (relating to nonpayment of premiums or fraud);

(4) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

(c) Alternative coverage permitted where no State mechanism

(1) In general

In the case of health insurance coverage offered in the individual market in a State in which the State is not implementing an acceptable alternative mechanism under section 300gg–44 of this title, the health insurance issuer may elect to limit the coverage offered under subsection (a) so long as it offers at least two different policy forms of health insurance coverage both of which—

(A) are designed for, made generally available to, and actively marketed to, and enroll

[1] See References in Text note below.

both eligible and other individuals by the issuer; and

(B) meet the requirement of paragraph (2) or (3), as elected by the issuer.

For purposes of this subsection, policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) Choice of most popular policy forms

The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in the State or applicable marketing or service area (as may be prescribed in regulation) by the issuer in the individual market in the period involved.

(3) Choice of 2 policy forms with representative coverage

(A) In general

The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers a lower-level coverage policy form (as defined in subparagraph (B)) and a higher-level coverage policy form (as defined in subparagraph (C)) each of which includes benefits substantially similar to other individual health insurance coverage offered by the issuer in that State and each of which is covered under a method described in section 300gg–44(c)(3)(A) of this title (relating to risk adjustment, risk spreading, or financial subsidization).

(B) Lower-level of coverage described

A policy form is described in this subparagraph if the actuarial value of the benefits under the coverage is at least 85 percent but not greater than 100 percent of a weighted average (described in subparagraph (D)).

(C) Higher-level of coverage described

A policy form is described in this subparagraph if—

(i) the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of the coverage described in subparagraph (B) offered by the issuer in the area involved; and

(ii) the actuarial value of the benefits under the coverage is at least 100 percent but not greater than 120 percent of a weighted average (described in subparagraph (D)).

(D) Weighted average

For purposes of this paragraph, the weighted average described in this subparagraph is the average actuarial value of the benefits provided by all the health insurance coverage issued (as elected by the issuer) either by that issuer or by all issuers in the State in the individual market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

(4) Election

The issuer elections under this subsection shall apply uniformly to all eligible individuals in the State for that issuer. Such an election shall be effective for policies offered during a period of not shorter than 2 years.

(5) Assumptions

For purposes of paragraph (3), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(d) Special rules for network plans

(1) In general

In the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the issuer may—

(A) limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees, and

(ii) it is applying this paragraph uniformly to individuals 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 health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

(e)[2] Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the individual market 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

[2] So in original. Two subsecs. (e) have been enacted.

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) 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 [42 U.S.C. 300gg note] 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) 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 mar-