**Section 2001.4 Guaranteed Availability and Renewability of Coverage**

a) Guaranteed Availability of Coverage in the Individual and Group Market

Subject to subsections (b) through (d), a health insurance issuer that offers health insurance coverage in the individual or group market in this State must offer to any individual or employer in this 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. (45 CFR 147.106)

b) Enrollment Periods

A health insurance issuer may restrict enrollment in health insurance coverage to open or special enrollment periods.

1) Open Enrollment Periods

A) Group Market

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. In the case of health insurance coverage offered in the small group market, a health insurance issuer may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules as defined in 45 CFR 147.106(b)(3), pursuant to 215 ILCS 97/30(B)(3) and, in the case of a QHP offered in the Small Business Health Option Program (SHOP), as permitted by 45 CFR 156.285(c). With respect to coverage in the small group market, and in the large group market if such coverage is offered in a SHOP in a state, coverage must become effective consistent with the dates described in 45 CFR 155.725(h).

B) 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 45 CFR 155.410(b) and (e). Coverage must become effective consistent with the dates described in 45 CFR 155.410(c) and (f).

2) Limited Open Enrollment Periods

A health insurance issuer in the individual market must provide a limited open enrollment period for the events described in 45 CFR 155.420(d), excluding paragraphs (d)(3) (concerning citizenship status), (d)(8) (concerning Indians), and (d)(9) (concerning exceptional circumstances). In addition, a health insurance issuer in the individual market must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

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 ERISA. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and Illinois law.

4) Length of Enrollment Periods

With respect to the group market, enrollees must be provided 30 calendar days after the date of the qualifying event described in subsection (b)(3) to elect coverage. With respect to the individual market, enrollees must be provided 60 calendar days after the date of an event described in subsections (b)(2) and (b)(3) to elect coverage.

5) Effective Date of Coverage for Limited Open and Special Enrollment Periods

With respect to an election made under subsection (b)(2) or (b)(3), coverage must become effective consistent with the dates described in 45 CFR 155.420(b). (45 CFR 147.106)

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:

A) 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.

B) Within the service area of the plan, deny coverage to employers and individuals if the issuer has demonstrated to the Director the following:

i) 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.

ii) It is applying this subsection (c)(1) 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 subsection (c)(1)(B), may not offer coverage in the individual or group market, as applicable, within the service area to any individual or employer, as applicable, for a period of 180 calendar days after the date the coverage is denied. This subsection (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 subsection (c)(2) is subject to the requirements of this Section. (45 CFR 147.106)

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 Director the following:

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

B) It is applying this subsection (d)(1) uniformly to all employers or individuals in the group or individual market, as applicable, in this State consistent with applicable Illinois 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 those individuals, employees and dependents.

2) An issuer that denies health insurance coverage to any employer or individual in this State under subsection (d)(1) may not offer coverage in the group or individual market, as applicable, in this State before the later of either of the following dates:

A) The 181st day after the date the issuer denies coverage;

B) The date the issuer demonstrates to the Director, if required under applicable Illinois law, that the issuer has sufficient financial reserves to underwrite additional coverage.

3) Subsection (d)(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.

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

5) The Director may provide for the application of this subsection (d) on a service-area-specific basis. (45 CFR 147.106)

e) Marketing

A health insurance issuer and its officials, employees, agents and representatives must comply with Illinois law 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, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. (45 CFR 147.106)

f) Guaranteed Renewability of Coverage General Rule.

Subject to subsections (g) through (i), a health insurance issuer offering health insurance coverage in the individual or group market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable. (45 CFR 147.106)

g) 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 Illinois law. For purposes of this subsection (g)(13), the following apply:

A) 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.

B) 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 Plan

The issuer is ceasing to offer coverage in the market in accordance with subsection (h) or (i) and applicable Illinois 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 45 CFR 147.104(c)(1)(i).

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. (45 CFR 147.106)

h) 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 Illinois law in the applicable market only if the following occurs:

1) The issuer provides notice in writing 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 subsection (h)(2), 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. (45 CFR 147.106)

i) Discontinuing All Coverage

1) An issuer may elect to discontinue offering all health insurance coverage in the individual or group market, or all markets, in this State in accordance with applicable Illinois law only if:

A) The issuer provides notice in writing to the Director 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

B) All health insurance policies issued or delivered for issuance in this 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 this State as described in this subsection (i) may not issue coverage in the applicable market (or markets) in this State during the 5-year period beginning on the date of discontinuation of the last coverage not renewed. (45 CFR 147.106)

j) Exception for Uniform Modification of Coverage

Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan in the following:

1) Large group market;

2) 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 Illinois law and is effective uniformly among group health plans with that product. (45 CFR 147.106)

k) 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. (45 CFR 147.106)

l) Applicability Date

The provisions of this Section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014. (45 CFR 147.106)

m) Grandfathered Health Plans

This Section does not apply to grandfathered health plans in accordance with 45 CFR 147.140. (45 CFR 147.106)

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