Subpart C—Requirements Related to Benefits

Subpart D—Enforcement; Penalties; Preemption

Subpart E—Grants to States for Operation of Qualified High Risk Pools

AUTHORITY: Secs. 2741 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg–41 through 300gg–63, 300gg–91, and 300gg–92).

SOURCE: 62 FR 16995, Apr. 8, 1997, unless otherwise noted.

Subpart A—General Provisions

§ 148.101 Basis and purpose.

This part implements sections 2741 through 2763 and 2791 and 2792 of the PHS Act. Its purpose is to improve access to individual health insurance coverage for certain eligible individuals who previously had group coverage, and to guarantee the renewability of all coverage in the individual market. It also provides certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth.

[63 FR 57561, Oct. 27, 1998]

§ 148.102 Scope, applicability, and effective dates.

(a) *Scope and applicability*. (1) Individual health insurance coverage includes all health insurance coverage (as defined in §144.103) that is neither health insurance coverage sold in connection with an employment-related group health plan, nor short-term, limited-duration coverage as defined in §144.103 of this subchapter. In some cases, coverage that may be considered group coverage under State law (such as coverage sold through certain associations) is considered individual coverage.

(2) The requirements of this part that pertain to guaranteed availability of individual health insurance coverage for certain eligible individuals apply to all issuers of individual health insurance coverage in a State, unless the State implements an acceptable alternative mechanism as described in §148.128. The requirements that pertain to guaranteed renewability for all individuals, and to protections for mothers and newborns with respect to hospital stays in connection with childbirth, apply to all issuers of individual health insurance coverage in the State, regardless of whether a State implements an alternative mechanism.

(b) *Effective date.* Except as provided in §§148.124 (certificate of coverage), 148.128 (alternative State mechanisms), and 148.170 (standards relating to benefits for mothers and newborns), the requirements of this part apply 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.

[62 FR 16995, Apr. 8, 1997; 62 FR 31695, June 10, 1997, as amended at 63 FR 57562, Oct. 27, 1998]

§ 148.103 Definitions.

Unless otherwise provided, the following definition applies:

Eligible individual means an individual who meets the following conditions:

(1) The individual has at least 18 months of creditable coverage (as determined under §146.113 of this subchapter) as of the date on which the individual seeks coverage under this part.

(2) The individual's 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 of these plans).

(3) The individual is not eligible for coverage under any of the following:

(i) A group health plan.

(ii) Part A or Part B of Title XVIII (Medicare) of the Social Security Act.

(iii) A State plan under Title XIX (Medicaid) of the Social Security Act (or any successor program).

(4) The individual does not have other health insurance coverage.

(5) The individual's most recent coverage was not terminated because of nonpayment of premiums or fraud. (For more information about nonpayment of premiums or fraud, see §146.152(b)(1) and (b)(2) of this subchapter.)

(6) If the individual has been offered the option of continuing coverage under a COBRA continuation provision or a similar State program, the individual has both elected and exhausted the continuation coverage.

Subpart B—Requirements Relating to Access and Renewability of Coverage

§148.120 Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

(a) *General rule.* Except as provided for in paragraph (c) of this section, an issuer that furnishes health insurance coverage in the individual market must meet the following requirements with respect to any eligible individual who requests coverage:

(1) May not decline to offer coverage or deny enrollment under any policy forms that it actively markets in the individual market, except as permitted in paragraph (c) of this section concerning alternative coverage when no State mechanism exists. An issuer is deemed to meet this requirement if, upon the request of an eligible individual, it acts promptly to do the following:

(i) Provide information about all available coverage options.

(ii) Enroll the individual in any coverage option the individual selects.

(2) May not impose any preexisting condition exclusion on the individual.

(b) *Exception.* The requirements of paragraph (a) of this section do not apply to health insurance coverage offered in the individual market in a State that chooses to implement an acceptable alternative mechanism described in §148.128.

(c) *Alternative coverage permitted where no State mechanism exists.* (1) *General rule.* If the State does not implement an acceptable alternative mechanism under §148.128, an issuer may elect to limit the coverage required under paragraph (a) of this section if it offers eligible individuals at least two policy forms that meet the following requirements:

(i) Each policy form must be designed for, made generally available to, and actively marketed to, and enroll, both eligible and other individuals.

(ii) The policy forms must be either the issuer's two most popular policy forms (as described in paragraph (c)(2) of this section) or representative samples of individual health insurance offered by the issuer in the State (as described in paragraph (c)(3) of this section).

(2) *Most popular policies.* The *two most popular policy forms* means the policy forms with the largest, and the second largest, premium volume for the last reporting year, for policies offered in that State. In the absence of applicable State standards, *premium volume* means earned premiums for the last reporting year. In the absence of applicable State standards, the last reporting year is the period from October 1 through September 30 of the preceding year. Blocks of business closed under applicable State law are not included in calculating premium volume.

(3) *Representative policy forms*—(i) *Definition of weighted average.* Weighted average means the average actuarial value of the benefits provided by all the health insurance coverage issued by one of the following:

(A) An issuer in the individual market in a State during the previous calendar year, weighted by enrollment for each policy form, but not including coverage issued to eligible individuals.

(B) All issuers in the individual market in a State if the data are available for the previous calendar year, weighted by enrollment for each policy form.

(ii) *Requirements.* The two representative policy forms must meet the following requirements:

(A) Include a lower-level coverage policy form under which the actuarial value of benefits under the coverage is