(ii) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage.

(iii) The coverage is for a period before July 1, 1996.

(iv) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan.

(v) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(2) *Evidence of creditable coverage*—(i) *Consideration of evidence.* An issuer must take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether or not an individual has 18 months of creditable coverage. An issuer must treat the individual as having furnished a certificate if the individual attests to the period of creditable coverage, the individual presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the issuer's efforts to verify the individual's coverage. For this purpose, cooperation includes providing (upon the issuer's request) a written authorization for the issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While an issuer may refuse to credit coverage if the individual fails to cooperate with the issuer's efforts to verify coverage, the issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may be established through means other than documentation, such as by a telephone call from the issuer to a third party verifying creditable coverage.

(3) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the issuer must treat the individual as having furnished a certificate showing the dependent status if the individual attests to the dependency and the period of the status and the individual cooperates with the issuer's efforts to verify the dependent status.

(Approved by the Office of Management and Budget under control number 0938–0703)

[62 FR 16998, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 148.126 Determination of an eligible individual.

(a) *General rule.* Each issuer offering health insurance coverage in the individual market is responsible for determining whether an applicant for coverage is an eligible individual as defined in § 148.103.

(b) *Specific requirements.* (1) The issuer must exercise reasonable diligence in making this determination.

(2) The issuer must promptly determine whether an applicant is an eligible individual.

(3) If an issuer determines that an individual is an eligible individual, the issuer must promptly issue a policy to that individual.

(c) *Insufficient information*—(1) *General rule.* If the information presented in or with an application is substantially insufficient for the issuer to make the determination described in paragraph (b)(2) of this section, the issuer may immediately request additional information from the individual, and must act promptly to make its determination after receipt of the requested information

(2) *Failure to provide a certification of creditable coverage.* If an entity fails to provide the certificate that is required

under this part or part 146 of this subchapter to the applicant, the issuer is subject to the procedures set forth in §148.124(d)(1) concerning an individual's right to demonstrate creditable coverage.

[62 FR 17000, Apr. 8, 1997]

EFFECTIVE DATE NOTE: At 62 FR 17000, Apr. 8, 1997, §148.126 was added. This section contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§148.128 State flexibility in individual market reforms—alternative mechanisms.

(a) *Waiver of requirements.* The requirements of §148.120, which set forth Federal requirements for guaranteed availability in the individual market, do not apply in a State that implements an acceptable alternative mechanism in accordance with the following criteria:

(1) The alternative mechanism meets the following conditions:

(i) Offers health insurance coverage to all eligible individuals.

(ii) Prohibits imposing preexisting condition exclusions and affiliation periods for coverage of an eligible individual.

(iii) Offers an eligible individual a choice of coverage that includes at least one policy form of coverage that is comparable to either one of the following:

(A) Comprehensive coverage offered in the individual market in the State.

(B) A standard option of coverage available under the group or individual health insurance laws of the State.

(2) The State is implementing one of the following provisions relating to risk:

(i) One of the following model acts, as adopted by the NAIC on June 3, 1996, but only if the model has been revised in State regulations to meet all of the requirements of this part and title 27 of the PHS Act.

(A) The Small Employer and Individual Health Insurance Availability Model Act to the extent it applies to individual health insurance coverage.

(B) The Individual Health Insurance Portability Model Act.

(ii) A qualified high risk pool, which, for purposes of this section, is a high risk pool that meets the following conditions:

(A) Provides to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion or affiliation periods for coverage of an eligible individual.

(B) Provides for premium rates and covered benefits for the coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect as of August 21, 1996), but only if the model has been revised in State regulations to meet all of the requirements of this part and title 27 of the PHS Act.

(iii) One of the following mechanisms:

(A) Any other mechanism that provides for risk adjustment, risk spreading, or a risk-spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers.

(B) A mechanism that provides a choice for each eligible individual of all individual health insurance coverage otherwise available.

(b) *Permissible forms of mechanisms.* A private or public individual health insurance mechanism (such as a health insurance coverage pool or program, a mandatory group conversion policy, guaranteed issue of one or more plans of individual health insurance coverage, or open enrollment by one or more health insurance issuers), or combination of these mechanisms, that is designed to provide access to health benefits for individuals in the individual market in the State, in accordance with this section, may constitute an acceptable alternative mechanism.

(c) *Establishing an acceptable alternative mechanism—transition rules.* CMS presumes a State to be implementing an acceptable alternative mechanism as of July 1, 1997 if the following conditions are met:

(1) By not later than April 1, 1997, as evidenced by a postmark date, or other such date, the chief executive officer of the State takes the following actions: