

§ 146.160

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 such employer.

(Approved by the Office of Management and Budget under control number 0938-0702.)

[62 FR 16958, Apr. 8, 1997; 62 FR 31670, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 146.160 Disclosure of information.

(a) *General rule.* In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer is required to—

(1) Make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this section; and

(2) Upon request of the employer, provide that information to the employer.

(b) *Information described.* Subject to paragraph (d) of this section, information that must be provided under paragraph (a)(2) of this section is information concerning the following:

(1) Provisions of coverage relating to the following:

(i) The issuer’s right to change premium rates and the factors that may affect changes in premium rates.

(ii) Renewability of coverage.

(iii) Any preexisting condition exclusion, including use of the alternative method of counting creditable coverage.

(iv) Any affiliation periods applied by HMOs.

(v) The geographic areas served by HMOs.

(2) The benefits and premiums available under all health insurance coverage for which the employer is qualified, under applicable State law. See § 146.150(b) through (f) for allowable limitations on product availability.

(c) *Form of information.* The information must be described in language that is understandable by the average small employer, with a level of detail that is sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. This requirement is satisfied

45 CFR Subtitle A (10–1–00 Edition)

if the issuer provides each of the following with respect to each product offered:

(1) An outline of coverage. For purposes of this section, outline of coverage means a description of benefits in summary form.

(2) The rate or rating schedule that applies to the product (with and without the preexisting condition exclusion or affiliation period).

(3) The minimum employer contribution and group participation rules that apply to any particular type of coverage.

(4) In the case of a network plan, a map or listing of counties served.

(5) Any other information required by the State.

(d) *Exception.* An issuer is not required to disclose any information that is proprietary and trade secret information under applicable law.

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[62 FR 16958, Apr. 8, 1997, as amended at 62 FR 35906, July 2, 1997]

Subpart F—Exclusion of Plans and Enforcement

§ 146.180 Treatment of non-Federal governmental plans.

The plan sponsor of a non-Federal governmental plan may elect to be exempted from any or all of the requirements identified in paragraph (a) of this section with respect to any portion of its plan that is not provided through health insurance coverage, if the election complies with the requirements of paragraphs (b) and (c) of this section. The election remains in effect for the period described in paragraph (d) of this section.

(a) *Exemption from requirements.* The election described in this section exempts a non-Federal governmental plan from the following requirements:

(1) Limitations on preexisting condition exclusion periods (§ 146.111).

(2) Special enrollment periods for individuals and dependents (§ 146.117).

(3) Prohibitions against discriminating against individual participants and beneficiaries based on health status (§ 146.121).

(4) Standards relating to benefits for mothers and newborns (section 2704 of the PHS Act).

(5) Parity in the application of certain limits to mental health benefits (section 2705 of the PHS Act).

(b) *Form and manner of election.* (1) The election must be in writing.

(2) The election document must include as an attachment a copy of the notice described in paragraphs (f) and (g) of this section.

(3) The election document must state the name of the plan and the name and address of the plan administrator.

(4) The election document must either state that the plan does not include health insurance coverage, or identify which portion of the plan is not funded through insurance.

(5) The election must be made in conformity with all the plan sponsor's rules, including any public hearing, if required, and the election document must certify that the person signing the election document, including if applicable a third party plan administrator, is legally authorized to do so by the plan sponsor.

(6) The election document must be signed by the person described in paragraph (b)(5) of this section.

(c) *Timing of election.* (1) For plans not subject to collective bargaining agreements, the election must be received by HCFA by the day preceding the beginning date of the plan year.

(2) For plans provided under a collective bargaining agreement, the election must be received by HCFA no later than 30 days after—

(i) The date of the agreement between the governmental entity and union officials; or

(ii) If applicable, ratification of the agreement.

(3) HCFA may extend the deadlines specified under paragraphs (c)(1) and (c)(2) of this section for good cause.

(4) If the plan sponsor fails to file a timely election in accordance with paragraphs (c)(1) through (c)(3) of this section, the plan is subject to the requirements described in paragraph (a) of this section for the entire plan year, or, in the case of a plan provided under a collective bargaining agreement, for the term of the agreement.

(d) *Period of election.* An election under paragraph (a) of this section applies—

(1) For a single specified plan year; or

(2) In the case of a plan provided under a collective bargaining agreement, for the term of the agreement. (For purposes of this section, if a collective bargaining agreement expires during the bargaining process for a new agreement, and the parties agree that the prior bargaining agreement continues in effect until the new agreement takes effect, the "term of the agreement" is deemed to continue until the new agreement takes effect.)

(e) *Subsequent elections.* An election under this section may be extended through subsequent elections.

(f) *Notice to participants.* (1) A plan that makes the election described in this section notifies the participant of the election, and explains the consequences of the election. This notice must be provided—

(i) to each participant at the time of enrollment under the plan; and

(ii) To all participants on an annual basis.

(2) The notice shall be in writing, and must include the information specified in paragraph (g) of this section.

(3) The notice shall be provided to each participant individually.

(4) Subject to paragraph (g) of this section, the requirements of paragraphs (f)(1) through (f)(3) of this section are considered to have been met if the notice is prominently printed in the summary plan document, or equivalent document, and each participant receives a copy of that document at the time of enrollment and annually thereafter.

(g) *Notice content.* The notice must contain at least the following information:

(1) A statement that, in general, Federal law imposes upon group health plans the requirements described in paragraph (a) of this section (which must be individually described in the notice).

(2) A statement that Federal law gives the plan sponsor of a non-Federal governmental plan the right to exempt the plan in whole or in part from the requirements described in paragraph

Pt. 148

(a) of this section, and that the plan sponsor has elected to do so.

(3) A statement identifying which parts of the plan are subject to the election, and each of the requirements of paragraph (a) of this section from which the plan sponsor has elected to be exempted.

(4) If the plan chooses to provide any of the protections of paragraph (a) of this section voluntarily, or is required to under State law, a statement identifying which protections apply.

(h) *Certification and disclosure of creditable coverage.* Notwithstanding an election under this section, a non-Federal governmental plan must provide for certification and disclosure of creditable coverage under the plan with respect to participants and their dependents in accordance with §146.115.

(i) *Effect of failure to comply with election requirements.* (1) Subject to paragraph (i)(2) of this section, a plan's failure to comply with the requirements of paragraphs (f) through (h) of this section invalidates an election made under this section.

(2) Upon a finding by HCFA that a non-Federal governmental plan has failed to comply with the requirements of paragraphs (f) through (h) of this section, and has failed to correct the noncompliance within 30 days (as provided in §150.341(a)(2)), HCFA notifies the plan that its election has been invalidated and that it is subject to the requirements of this part.

(3) A non-Federal governmental plan described in paragraph (i)(2) of this section that fails to comply with the requirements of this part is subject to Federal enforcement by HCFA under part 150 of this subchapter, including appropriate civil money penalties.

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PART 147 [RESERVED]

45 CFR Subtitle A (10-1-00 Edition)

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

Subpart A—General Provisions

Sec.

148.101 Basis and purpose.

148.102 Scope, applicability, and effective dates.

148.103 Definitions.

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.

148.122 Guaranteed renewability of individual health insurance coverage.

148.124 Certification and disclosure of coverage.

148.126 Determination of an eligible individual.

148.128 State flexibility in individual market reforms—alternative mechanisms.

Subpart C—Requirements Related to Benefits

148.170 Standards relating to benefits for mothers and newborns.

Subpart D—Enforcement; Penalties; Preemption

148.210 Preemption.

148.220 Excepted benefits.

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).

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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