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(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.

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

[62 FR 16958, Apr. 8, 1997; 62 FR 31694, June 10, 1997, as amended at 62 FR 35906, July 2, 1997; 64 FR 45795, Aug. 20, 1999]

**PART 147 [RESERVED]**

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

**PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET**

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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,