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, to protections for mothers and newborns with respect to hospital stays in connection with childbirth, and to protections against discrimination based on genetic information apply to all issuers of individual health insurance coverage in the State, regardless of whether a State implements an alternative mechanism under §148.128 of this part.

(b) *Effective date.* Except as provided in §148.124 (certificate of creditable coverage), §148.128 (alternative State mechanisms), §148.170 (standards relating to benefits for mothers and newborns), and §148.180 (prohibition of health discrimination based on genetic information) of this part, 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; 74 FR 51693, Oct. 7, 2009]

§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 at least 85 percent but not greater than 100 percent of the weighted average.

(B) Include a higher-level coverage policy form under which the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of the lower-level coverage policy form offered by an issuer in that State and at least 100 percent, but not greater than 120 percent, of the weighted average.

(C) Include benefits substantially similar to other individual health insurance coverage offered by the issuer in the State.

(D) Provide for risk adjustment, risk spreading, or a risk spreading mechanism, or otherwise provide some financial subsidization for eligible individuals.

(E) Meet all applicable State requirements.

(iii) *Actuarial value of benefits.* The actuarial value of benefits provided under individual health insurance coverage must be calculated based on a standardized population, and a set of standardized utilization and cost factors under applicable State law.

(4) *Election.* All issuer elections must be applied uniformly to all eligible individuals in the State and must be effective for all policies offered during a period of at least 2 years.

(5) *Documentation.* The issuer must document the actuarial calculations it makes as follows:

(i) *Enforcement by State.* In a State that elects to enforce the provisions of this section in lieu of an alternative mechanism under §148.128, the issuer must provide the appropriate State authorities with the documentation required by the State.

(ii) *Enforcement by CMS.* If CMS acts to enforce the provisions of this section under part 150, the issuer must provide to CMS, within the following time

frames, any documentation CMS requests:

(A) For policy forms already being marketed as of July 1, 1997—no later than September 1, 1997.

(B) For other policy forms—90 days before the beginning of the calendar year in which the issuer wants to market the policy form.

(d) *Special rules for network plans.* (1) An issuer that offers coverage in the individual market through a network plan may take the following actions:

(i) Specify that an eligible individual may only enroll if he or she lives, resides, or works within the service area for the network plan.

(ii) Deny coverage to an eligible individual if the issuer has demonstrated the following to the applicable State authority (if required by the State):

(A) It does not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to provide services to current group contract holders and enrollees, and to current individual enrollees.

(B) It uniformly denies coverage to individuals without regard to any health status-related factor, and without regard to whether the individuals are eligible individuals.

(iii) Not offer any coverage in the individual market, within the service area identified for purposes of paragraph (d)(1)(ii) of this section, for a period of 180 days after the coverage is denied.

(2) In those States in which CMS is enforcing the individual market provisions of this part in accordance with part 150, the issuer must make the demonstration described in paragraph (d)(1)(ii) of this section to CMS rather than to the State, and the issuer may not deny coverage to any eligible individual until 30 days after CMS receives and approves the information.

(e) *Application of financial capacity limits.* (1) An issuer may deny coverage to an eligible individual if the issuer has demonstrated the following to the applicable State authority (if required by the State):

(i) It does not have the financial reserves necessary to underwrite additional coverage.

(ii) It uniformly denies coverage to all individuals in the individual market, consistent with applicable State law, without regard to any health status-related factor of the individuals, and without regard to whether the individuals are eligible individuals.

(2) In those States in which CMS is enforcing the individual market provisions of this part in accordance with part 150, the issuer must make the demonstration described in paragraph (e)(1) of this section to CMS rather than to the State, and the issuer may not deny coverage to any eligible individual until 30 days after CMS receives and approves the information.

(3) An issuer that denies coverage in any service area according to paragraph (e)(1) of this section is prohibited from offering that coverage in the individual market for a period of 180 days after the later of the date—

(i) The coverage is denied; or

(ii) The issuer demonstrates to the applicable State authority (if required under applicable State law) that the issuer has sufficient financial reserves to underwrite additional coverage.

(4) A State may apply the 180-day suspension described in paragraph (e)(3) of this section on a service-area-specific basis.

(f) *Rules for dependents*—(1) *General rule.* Except as prohibited by §148.180, if an eligible individual elects to enroll in individual health insurance coverage that provides coverage for dependents, the issuer may apply a preexisting condition exclusion on any dependent who is not an eligible individual.

(2) *Exception for certain children.* A child is deemed to be an eligible individual if the following conditions are met:

(i) The child was covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption (or longer if the State provides for a longer special enrollment period than required under §146.117(a)(6) of this subchapter).

(ii) The child has not had a significant break in coverage.

(3) *Examples.* The following examples illustrate the requirements of this paragraph (f) for certain children:

Example 1: Individual *A* had self-only coverage under his employer's group health plan

for five years. *A* has two children, ages 11 and 15, but never enrolled in family coverage. *A* leaves his job to become self-employed, and qualifies as an eligible individual because he is not entitled to any continuation coverage, Medicare or Medicaid, and has no other health insurance coverage. He applies to Issuer *R* for coverage in the individual market under a policy with family coverage that *R* makes available to eligible individuals. *R* must sell *A* the policy, but he may refuse coverage to *A*'s children, or may apply a preexisting condition exclusion to them if allowed under applicable State law, because they did not have prior creditable coverage, and therefore do not qualify as eligible individuals.

Example 2: Individual *B* was also covered under a group health plan for 5 years before losing his job. He originally had coverage only for himself and his wife, but 3 months before his employment ended, his wife had a baby. *B* took advantage of the special enrollment period that applied, changed to family coverage, and enrolled the baby in the group health plan within 20 days. Immediately after losing his job, *B* applied to Issuer *R* for family coverage. *B* and his wife qualify as eligible individuals, and the baby is deemed to be an eligible individual even though she has less than 3 months of creditable coverage. Therefore *R* must make the policy available to all three members of the family, and cannot impose any preexisting condition exclusions.

(g) *Clarification of applicability.* (1) An issuer in the individual market is not required to offer a family coverage option with any policy form.

(2) An issuer offering health insurance coverage only in connection with group health plans, or only through one or more bona fide associations, or both, is not required to offer that type of coverage in the individual market.

(3) An issuer offering health insurance coverage in connection with a group health plan is not deemed to be a health insurance issuer offering individual health insurance coverage solely because the issuer offers a conversion policy.

(4) Except as prohibited by §148.180, this section does not restrict the amount of the premium rates that an issuer may charge an individual under State law for health insurance coverage provided in the individual market.

(5) This section does not prevent an issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates, or modifying otherwise applicable copayments or deductibles, in return for adherence to programs of health promotion and disease prevention.

(6) This section does not require issuers to reopen blocks of business closed under applicable State law.

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

[62 FR 16996, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997; 74 FR 51693, Oct. 7, 2009]

§148.122 Guaranteed renewability of individual health insurance coverage.

(a) *Applicability.* This section applies to all health insurance coverage in the individual market.

(b) *General rules.* (1) Except as provided in paragraph (c) of this section, an issuer must renew or continue in force the coverage at the option of the individual.

(2) Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market.

(c) *Exceptions to renewing coverage.* An issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) *Nonpayment of premiums.* The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

(2) *Fraud.* The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) *Termination of plan.* The issuer is ceasing to offer coverage in the individual market in accordance with paragraphs (d) and (e) of this section and applicable State law.

(4) *Movement outside the service area.* For network plans, the individual no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals.