(5) *Association membership ceases.* For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(d) *Discontinuing a particular type of coverage.* An issuer may discontinue offering a particular type of health insurance coverage offered in the individual market only if it meets the following requirements:

(1) Provides notice in writing to each individual provided coverage of that type of health insurance at least 90 days before the date the coverage will be discontinued.

(2) Offers to each covered individual, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in that market.

(3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(e) *Discontinuing all coverage.* An issuer may discontinue offering all health insurance coverage in the individual market in a State only if it meets the following requirements.

(1) Provides notice in writing to the applicable State authority and to each individual of the discontinuation at least 180 days before the date the coverage will expire.

(2) Discontinues and does not renew all health insurance policies it issues or delivers for issuance in the State in the individual market.

(3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(f) *Prohibition on market reentry.* An issuer who elects to discontinue offering all health insurance coverage under paragraph (e) of this section may not issue coverage in the market and State involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

(g) *Exception for uniform modification of coverage.* An issuer may, only at the time of coverage renewal, modify the health insurance coverage for a policy form offered in the individual market if the modification is consistent with State law and is effective uniformly for all individuals with that policy form.

(h) *Application to coverage offered only through associations.* In the case of health insurance coverage that is made available by a health insurance issuer in the individual market only through one or more associations, any reference in this section to an ''individual'' is deemed to include a reference to the association of which the individual is a member.

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

§ 148.124 Certification and disclosure of coverage.

(a) *Applicability*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, this section applies to all issuers of health insurance coverage.

(2) *Exception.* The provisions of this section do not apply to issuers of the following types of coverage:

(i) Health insurance coverage furnished in connection with a group health plan defined in §144.103 of this subchapter. (These issuers are required under §146.115 of this subchapter to provide a certificate of coverage.)

(ii) Excepted benefits described in §148.220.

(iii) Short-term, limited duration coverage defined in §144.103 of this subchapter.

(b) *General rules*—(1) *Individuals for whom a certificate must be provided; timing of issuance.* A certificate must be provided, without charge, for individuals and dependents who are or were covered under an individual health insurance policy as follows:

(i) *Issuance of automatic certificates.* An automatic certificate must be provided within a reasonable time period consistent with State law after the individual ceases to be covered under the policy.

(ii) *Any individual upon request.* Requests for certificates may be made by, or on behalf of, an individual within 24

months after coverage ends. For example, an entity that provides coverage to an individual in the future may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from the issuer of the individual's prior coverage. After the request is received, an issuer must provide the certificate by the earliest date the issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate must be provided under this paragraph even if the individual has previously received a certificate under this paragraph (b)(1)(ii) or an automatic certificate under paragraph (a)(l)(i) of this section.

(2) *Form and content of certificate*—(i) *Written certificate*—(A) *General rule.* Except as provided in paragraph (b)(2)(i)(B) of this section, the issuer must provide the certificate in writing (including any form approved by CMS).

(B) *Other permissible forms.* No written certificate must be provided if all of the following occur:

(*1*) An individual is entitled to receive a certificate.

(*2*) The individual requests that the certificate be sent to another plan or issuer instead of to the individual.

(*3*) The plan or issuer that would otherwise receive the certificate agrees to accept the information in paragraph (a)(3) of this section through means other than a written certificate (for example, by telephone).

(*4*) The receiving plan or issuer receives the information from the sending issuer in the prescribed form within the time periods required under paragraph (b)(1) of this section.

(ii) *Required information.* The certificate must include the following:

(A) The date the certificate is issued.

(B) The name of the individual or dependent for whom the certificate applies, and any other information necessary for the issuer providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the policy and the name of the policyholder if the certificate is for (or includes) a dependent.

(C) The name, address, and telephone number of the issuer required to provide the certificate.

(D) The telephone number to call for further information regarding the certificate (if different from paragraph (b)(2)(ii)(C) of this section).

(E) Either one of the following:

(*1*) A statement that the individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage as defined in §146.113(b)(2)(iii) of this subchapter.

(*2*) Both the date the individual first sought coverage, as evidenced by a substantially complete application, and the date creditable coverage began.

(F) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(iii) *Periods of coverage under a certificate.* If an automatic certificate is provided under paragraph (b)(1)(i) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate under paragraph (b)(1)(ii) of this section, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each period of continuous coverage.

(iv) *Single certificate permitted for families.* An issuer may provide a single certificate for both an individual and the individual's dependents if it provides all the required information for each individual and dependent, and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (b)(2)(ii) of this section are satisfied if the issuer provides a certificate in accordance with a model certificate as provided by CMS.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in §148.220. If excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to

be disclosed under paragraph (c) of this section.

(3) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided, without charge, to each individual described in paragraph (b)(1) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the individual and the individual's spouse at the individual's last known address, the requirements of this paragraph (b)(3) are satisfied with respect to all individuals and dependents residing at that address. If a dependent's last known address is different than the individual's last known address, a separate certificate must be provided to the dependent at the dependent's last known address. If separate certificates are provided by mail to individuals and dependents who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* An issuer must establish a procedure for individuals and dependents to request and receive certificates under paragraph (b)(1)(ii) of this section.

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (b)(1)(i) of this section, and the individual or dependent entitled to receive the certificate designates another individual or entity to receive the certificate, the issuer responsible for providing the certificate may provide the certificate to the designated party. If a certificate must be provided upon request under paragraph (b)(1)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the issuer responsible for providing the certificates must provide the certificate to the designated party.

(4) *Special rules concerning dependent coverage*—(i) *Reasonable efforts.* An issuer must use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. If an automatic certificate must be furnished with respect to a dependent under paragraph (b)(1)(i) of this section, no individual certificate must be furnished until the issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the policy.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by an issuer does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (d)(3) of this section for demonstrating dependent status. An individual may, if necessary, use these procedures to demonstrate that a child was enrolled within 30 days of birth, adoption, or placement for adoption, in which case the child would not be subject to a preexisting condition exclusion under §148.120(f)(2).

(iii) *Transition rule for dependent coverage through June 30, 1998*—(A) *General rule.* An issuer that cannot provide the names of dependents (or related coverage information) for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of paragraph (b)(2)(ii)(C) of this section by providing the name of the policyholder and specifying that the type of coverage described in the certificate is for dependent coverage (for example, family coverage or individual-plus-spouse coverage).

(B) *Certificates provided on request.* For purposes of certificates provided on the request of, or on behalf of, an individual under paragraph (b)(1)(ii) of this section, an issuer must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate if the information is requested. If a certificate does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (d)(3) of this section for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

(C) *Demonstrating a dependent's creditable coverage.* See paragraph (d)(3) of this section for special rules to demonstrate dependent status.

(D) *Duration.* The transitional rules of this paragraph (b)(4)(iii) are effective for certifications provided with respect to an event occurring before July 1, 1998.

(5) *Optional notice.* This paragraph applies to events described in paragraph (b)(1)(i) of this section, that occur after September 30, 1996, but before June 30, 1997. An issuer offering individual health insurance coverage is deemed to satisfy paragraphs (b)(1) and (b)(2) of this section if a notice is provided in accordance with the provisions of §146.125(e)(3)(ii) through (e)(3)(iv) of this subchapter.

(c) *Disclosure of coverage to a plan, or issuer, electing the alternative method of creating coverage*—(1) *General rule.* If an individual enrolls in a group health plan and the plan or issuer uses the alternative method of determining creditable coverage described in §146.113(c) of this subchapter, the individual provides a certificate of coverage under paragraph (b) of this section or demonstrates creditable coverage under paragraph (d) of this section, and the plan or coverage in which the individual enrolls requests from the prior entity, the prior entity must disclose promptly to the requesting plan or issuer (''requesting entity'') the information set forth in paragraph (c)(2) of this section.

(2) *Information to be disclosed.* The prior entity must identify to the requesting entity the categories of benefits under which the individual was covered and with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs to determine the individual's creditable coverage with respect to any of those categories. The prior entity must promptly disclose to the requesting entity the creditable coverage information that was requested.

(3) *Charge for providing information.* The prior entity furnishing the information under paragraph (c)(2) of this section may charge the requesting entity for the reasonable cost of disclosing the information.

(d) *Ability of an individual to demonstrate creditable coverage and waiting period information*—(1) *General rule.* Individuals may establish creditable coverage through means other than certificates. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make a demonstration if one of the following occurs:

(i) An entity has failed to provide a certificate within the required time period.

(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.

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§ 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,