

(b) The protections afforded under 45 CFR parts 144 through 148 to individuals and employers (and other sponsors of health insurance offered in connection with a group health plan) are determined by whether the coverage involved is obtained in the small group market, the large group market, or the individual market. Small employers, and individuals who are eligible to enroll under the employer's plan, are guaranteed availability of insurance coverage sold in the small group market. Small and large employers are guaranteed the right to renew their group coverage, subject to certain exceptions. Eligible individuals are guaranteed availability of coverage sold in the individual market, and all coverage in the individual market must be guaranteed renewable. All coverage issued in the small or large group market, and in the individual market, must provide certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth.

(c) Coverage that is provided to associations, but is not related to employment, is not considered group coverage under 45 CFR parts 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under State law.

(d) Provisions relating to CMS enforcement of one or more provisions of part 146 or the requirements of part 148, or both, are contained in part 150 of this subchapter.

[62 FR 16955, Apr. 8, 1997, as amended at 63 FR 57558, Oct. 27, 1998; 64 FR 45795, Aug. 20, 1999]

#### § 144.103 Definitions.

For purposes of parts 146 (group market), 148 (individual market), and 150 (enforcement) of this subchapter, the following definitions apply unless otherwise provided:

*Affiliation period* means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

*Applicable State authority* means, with respect to a health insurance issuer in a State, the State insurance commis-

sioner or official or officials designated by the State to enforce the requirements of 45 CFR parts 146 and 148 for the State involved with respect to the issuer.

*Beneficiary* has the meaning given the term under section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which states, "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit" under the plan.

*Bona fide association* means, with respect to health insurance coverage offered in a State, an association that meets the following conditions:

(1) Has been actively in existence for at least 5 years.

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance.

(3) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee).

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(6) Meets any additional requirements that may be imposed under State law.

*Church plan* means a Church plan within the meaning of section 3(33) of ERISA.

*COBRA* definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601–608 of the Employee Retirement Income Security Act, section 4980B of the Internal Revenue Code of 1986 (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), or Title XXII of the PHS Act.

(4) *Continuation coverage* means coverage under a COBRA continuation provision or a similar State program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar State program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

(5) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

(6) *Exhaustion of continuation coverage* means that an individual's continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted continuation coverage if—

(i) Coverage ceases due to the failure of the employer or other responsible

entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other continuation coverage available to the individual.

*Condition* means a *medical condition*.

*Creditable coverage* has the meaning given the term in 45 CFR 146.113(a).

*Dependent* means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

*Eligible individual*, for purposes of—

(1) The group market provisions in 45 CFR part 146, subpart E, is defined in 45 CFR 146.150(b); and

(2) The individual market provisions in 45 CFR part 148, is defined in 45 CFR 148.103.

*Employee* has the meaning given the term under section 3(6) of ERISA, which states, “any individual employed by an employer.”

*Employer* has the meaning given the term under section 3(5) of ERISA, which states, “any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.”

*Enroll* means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

*Enrollment date* definitions (*enrollment date*, *first day of coverage*, and *waiting*

*period*) are set forth in 45 CFR 146.111(a)(3)(i) through (iii).

*ERISA* stands for the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

*Excepted benefits*, consistent for purposes of the—

(1) Group market provisions in 45 CFR part 146 subpart D, is defined in 45 CFR 146.145(c); and

(2) Individual market provisions in 45 CFR part 148, is defined in 45 CFR 148.220.

*Federal governmental plan* means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

*Genetic information* has the meaning specified in §146.122(a) of this subchapter.

*Governmental plan* means a governmental plan within the meaning of section 3(32) of ERISA.

*Group health insurance coverage* means health insurance coverage offered in connection with a group health plan.

*Group health plan* or *plan* means a group health plan within the meaning of 45 CFR 146.145(a).

*Group market* means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of *individual market* in this section.)

*Health insurance coverage* means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

*Health insurance issuer* or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance

(within the meaning of section 514(b)(2) of ERISA). This term does not include a group health plan.

*Health maintenance organization* or *HMO* means—

(1) A Federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

*Health status-related factor* is any factor identified as a health factor in 45 CFR 146.121(a).

*Individual health insurance coverage* means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

*Individual market* means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

*Internal Revenue Code* means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

*Issuer* means a *health insurance issuer*.

*Large employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

*Large group market* means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer, unless otherwise provided under State law.

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*Late enrollment* definitions (*late enrollee* and *late enrollment*) are set forth in 45 CFR 146.111(a)(3)(v) and (vi).

*Medical care* means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

*Medical condition* or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

*Network plan* means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

*Non-Federal governmental plan* means a governmental plan that is not a Federal governmental plan.

*Participant* has the meaning given the term under section 3(7) of ERISA, which States, “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.”

*PHS Act* stands for the Public Health Service Act (42 U.S.C. 201 *et seq.*).

*Placement, or being placed, for adoption* means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child’s adoption. The child’s placement for adoption with such person ends upon the termination of such legal obligation.

*Plan sponsor* has the meaning given the term under section 3(16)(B) of ERISA, which states, “(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.”

*Plan year* means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer’s taxable year; or

(4) In any other case, the plan year is the calendar year.

*Policy Year* means in the individual health insurance market the 12-month period that is designated as the policy year in the policy documents of the individual health insurance coverage. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year.

*Preexisting condition exclusion* means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant

to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

*Public health plan* has the meaning given the term in 45 CFR 146.113(a)(1)(ix).

*Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.

*Significant break in coverage* has the meaning given the term in 45 CFR 146.113(b)(2)(iii).

*Small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

*Small group market* means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

*Special enrollment* means enrollment in a group health plan or group health insurance coverage under the rights described in 45 CFR 146.117.

*State* means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

*State health benefits risk pool* has the meaning given the term in 45 CFR § 146.113(a)(1)(vii).

*Waiting period* has the meaning given the term in 45 CFR 146.111(a)(3)(iii).

[69 FR 78781, Dec. 30, 2004, as amended at 74 FR 51688, Oct. 7, 2009; 75 FR 27138, May 13, 2010; 75 FR 37235, June 28, 2010]

### Subpart B—Qualified State Long-Term Care Insurance Partnerships: Reporting Requirements for Insurers

SOURCE: 73 FR 76968, Dec. 18, 2008, unless otherwise noted.

#### § 144.200 Basis.

This subpart implements—

(a) Section 1917(b)(1)(C)(iii)(VI) of the Social Security Act, (Act) which requires the issuer of a long-term care insurance policy issued under a qualified State long-term care insurance partnership to provide specified regular reports to the Secretary.

(b) Section 1917(b)(1)(C)(v) of the Act, which specifies that the regulations of the Secretary under section 1917(b)(1)(C)(iii)(VI) of the Act shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data to be reported and the frequency with which such reports are to be made. This section of the statute also provides that the Secretary provide copies of the reports to the States involved.

#### § 144.202 Definitions.

As used in this Subpart—

*Partnership qualified policy* refers to a qualified long-term care insurance policy issued under a qualified State long-term care insurance partnership.

*Qualified long-term care insurance policy* means an insurance policy that has