[81 FR 61565, Sept. 6, 2016, as amended at 82 FR 9175, Feb. 3, 2017]

SUBCHAPTER B—REQUIREMENTS RELATING TO HEALTH CARE ACCESS

PARTS 140–143 [RESERVED]

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

Subpart A—General Provisions

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

AUTHORITY: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

SOURCE: 62 FR 16955, Apr. 8, 1997, unless otherwise noted.

Subpart A—General Provisions

§ 144.101 Basis and purpose.

(a) Part 146 of this subchapter implements requirements of Title XXVII of the Public Health Service Act (PHS Act, 42 U.S.C. 300gg, *et seq.*) that apply to group health plans and group health insurance issuers.

(b) Part 147 of this subchapter implements the provisions of the Patient Protection and Affordable Care Act that apply to both group health plans and health insurance issuers in the Group and Individual Markets.

(c) Part 148 of this subchapter implements Individual Health Insurance Market requirements of the PHS Act. Its purpose is to improve access to individual health insurance coverage for certain individuals who previously had group coverage, guarantee the renewability of all health insurance coverage in the individual market, and provide certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth, and to provide certain protections for patients who elect breast reconstruction in connection with a mastectomy.

(d) Part 150 of this subchapter implements the enforcement provisions of sections 2723 and 2761 of the PHS Act with respect to the following:

(1) States that fail to substantially enforce one or more provisions of part 146 concerning group health insurance, one or more provisions of part 147 concerning group or individual health insurance, or the requirements of part 148 of this subchapter concerning individual health insurance.

(2) Insurance issuers in States described in paragraph (d)(1) of this section.

(3) Group health plans that are non-Federal governmental plans.

(e) Sections 2791 and 2792 of the PHS Act define terms used in the regulations in this subchapter and provide the basis for issuing these regulations.

[64 FR 45795, Aug. 20, 1999, as amended at 74 FR 51688, Oct. 7, 2009; 75 FR 27137, May 13, 2010; 78 FR 13435, Feb. 27, 2013]

§ 144.102 Scope and applicability.

(a) For purposes of 45 CFR parts 144 through 148, all health insurance coverage is generally divided into two markets—the group market and the individual market. The group market is further divided into the large group market and the small group market.

(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.

(c) Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage under 45 CFR parts 144 through 148. If the coverage is offered to an association member other than in connection with a group health plan, the coverage is considered individual health insurance coverage for purposes of 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. If the health insurance coverage is offered in connection with a group health plan as defined at 45 CFR 144.103, it is considered group health insurance coverage for purposes of 45 CFR parts 144 through 148.

(d) Provisions relating to CMS enforcement of parts 146, 147, and 148 are contained in part 150 of this subchapter.

[78 FR 13435, Feb. 27, 2013, as amended at 78 FR 65091, Oct. 30, 2013]

§ 144.103 Definitions.

For purposes of parts 146 (group market), 147 (group and individual 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 commissioner 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 means the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

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(b); 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.

First day of coverage means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

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.

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, or other than coverage offered pursuant to a contract between the health insurance issuer with the Medicaid, Children's Health Insurance Program, or Basic Health programs.

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 1 employee on the first day of the plan year. A State may elect to define large employer by substituting ''101 employees'' for ''51 employees.'' In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

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.

Late enrollee means an individual whose enrollment in a plan is a late enrollment.

Late enrollment means enrollment of an individual under a group health plan other than on the earliest date on which coverage can become effective for the individual under the terms of the plan; or through special enrollment. (For rules relating to special enrollment and limited open enrollment, see §§146.117 and 147.104 of this subchapter.) If an individual ceases to be eligible for coverage under a plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

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 means, with respect to a product, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area. The product comprises all plans offered with those characteristics and the combination of the service areas for all plans offered within a product constitutes the total service area of the product. With respect to a plan that has been modified at the time of coverage renewal consistent with §147.106 of this subchapter—

(1) The plan will be considered to be the same plan if it:

(i) Has the same cost-sharing structure as before the modification, or any variation in cost sharing is solely related to changes in cost or utilization of medical care, or is to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act;

(ii) Continues to cover a majority of the same service area; and

(iii) Continues to cover a majority of the same provider network. For this purpose, the plan's provider network on the first day of the plan year is compared with the plan's provider network on the first day of the preceding plan year (as applicable).

(2) The plan will not fail to be treated as the same plan to the extent the modification(s) are made uniformly and solely pursuant to applicable Federal and State requirements if—

(i) The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement;

(ii) The modification is directly related to the imposition or modification of the Federal or State requirement.

(3) A State may permit greater changes to the cost-sharing structure, or designate a lower threshold for maintenance of the same provider network or service area for a plan to still be considered the same plan.

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, with respect to—

(1) A grandfathered health plan offered in the individual health insurance market and student health insurance coverage, the 12-month period that is designated as the policy year in the policy documents of the 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.

(2) A non-grandfathered health plan offered in the individual health insurance market, or in a market in which the State has merged the individual and small group risk pools, for coverage issued or renewed beginning January 1, 2014, a calendar year for which health insurance coverage provides coverage for health benefits.

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.

Product means a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area. In the case

of a product that has been modified, transferred, or replaced, the resulting new product will be considered to be the same as the modified, transferred, or replaced product if the changes to the modified, transferred, or replaced product meet the standards of §146.152(f), §147.106(e), or §148.122(g) of this subchapter (relating to uniform modification of coverage), as applicable.

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:

(1) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date of the contract; and

(2) Displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following: ''THIS IS NOT QUALIFYING HEALTH COVERAGE (''MINIMUM ESSENTIAL COVERAGE'') THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.''

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 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. A State may elect to define small employer by substituting ''100 employees'' for ''50 employees.'' In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

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 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands; except that for purposes of part 147, the term does not include 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).

Student health insurance coverage has the meaning given the term in §147.145.

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

Waiting period has the meaning given the term in 45 CFR 147.116(b).

[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; 77 FR 16468, Mar. 21, 2012; 78 FR 65091, Oct. 30, 2013; 79 FR 10313, Feb. 24, 2014; 79 FR 13833, Mar. 11, 2014; 79 FR 14151, Mar. 12, 2014; 79 FR 30335, May 27, 2014; 80 FR 10861, Feb. 27, 2015; 80 FR 72274, Nov. 18, 2015; 81 FR 12333, Mar. 8, 2016; 81 FR 75326, Oct. 31, 2016; 81 FR 94172, Dec. 22, 2016]

EFFECTIVE DATE NOTE: At 83 FR 38243, Aug. 3, 2018, §144.103 was amended by revising the definition of ''Short-term, limited-duration insurance'', effective Oct. 2, 2018. For the convenience of the user, the revised text is set forth as follows:

§ 144.103 Definitions.

* * * * *

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 1, excluding the heading ''Notice 1,'' with any additional information required by applicable state law:

NOTICE 1:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not ''minimum essential coverage.'' If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 2, excluding the heading ''Notice 2,'' with any additional information required by applicable state law:

NOTICE 2:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

(4) If a court holds the 36-month maximum duration provision set forth in paragraph (1) of this definition or its applicability to any person or circumstances invalid, the remaining provisions and their applicability to other people or circumstances shall continue in effect.

* * * * *

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 been determined by a State insurance commissioner to meet the requirements of sections 1917(b)(1)(C)(iii)(I) through (IV) and 1917(b)(5) of the Act. It includes a certificate issued under a group insurance contract.

Qualified State long-term care insurance partnership means an approved Medicaid State plan amendment that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy that has been determined by a State insurance commissioner to meet the requirements of section 1917(b)(1)(C)(iii) of the Act.

§ 144.204 Applicability of regulations.

The regulations contained in this subpart for reporting data apply only to those insurers that have issued qualified long-term care insurance policies to individuals under a qualified State long-term care insurance partnership. They do not apply to the reporting of data by insurers for States with a Medicaid State plan amendment that established a long-term care partnership on or before May 14, 1993.

§ 144.206 Reporting requirements.

(a) *General requirement.* Any insurer that sells a qualified long-term care insurance policy under a qualified State long-term care insurance partnership must submit, in accordance with the requirements of this section, data on insured individuals, policyholders, and claimants who have active partnership qualified policies or certificates for a reporting period.

(b) *Specific requirements.* Insurers of qualified long-term care insurance policies must submit the following data to the Secretary by the deadlines specified in paragraph (c) of this section:

(1) *Registry of active individual and group partnership qualified policies or certificates.* (i) Insurers must submit data on—

(A) Any insured individual who held an active partnership qualified policy or certificate at any point during a reporting period, even if the policy or certificate was subsequently cancelled, lost partnership qualified status, or otherwise terminated during the reporting period; and

(B) All active group long-term care partnership qualified insurance policies, even if the identity of the individual policy/certificate holder is unavailable.

(ii) The data required under paragraph (b)(1)(i) of this section must cover a 6-month reporting period of January through June 30 or July 1 through December 31 of each year; and

(iii) The data must include, but are not limited to—

(A) Current identifying information on the insured individual;

(B) The name of the insurance company and issuing State;

(C) The effective date and terms of coverage under the policy.

(D) The annual premium.

(E) The coverage period.

(F) Other information, as specified by the Secretary in ''State Long-Term Care Partnership Insurer Reporting Requirements.''

(2) *Claims paid under partnership qualified policies or certificates.* Insurers must submit data on all partnership qualified policies or certificates for which the insurer paid at least one claim during the reporting period. This includes data for employer-paid core plans and buy-up plans without individual insured data. The data must—

(i) Cover a quarterly reporting period of 3 months;

(ii) Include, but are not limited to—

(A) Current identifying information on the insured individual;

(B) The type and cash amount of the benefits paid during the reporting period and lifetime to date;

(C) Remaining lifetime benefits;

(D) Other information, as specified by the Secretary in ''State Long-Term

Care Partnership Insurer Reporting Requirements.''

§ 144.208 Deadlines for submission of reports.

(a) Transition provision for insurers who have issued or exchanged a qualified partnership policy prior to the effective date of these regulations.

The first reports required for these insurers will be the reports that pertain to the reporting period that begins no more than 120 days after the effective date of the final regulations.

(b) All reports on the registry of qualified long-term care insurance policies issued to individuals or individuals under group coverage specified in §144.206(b)(1)(ii) must be submitted within 30 days of the end of the 6-month reporting period.

(c) All reports on the claims paid under qualified long-term care insurance policies issued to individual and individuals under group coverage specified in §144.206(b)(2)(i) must be submitted within 30 days of the end of the 3-month quarterly reporting period.

§ 144.210 Form and manner of reports.

All reports specified in §144.206 must be submitted in the form and manner specified by the Secretary.

§ 144.212 Confidentiality of information.

Data collected and reported under the requirements of this subpart are subject to the confidentiality of information requirements specified in regulations under 42 CFR part 401, subpart B, and 45 CFR part 5, subpart F.

§ 144.214 Notifications of noncompliance with reporting requirements.

If an insurer of a qualified long-term care insurance policy does not submit the required reports by the due dates specified in this subpart, the Secretary notifies the appropriate State insurance commissioner within 45 days after the deadline for submission of the information and data specified in §144.208.

PART 145 [RESERVED]

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

Subpart A—General Provisions

Subpart B—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

Subpart C—Requirements Related to Benefits

Subpart D—Preemption and Special Rules

Subpart E—Provisions Applicable to Only Health Insurance Issuers

Subpart F—Exclusion of Plans and Enforcement

AUTHORITY: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92).