

SUBCHAPTER B—REQUIREMENTS RELATING TO HEALTH CARE ACCESS

PARTS 140–143 [RESERVED]

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

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AUTHORITY: 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

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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 active in existence for at least 5 years.

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(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.