

§ 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.

(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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§ 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 indi-

vidual has previously received a certificate under this paragraph (b)(1)(ii) or an automatic certificate under paragraph (a)(1)(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.