§ 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

Sec.
146.101 Basis and scope.

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

146.111 Limitations on preexisting condition exclusion periods.
146.113 Rules relating to creditable coverage.
146.115 Certification and disclosure of previous coverage.
146.117 Special enrollment periods.
146.119 HMO affiliation period as an alternative to preexisting condition exclusion.
146.120 Interaction with the Family and Medical Leave Act. [Reserved]
146.121 Prohibiting discrimination against participants and beneficiaries based on a health factor.
146.122 Additional requirements prohibiting discrimination based on genetic information.
146.125 Applicability dates.

Subpart C—Requirements Related to Benefits

146.130 Standards relating to benefits for mothers and newborns.
146.136 Parity in mental health and substance use disorder benefits.

Subpart D—Preemption and Special Rules

146.143 Preemption; State flexibility; construction.
146.145 Special rules relating to group health plans.

Subpart E—Provisions Applicable to Only Health Insurance Issuers

146.150 Guaranteed availability of coverage for employers in the small group market.
146.152 Guaranteed renewability of coverage for employers in the group market.
146.160 Disclosure of information.

Subpart F—Exclusion of Plans and Enforcement

146.180 Treatment of non-Federal governmental plans.

AUTHORITY: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act