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

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 (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92).

SOURCE: 62 FR 16958, Apr. 8, 1997, unless otherwise noted.

Subpart A—General Provisions

§146.101 Basis and scope.

(a) *Statutory basis.* This part implements the Group Market requirements of the PHS Act. Its purpose is to improve access to group health insurance coverage, to guarantee the renewability of all coverage in the group market, and to provide certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth. Sections 2791 and 2792 of the PHS Act define terms used in the regulations in this