

26 CFR 54.9802–1T: Prohibiting discrimination against participants and beneficiaries based on a health factor (temporary)

T.D. 8931

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 54

DEPARTMENT OF LABOR
Pension and Welfare Benefits
Administration
29 CFR Part 2590

**Section 9802.—Prohibiting
Discrimination Against Individual
Participants and Beneficiaries
Based on Health Status**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
45 CFR Part 146

Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market

AGENCIES: Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Department of Labor; Health Care Financing Administration, Department of Health and Human Services.

ACTION: Interim final rules with request for comments.

SUMMARY: This document contains interim final rules governing the provisions prohibiting discrimination based on a health factor for group health plans and issuers of health insurance coverage offered in connection with a group health plan. The rules contained in this document implement changes made to the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DATES: *Effective date.* The interim final rules are effective March 9, 2001.

Applicability dates. For rules describing when this section applies to group health plans and group health insurance issuers, see paragraph (i) of these interim regulations.¹

Comment date. Written comments on these interim regulations are invited and must be received by the Departments on or before April 9, 2001.

ADDRESSES: Written comments should be submitted with a signed original and three copies (except for electronic sub-

missions to the Internal Revenue Service (IRS) or Department of Labor) to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments.

Comments to the IRS can be addressed to:

CC:M&SP:RU (REG-109707-97)
Room 5226
Internal Revenue Service
POB 7604, Ben Franklin Station
Washington, DC 20044

In the alternative, comments may be hand-delivered between the hours of 8 a.m. and 5 p.m. to:

CC:M&SP:RU (REG-109707-97)
Courier's Desk
Internal Revenue Service
1111 Constitution Avenue, NW.
Washington, DC 20224

Alternatively, comments may be transmitted electronically via the IRS Internet site at:

http://www.irs.gov/tax_regs/regslst.html.

Comments to the Department of Labor can be addressed to:

U.S. Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Avenue NW.,
Room C-5331
Washington, DC 20210

Attention: Nondiscrimination Comments

Alternatively, comments may be hand-delivered between the hours of 9 a.m. and 5 p.m. to the same address. Comments may also be transmitted by e-mail to: HIPAA702@pwba.dol.gov.

Comments to HHS can be addressed to:
Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA-2022-IFC
P.O. Box 26688
Baltimore, MD 21207

In the alternative, comments may be hand-delivered between the hours of 8:30 a.m. and 5 p.m. to either:

Room 443-G
Hubert Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

or
Room C5-14-03
7500 Security Boulevard
Baltimore, MD 21244-1850

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC, from 9 a.m. to 4 p.m.

All submissions to the Department of Labor will be open to public inspection and copying in the Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-1513, 200 Constitution Avenue, NW., Washington, DC, from 8:30 a.m. to 5:30 p.m.

All submissions to HHS will be open to public inspection and copying in room 309-G of the Department of Health and Human Services, 200 Independence Avenue, SW., Washington, DC, from 8:30 a.m. to 5 p.m.

FOR FURTHER INFORMATION

CONTACT: Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Amy J. Turner, Pension and Welfare Benefits Administration, Department of Labor, at (202) 219-7006; or Ruth A. Bradford, Health Care Financing Administration, Department of Health and Human Services, at (410) 786-1565.

CUSTOMER SERVICE INFORMATION:

Individuals interested in obtaining additional information on HIPAA's nondiscrimination rules may request a copy of the Department of Labor's booklet entitled "Questions and Answers: Recent Changes in Health Care Law" by calling the PWBA Toll-Free Publication Hotline at 1-800-998-7542 or may request a copy of the Health Care Financing Administration's new publication entitled "Protecting Your Health Insurance Coverage" by calling (410) 786-1565. Information on HIPAA's nondiscrimination rules and other recent health care laws is also available on the Department of Labor's website (<http://www.dol.gov/dol/pwba>) and the Department of Health and Human Services' website (<http://hipaa.hcfa.gov>).

SUPPLEMENTARY INFORMATION:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. HIPAA amended the Internal Revenue Code of 1986 (Code),

¹ Reference in this preamble to a specific paragraph in the interim regulations are to paragraphs in each of the three sets of regulations being published as part of this document. Specifically, references are to paragraphs in 26 CFR 54.9802-1 and 26 CFR 54.9802-1T (see discussion and table in "C. Format of Regulations" below), 29 CFR 2590.702, and 45 CFR 146.121.

the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) to provide for, among other things, improved portability and continuity of health coverage. HIPAA added section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act, which prohibit discrimination in health coverage. Interim final rules implementing the HIPAA provisions were first made available to the public on April 1, 1997 (published in the **Federal Register** on April 8, 1997, 62 F.R. 16894) (April 1997 interim rules). On December 29, 1997, the Departments published a clarification of the April 1997 interim rules as they relate to individuals who were denied coverage before the effective date of HIPAA on the basis of any health factor (62 F.R. 67689).

In the preamble to the April 1997 interim rules, the Departments invited comments on whether additional guidance was needed concerning —

- The extent to which the statute prohibits discrimination against individuals in eligibility for particular benefits;
- The extent to which the statute may permit benefit limitations based on the source of an injury;
- The permissible standards for defining groups of similarly situated individuals;
- Application of the prohibitions on discrimination between groups of similarly situated individuals; and
- The permissible standards for determining bona fide wellness programs.

In the preamble to the April 1997 interim rules, the Departments stated that they intend to issue further regulations on the nondiscrimination rules and that in no event would the Departments take any enforcement action against a plan or issuer that had sought to comply in good faith with section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act before the additional guidance is provided. Accordingly, with the issuance of these interim regulations, the Departments have determined that the period for nonenforcement in cases of good faith compliance ends in accordance with the rules described in paragraph (i) of these interim regulations.² However, because the in-

terim regulations do not include a discussion of bona fide wellness programs (see proposed regulations REG–114084–00 relating to bona fide wellness programs on page 633 of this Bulletin), the period for good faith compliance continues with respect to those provisions until further guidance is issued.

II. Overview of the Regulations

Section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act (the HIPAA nondiscrimination provisions) establish rules generally prohibiting group health plans and group health insurance issuers from discriminating against individual participants or beneficiaries based on any health factor of such participants or beneficiaries. These interim regulations interpret the HIPAA nondiscrimination provisions. Among other things, the interim regulations —

- Explain the application of these provisions to benefits;
- Clarify the relationship between the HIPAA nondiscrimination provisions and the HIPAA preexisting condition exclusion limitations;
- Explain the application of these provisions to premiums;
- Describe similarly situated individuals;
- Explain the application of these provisions to actively-at-work and nonconfinement clauses; and
- Clarify that more favorable treatment of individuals with medical needs generally is permitted.

Described in REG–114084–00 are proposed standards for defining bona fide wellness programs.

Of course, plans and benefits that are not subject to the HIPAA portability provisions (set forth in Chapter 100 of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act) are not subject to the HIPAA nondiscrimination requirements. Accordingly, the following plans and benefits are not subject to the HIPAA nondiscrimination requirements: benefits that qualify under the HIPAA portability provisions as excepted benefits; plans with fewer than two participants who are current employees on the first day of the plan year³; and self-funded non-Federal governmental

plans that elect, under 45 CFR 146.180, to be exempt from these nondiscrimination requirements. In addition, under a proposed regulation published by the Department of the Treasury and described in REG–114083–00 on page 630 of this Bulletin, certain church plans are treated as not violating the general HIPAA nondiscrimination provisions if the plan requires evidence of good health for the coverage of certain individuals.

Health Factors

The HIPAA nondiscrimination provisions set forth eight health status-related factors. The interim regulations refer to these as “health factors.” The eight health factors are health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. These terms are largely overlapping and, in combination, include any factor related to an individual’s health.

Evidence of insurability. Several commenters urged that the health factor “evidence of insurability” be interpreted to prohibit plans and issuers from denying coverage to individuals who engage in certain types of activities. Commenters cited language in the conference report that states, “The inclusion of evidence of insurability in the definition of health status is intended to ensure, among other things, that individuals are not excluded from health care coverage due to their participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities.” H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 186 (1996). The interim regulations clarify that evidence of insurability includes participation in activities listed in the conference report. In addition, the interim regulations incorporate the statutory clarification that evidence of insurability includes conditions arising out of acts of domestic violence. See also the discussion below concerning source-of-injury restrictions

³ However, a State may impose the requirements of the HIPAA portability provisions, in whole or in part, on health insurance coverage sold to groups that contain fewer than 2 current employees on the first day of the plan year. See sections 2723 and 2791(e) of the PHS Act.

² See footnote 1.

under the heading “Application to Benefits.”

Late enrollees and special enrollees. Some commenters asked whether treating late enrollees differently from other enrollees is discrimination based on one or more health factors. HIPAA was designed to encourage individuals to enroll in health coverage when first eligible and to maintain coverage for as long as they continue to be eligible. Permitting plans and issuers to treat late enrollees less favorably than other enrollees is consistent with this objective. The interim regulations clarify that the decision whether to elect health coverage, including the time an individual chooses to enroll, such as late enrollment, is not itself within the scope of any health factor. Thus, the interim regulations permit plans and issuers to treat late enrollees differently from similarly situated individuals who enroll when first eligible.

Although the HIPAA nondiscrimination requirements do not prohibit different treatment of special enrollees, any differential treatment would violate the HIPAA special enrollment requirements. These interim regulations provide a cross-reference to the HIPAA regulations requiring special enrollees to be treated the same as individuals who enroll when first eligible.

Prohibited Discrimination in Rules for Eligibility

These interim regulations provide that group health plans and group health insurance issuers generally may not establish any rule for eligibility of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. Under these interim regulations, rules for eligibility include, but are not limited to, rules relating to enrollment, the effective date of coverage, waiting (or affiliation) periods, late and special enrollment, eligibility for benefit packages (including rules for individuals to change their selection among benefit packages), benefits (as described below under the heading “Application to Benefits”), continued eligibility, and terminating coverage of any individual under the plan.

The rules for eligibility apply in tandem with the rules describing similarly situat-

ed individuals (described below under the heading “Similarly Situated Individuals”) to prevent discrimination in eligibility based on any health factor. Thus, while it is permissible for a plan or issuer to impose waiting periods of different lengths on different groups of similarly situated individuals, a plan or issuer would violate the interim regulations if it imposed a longer waiting period for individuals within the same group of similarly situated individuals based on the higher claims of those individuals (or based on any other adverse health factor of those individuals).

While the interim regulations clarify that late enrollment itself is not within the scope of any health factor, eligibility for late enrollment comes within the scope of rules for eligibility under which discrimination based on one or more health factors is prohibited. The effect of these rules is to permit plans or issuers to treat late enrollees differently from individuals who enroll when first eligible but to prohibit plans and issuers from distinguishing among applicants for late enrollment based on any health factor of the applicant. Thus, a plan could impose an 18-month preexisting condition exclusion on late enrollees while imposing no preexisting condition exclusion on individuals who enroll in the plan when first eligible, but a plan would violate the interim regulations if it conditioned the ability to enroll as a late enrollee on the passing of a physical examination (or on any other health factor of the individual, such as having incurred health claims during a past period below a certain dollar amount).

Application to Benefits

General rules. The extent to which the statutory language prohibits discrimination against individuals in eligibility for particular benefits is subject to a wide range of interpretations. At one extreme, the language could be interpreted as applying only to enrollment and to premiums. Under this interpretation, for example, it would be possible for a plan or issuer to impose a \$100 lifetime limit on a particular individual with a history of high health claims (provided that the individual is permitted to enroll in the plan and is charged the same premium as similarly situated individuals), while imposing a \$1

million lifetime limit on all other participants in the plan.

At the other extreme, the statutory language could be interpreted to mandate parity in health benefits. This interpretation would prevent plans and issuers from designing benefit packages that control costs and are responsive to employees’ preferences for balancing additional benefits with additional costs.

In the preamble to the April 1997 interim rules, the Departments specifically invited comments on whether guidance was needed concerning this issue. The comments received ranged between these two extremes. The approach in these interim regulations takes into account the concerns expressed by commenters, as well as the conference report. Specifically, the conference report states that:

It is the intent of the conferees that a plan cannot knowingly be designed to exclude individuals and their dependents on the basis of health status. However, generally applicable terms of the plan may have a disparate impact on individual enrollees. For example, a plan may exclude all coverage of a specific condition, or may include a lifetime cap on all benefits, or a lifetime cap on specific benefits. Although individuals with the specific condition would be adversely affected by an exclusion of coverage for that condition . . . such plan characteristics would be permitted as long as they are not directed at individual sick employees or dependents.

H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 186 – 187 (1996).

The interim regulations clarify that they do not require a plan or issuer to provide coverage for any particular benefit to any group of similarly situated individuals. However, benefits provided under a plan or group health insurance coverage must be uniformly available to all similarly situated individuals. Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan or issuer may limit or exclude benefits in relation to a specific

disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan or issuer may impose annual, lifetime, or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.⁴ These interim regulations clarify that whether any plan provision with respect to benefits complies with the interim regulations does not affect whether the provision is permitted under the Americans with Disabilities Act (ADA), or any other law, whether State or federal.⁵

Accordingly, for example, a group health plan may apply a lifetime limit on all benefits provided to each participant covered under the plan. While this limitation on all benefits may adversely impact individuals with serious medical conditions, the limitation is permitted provided that it applies to all similarly situated individuals and is not directed at individual participants or beneficiaries. Similarly, a plan or issuer may establish a specific lifetime limit on the treatment of a particular condition (such as the treatment of temporomandibular joint syndrome (TMJ)) for all similarly situated individuals in the plan. Although individuals with TMJ may be adversely affected by this limitation, because benefits for the treat-

ment of TMJ are available uniformly to all similarly situated individuals and because the limit on benefits for TMJ applies to all similarly situated individuals, the limit is permissible.

Under these interim regulations, plans and issuers therefore have significant flexibility in designing benefits. However, to prevent plans and issuers from restricting benefits based on a specific health factor of an individual under the plan, the interim regulations prohibit benefit restrictions, even if applied uniformly to all similarly situated individuals, from being directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. The interim regulations clarify that a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at individual participants and beneficiaries. This exception to the general facts and circumstances determination that a change is directed at an individual is necessary to preserve the flexibility of small employers that might otherwise be disproportionately affected and prevented from adopting changes in benefit design. If small employers are unable to modify future benefits to keep health coverage affordable, their alternative may be to eliminate health coverage entirely. At the same time, the exception reflects the common practice of modifying the terms of a plan on an annual basis. Finally, changes in benefit design that are effective earlier than the first day of the next plan year remain subject to a facts and circumstances determination regarding whether the change is directed at individual participants and beneficiaries.

An example illustrates that if an individual files a claim for the treatment of a condition, and shortly thereafter the plan is modified to restrict benefits for the treatment of the condition, effective before the beginning of the next plan year, the restriction would be directed at the individual based on a health factor (absent additional facts to indicate that the change was made independent of the claim) and the plan would violate these interim regulations.

Source-of-injury restrictions. While a person cannot be excluded from a plan for

engaging in certain recreational activities (see previous discussion on evidence of insurability under the heading “Health Factors”), benefits for a particular injury can, in some cases, be excluded based on the source of an injury. These plan restrictions are known as source-of-injury restrictions.⁶ Under these interim regulations, if a plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not use a source-of-injury restriction to deny benefits otherwise provided for treatment of the injury if it results from an act of domestic violence or a medical condition (including both physical and mental health conditions). An example in the interim regulations clarifies that benefits for injuries generally covered under the plan cannot be excluded merely because they were self-inflicted or were sustained in connection with a suicide or attempted suicide if the injuries resulted from a medical condition such as depression. Another example illustrates that a plan can nonetheless exclude benefits for injuries because they were sustained in connection with various recreational activities if the accident did not result from any medical condition (or from domestic violence).

The Relationship Between the HIPAA Nondiscrimination Provisions and the HIPAA Preexisting Condition Exclusion Provisions

Restrictions on benefits based on the fact that a medical condition was present before the first day of coverage discriminate against individuals based on one or more health factors. The statute nonetheless provides that the nondiscrimination provisions are intended to be construed in a manner consistent with the HIPAA provisions specifically allowing the application of preexisting condition exclusions. These latter provisions restrict the ability of a group health plan or group health insurance issuer to apply preexisting condition exclusions, both by restricting the

⁴ For special rules that apply to cost-sharing mechanisms that are part of a bona fide wellness program, see the proposed regulations relating to bona fide wellness programs published elsewhere in this issue of the Bulletin.

⁵ In this regard, the Equal Employment Opportunity Commission has commented, by letter of July 7, 1997, “Title I of the ADA prohibits disability-based employment discrimination, including discrimination in fringe benefits such as health insurance plans.”

⁶ A commenter pointed out that this type of restriction is distinct from two other restrictions sometimes referred to as “source-of-injury restrictions” — (1) those based on the geographic location where the injury occurred, and (2) those based on when the injury occurred and whether other coverage was in effect.

circumstances under which an individual's condition is considered preexisting and by limiting the length of the exclusion period. The interim regulations clarify that a preexisting condition exclusion that satisfies the requirements of the HIPAA preexisting condition exclusion provisions is permitted under the HIPAA nondiscrimination requirements if the exclusion applies uniformly to individuals within the same group of similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. A plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at individual participants or beneficiaries.

The examples illustrate that a typical preexisting condition exclusion permitted under the HIPAA preexisting condition exclusion requirements does not violate the HIPAA nondiscrimination requirements even though the exclusion inherently discriminates based on one or more health factors. The examples also illustrate that a plan nonetheless must apply the preexisting condition exclusion to similarly situated individuals in a uniform manner and cannot apply a longer preexisting condition exclusion period based on the submission of claims during the first part of the exclusion period.

Prohibited Discrimination in Premiums or Contributions

Under the interim regulations, a group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan or group health insurance coverage, based on any health factor that relates to that individual or a dependent of that individual. Under the interim regulations, when determining an individual's premium or contribution rate, dis-

counts, rebates, payments in kind, or other premium differential mechanisms are taken into account.⁷

In general, the interim regulations do not restrict the amount that an employer may be quoted or charged by an issuer (or, in the case of a multiemployer plan, by the plan) for coverage of a group of similarly situated individuals. However, the interim regulations prohibit certain billing practices because in many instances they could directly or indirectly result in an individual's being charged more than a similarly situated individual based on a health factor.

Some health insurance issuers that offer health insurance coverage in connection with a group health plan use billing practices with separate individual rates that vary based, in part, on the health factors of the individuals who are eligible to participate in the plan. This practice is generally known as list billing. List billing based on a health factor is prohibited under the interim regulations.

The HIPAA nondiscrimination requirements do not prohibit an issuer from considering all relevant health factors of individuals in order to establish aggregate rates for coverage provided under the group health plan. However, an individual may not be required to pay a higher premium based on any health factor of the individual. Under the interim regulations, an issuer (or a multiemployer plan) may not quote or charge an employer different premium rates on an individual-by-individual basis in a group of similarly situated individuals based on any health factor of the individuals, even if the employer does not pass the different rates through to the individuals. If an issuer wishes to increase rates to cover the additional exposure to expenses that may result from an individual's health factor, the issuer must blend the increase into an overall group rate and then quote or charge a higher per-participant rate. Nonetheless, the prohibition on the practice of list billing based on a health factor does not

⁷ However, a group health plan or a health insurance issuer offering group health insurance coverage may establish premium or contribution differentials through a bona fide wellness program. (See proposed regulations relating to bona fide wellness programs published elsewhere in this issue of the Bulletin.)

restrict communications between issuers and plans regarding rate calculations.

Similarly Situated Individuals

The statutory HIPAA nondiscrimination requirements clarify that the general rule prohibiting discrimination in eligibility does not prevent a group health plan or group health insurance coverage from establishing limitations or restrictions on the amount, level, extent, or nature of benefits for "similarly situated individuals" enrolled in the plan or coverage. The statutory rule prohibiting discrimination in charging individuals premiums or contributions prohibits a plan or issuer from requiring any individual, based on any health factor of that individual or a dependent of that individual, to pay a premium or contribution that is greater than the premium or contribution required of a "similarly situated individual." In the preamble to the April 1997 interim rules, the Departments requested comments both on the permissible standards for defining groups of similarly situated individuals and on the application of the prohibitions on discrimination between groups of similarly situated individuals.

Many commenters suggested that discrimination between groups of similarly situated individuals should be permitted, with the caveat that it should not be permissible to define a group based on a health factor. These interim regulations provide that the nondiscrimination rules apply only within a group of similarly situated individuals. Thus, these interim regulations do not prohibit discrimination between or among groups of similarly situated individuals. However, these interim regulations also provide that if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted. This is intended to be a broad anti-abuse standard that applies based on the relevant facts and circumstances of each case.

The permissibility of discrimination between or among groups of similarly situated individuals increases the possibility of abuse in establishing groups of similarly situated individuals. Most commenters addressing this issue focused on the clas-

sification of participants and suggested that classifications should be based on work activities and not on a health factor or on activities unrelated to employment. The interim regulations provide generally that participants may be treated as two or more groups of similarly situated individuals if the distinction between or among the groups is based on a bona fide employment-based classification consistent with the employer's usual business practice. The validity of a category as a bona fide employment-based classification is determined based on all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to the anti-abuse standard (described in the preceding paragraph), the interim regulations allow distinctions to be made based on full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations.

Some commenters expressed concern that allowing similarly situated individuals to be determined based on occupation or geographic location would allow plans and issuers to create artificial classifications, ostensibly based on occupation or geographic location, that are actually designed to discriminate based on a health factor of an individual or individuals. These interim regulations permit bona fide classifications based on occupation or geographic location. In this connection, commenters had two principal concerns. First, there was a concern about reclassifications targeting unhealthy individuals. For example, a participant receiving expensive medical treatment might be reclassified to a separate employment category either with reduced health benefits or none at all. The broad anti-abuse standard of these interim regulations is intended, among other things, to prohibit reclassifications directed at individuals such as this.

A second concern that commenters had was that plans and issuers might design health benefits differently for employees in different occupations or geographic

locations based, at least in part, on the health factors of these groups of individuals. One example is a plan that offers fewer benefits to employees in one occupation than to employees in another occupation at least in part because of the higher average historical claims of the employees in the first occupation. A second example is a plan that charges employees in one area more than employees in another area at least in part because the cost of medical care is generally higher in the first area. The statute and legislative history appear to allow this practice, and thus these interim regulations do not prohibit the provision of different health benefits for employees in different occupations or geographic locations, based at least in part on the health factors of the group as a whole, if the classifications are not directed at individual participants or beneficiaries based on a health factor of the participants or beneficiaries.

These interim regulations also permit plans and issuers, in certain circumstances, to treat beneficiaries as different groups of similarly situated individuals. Beneficiaries may be treated as a group of similarly situated individuals separate from participants, and different treatment is permitted among beneficiaries based on bona fide employment-based classifications of the participants through whom the beneficiaries are receiving coverage. Thus, if the plan provides different benefits to full-time employees than to part-time employees, then it may also provide different benefits to dependents of full-time employees than to dependents of part-time employees. Similarly, different treatment is permitted based on the beneficiary's relationship to the participant (for example, as a spouse or as a dependent child). Different treatment is also permitted based on the beneficiary's marital status, based on a dependent child's age or student status, or based on any other factor if the factor is not a health factor.

The rules in these interim regulations allowing the different treatment of individuals in different groups of similarly situated individuals are distinct from rules requiring that qualified beneficiaries under a COBRA continuation provision⁸

⁸ The term *COBRA continuation provision* is defined in 26 CFR 54.9801-2T, 29 CFR 2590.701-2, and 45 CFR 144.103.

have available the same coverage as similarly situated non-COBRA beneficiaries. Although these interim regulations would not prohibit making benefit packages available to non-COBRA beneficiaries (such as current employees) that are not made available to COBRA qualified beneficiaries (such as former employees), the COBRA continuation provisions prohibit such a difference.

Finally, all of the requirements relating to determining groups of similarly situated individuals are subject to other rules in these interim regulations permitting favorable treatment of individuals with certain adverse health factors (discussed below under the heading "More Favorable Treatment of Individuals with Adverse Health Factors Permitted").

Nonconfinement Provisions

Some group health plans and health insurance issuers refuse to provide benefits to an individual based on the individual's confinement to a hospital or other health care institution at the time coverage otherwise would become effective. Plan provisions like these are often called "nonconfinement clauses." Any reasonable interpretation or application of the statutory HIPAA nondiscrimination provisions prohibits a plan or issuer from imposing a nonconfinement clause.⁹ Thus, a plan or issuer may not deny the eligibility of any individual to enroll for benefits or charge any individual a higher premium (or contribution) because the individual, or a dependent of the individual, is confined to a hospital or other health care institution. In addition, some plans and issuers refuse to provide benefits to an individual based on an individual's inability to engage in normal life activities. A plan or issuer generally may not deny the eligibility of any individual to enroll for benefits or charge any individual a higher premium (or contribution) based on any individual's ability to engage in normal life activities. However,

⁹ For an example illustrating that the imposition of a nonconfinement clause is not a good faith interpretation of the HIPAA nondiscrimination provisions, and the rule requiring that individuals denied enrollment without a good faith interpretation of the law be provided an opportunity to enroll, see the discussion below under the heading "Transitional Rule for Individuals Previously Denied Coverage Based on a Health Factor."

these interim regulations provide an exception that permits plans and issuers to distinguish among employees based on the performance of services. Although in practice nonconfinement clauses generally apply only to dependents, in some cases they apply also to employees. Thus, the interim regulations clarify that a nonconfinement clause would also be impermissible if applied to an employee.

These rules are of particular interest in the case of a group health plan switching coverage from one health insurance issuer to a succeeding health insurance issuer. In such a case, the HIPAA nondiscrimination provisions prohibit the succeeding issuer from denying eligibility to any individual due to confinement to a hospital or other health care institution because such a denial would discriminate in eligibility based on one or more health factors. The obligation of the succeeding issuer to provide coverage to such an individual does not preempt any obligation that the prior issuer may have under other applicable law, including State extension of benefits laws.

Actively-At-Work and Other Service Requirements

Some group health plans and health insurance issuers refuse to provide benefits to an individual if the individual is not actively at work on the day the individual would otherwise become eligible for benefits. Plan provisions like these are often called “actively-at-work clauses.” These interim regulations provide that a plan or issuer generally may not impose an “actively-at-work clause.” That is, these interim regulations prohibit a plan or issuer from denying the eligibility of any individual to enroll for benefits or charging any individual a higher premium or contribution based on whether an individual is actively at work (including whether an individual is continuously employed). However, an actively-at-work clause is permitted if individuals who are absent from work due to any health factor (for example, individuals taking sick leave) are treated, for purposes of health coverage, as if they are actively at work. Accordingly, plan provisions that delay enrollment until an individual is actively at work on a day following a waiting period (or for a continuous period) are prohibited unless absence from work due to

any health factor is considered being actively at work.

These interim regulations also provide an exception for the first day of work to the general prohibition against actively-at-work clauses. Under the exception, a plan or issuer may require an individual to begin work before coverage may become effective.

The interim regulations explain the relationship between the rules governing actively-at-work clauses and the rules describing similarly situated individuals. Under the interim regulations, a plan or issuer is generally permitted to distinguish between groups of similarly situated individuals (provided the distinction is not directed at individual participants or beneficiaries based on a health factor). Examples illustrate that a plan or issuer may condition coverage on an individual’s meeting the plan’s requirement of working full-time (such as a minimum of 250 hours in a three-month period or 30 hours per week). In addition, a plan or issuer may terminate coverage for former employees while providing coverage to current employees without violating the HIPAA nondiscrimination provisions if the rules describing similarly situated individuals are satisfied, even if the former employee is unable to work due to a health factor. Similarly, a plan or issuer may charge a higher premium to employees no longer performing services than to employees currently performing services without violating the HIPAA nondiscrimination provisions if the rules describing similarly situated individuals are met. An example illustrates that the interim regulations would not, however, permit a plan or issuer to treat individuals on annual or bereavement leave better than individuals on sick leave because groups of similarly situated individuals cannot be established based on any health factor (including the taking of sick leave).

In any case, other federal or State laws, including the COBRA continuation provisions and the Family and Medical Leave Act of 1993 (FMLA), may require individuals to be offered coverage and set limits on the premium or contribution rate.

Bona Fide Wellness Programs

The HIPAA nondiscrimination provisions do not prevent a plan or issuer from establishing premium discounts or rebates

or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. Thus, there is an exception to the general rule prohibiting discrimination based on a health factor if the reward, such as a premium discount or waiver of a cost-sharing requirement, is based on participation in a program of health promotion or disease prevention. The April 1997 interim rules, these interim regulations, and proposed regulations published elsewhere in this issue of the **Bulletin** refer to programs of health promotion and disease prevention allowed under this exception as “bona fide wellness programs.” For a discussion of bona fide wellness programs, see the preamble to proposed regulations published elsewhere in this issue of the **Bulletin**.

More Favorable Treatment of Individuals with Adverse Health Factors Permitted

Many group health plans make certain periods of extended coverage available to employees no longer performing services only if the employee is unable to work due to disability, and many plans make coverage available to dependent children past a certain age only if the child is disabled. Some plans waive or reduce the required employee contribution for coverage if the employee or a member of the employee’s immediate family is in a critical medical condition for a prolonged period. Disability and medical condition are listed in the statute as health factors, and several commenters recognized that, under one possible interpretation of the HIPAA nondiscrimination requirements, plan provisions or practices such as these would be impermissible. These commenters asked for guidance clarifying that plan provisions and practices like these would be permissible. Other commenters cited the rule under the COBRA continuation provisions permitting plans to require payment of a higher amount during the disability extension than during other periods of COBRA coverage and asked whether following this COBRA rule is permissible under the HIPAA nondiscrimination requirements.

Eligibility. These interim regulations permit plans and issuers to establish rules for eligibility favoring individuals based on an adverse health factor, such as dis-

ability. Thus, a plan or issuer does not violate the HIPAA nondiscrimination requirements by making extended coverage available to employees no longer providing services only if the employee is unable to work due to disability nor by making coverage available to dependent children past a certain age only if the child is disabled. Examples clarify this rule.

Premiums. These interim regulations also address the circumstances under which differential premiums (or contributions) may be charged to an individual based on an adverse health factor. These interim regulations permit plans and issuers to charge a higher rate in some situations and also a lower rate to individuals based on an adverse health factor, such as disability. A higher rate may be charged only in situations where the individual with the adverse health factor would not have coverage were it not for the adverse health factor. Thus, in a case where a plan or issuer makes extended coverage available to employees no longer performing services only if the employee is unable to work due to disability, the plan could require a higher payment from the employee only while the employee is receiving coverage under that special eligibility provision. However, the plan could not charge a disabled employee a higher rate than nondisabled employees while the disabled employee was still eligible under a generally-applicable eligibility provision, rather than the special extended coverage provision. Accordingly, under the interim regulations, a plan or issuer could charge a higher rate for COBRA coverage during the disability extension than for COBRA coverage outside the disability extension (and the result is the same if the extended coverage for disability is provided pursuant to State law or plan provision rather than pursuant to a COBRA continuation provision).¹⁰

Although charging a higher rate based on an adverse health factor is limited to the situation in which coverage would not be available but for the adverse health fac-

tor, under these interim regulations a plan or issuer is always permitted to charge an individual a lower rate based on an adverse health factor. Thus, even though an employee is receiving coverage under the same eligibility provision as other employees who are required to pay the full employee share of the premium, under the interim regulations it is permissible to waive or reduce the employee share of the premium if the employee or a family member is in critical medical condition for a prolonged period.

No Effect on Other Laws

Compliance with these interim regulations is not determinative of compliance with any other provision of ERISA, or any other State or federal law, including the Americans with Disabilities Act. Therefore, while these interim regulations generally do not impose any new disclosure requirements on plans or issuers, other applicable law continues to apply. For example, under Title I of ERISA, administrators of ERISA-covered group health plans are required to provide participants and beneficiaries with a summary plan description that is sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.¹¹ In addition, some courts have held that fiduciaries of ERISA-covered group health plans are obligated to ensure that plan documents and disclosures are consistent with applicable disclosure requirements and do not serve to mislead or misinform participants and beneficiaries concerning their rights and obligations under the plans in which they participate.¹² Fiduciaries are advised to take steps to ensure that plan disclosures are accurate and are not misleading.

These interim regulations are also not determinative of compliance with the COBRA continuation provisions, or any other State or federal law, such as the Americans with Disabilities Act.

Applicability Date

These interim regulations generally apply for plan years beginning on or after

July 1, 2001 (although some provisions apply earlier, as discussed below under the heading “III. Format of Regulations”). As noted above, in the preamble to the April 1997 interim rules the Departments stated that they intended to issue further regulations on the statutory nondiscrimination rules. That preamble also stated that in no event would the Departments take any enforcement action against a plan or issuer that had sought to comply in good faith with the statutory nondiscrimination provisions before the additional guidance was issued. The Departments will not take any enforcement action against a plan or issuer with respect to efforts to comply in good faith with the statutory nondiscrimination provisions before the first plan year beginning on or after July 1, 2001. (See the description of transitional rules immediately below regarding certain interpretations that are not good faith interpretations of the statutory nondiscrimination requirements.) Upon the applicability of these regulations, however, good faith efforts to comply with the statutory provisions addressed by these interim regulations may not be sufficient to avoid adverse enforcement actions by the Departments. Therefore, for plan years beginning on or after July 1, 2001, plans and issuers must comply with the requirements of these regulations in order to avoid adverse enforcement actions. As discussed earlier, under the heading “Background,” the period for good faith compliance continues with respect to bona fide wellness programs until further guidance is issued.

Transitional Rules for Individuals Previously Denied Coverage Based on a Health Factor

The April 1997 interim rules clarified that a plan or issuer violates the HIPAA nondiscrimination requirements if it requires an individual to pass a physical examination as a condition for enrollment, even if the condition is imposed only on late enrollees. The HIPAA nondiscrimination requirements apply both to eligibility and continued eligibility of any individual to enroll under a plan. Consequently, once HIPAA became effective with respect to a plan or health insurance issuer, it was a violation of the nondiscrimination requirements to continue to deny an individual eligibility to

¹⁰ This result is consistent with the result under the COBRA continuation provisions. Under those provisions, plans are generally permitted to require payment of up to 102 percent of the applicable premium but are permitted to require payment for coverage of a disabled qualified beneficiary of up to 150 percent of the applicable premium during the disability extension period.

¹¹ See ERISA section 102, and the Department of Labor’s regulations issued thereunder.

¹² See *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996).

enroll if the reason the individual was denied enrollment previously was due to one or more health factors (such as requiring the individual to pass a physical examination).

On December 29, 1997, the Departments issued in the **Federal Register** a clarification of the April 1997 interim rules relating to individuals who were denied coverage due to a health factor before the effective date of HIPAA (62 F.R. 67689). The clarification restates the requirement of the April 1997 interim rules that an individual cannot be denied coverage based on a health factor on or after the effective date of HIPAA. The clarification then states that individuals to whom coverage had not been made available before the effective date of HIPAA based on a health factor and who enrolled when first eligible on or after the effective date of the HIPAA nondiscrimination provisions could not be treated as a late enrollee for purposes of the HIPAA preexisting condition exclusion provisions. Under the clarification, individuals to whom coverage had not been made available include any individual who did not apply for coverage because it was reasonable to believe that the application would have been futile. The rules in the clarification apply whether or not the plan offered late enrollment.

Neither the April 1997 interim rules nor the December 1997 guidance clearly addressed the situation where an individual was denied only late enrollment based on a health factor prior to the effective date of HIPAA and, by the effective date of HIPAA, the plan eliminated late enrollment. For example, prior to HIPAA many plans and issuers allowed individuals to enroll when first eligible without regard to health status, but allowed late enrollees to enroll only if they could pass a physical examination (or present evidence of good health). Upon the effective date of HIPAA, some of these plans and issuers eliminated late enrollment.

Any plan or issuer that permitted these individuals to enroll once the HIPAA nondiscrimination provisions took effect, of course, is in compliance with this provision of the nondiscrimination rules. In contrast, a plan or issuer that continued to deny coverage to these individuals may have done so based on a good faith interpretation of the statute and the

Departments' published guidance. For example, a plan or issuer might reasonably have thought that HIPAA did not require it to remedy pre-HIPAA denials of late enrollment based on a health factor for individuals who could have enrolled initially without regard to their health if the plan or issuer eliminated late enrollment by the effective date of HIPAA.

The interim regulations provide transitional rules for situations where coverage was denied to individuals based on one or more health factors, both where the denial was based on a good faith interpretation of the statute or the Departments' published guidance and where it was not. In either event, a safe harbor provides that the Departments will not take any enforcement action with respect to such a denial of coverage if the plan or issuer complies with the transitional rules.

Where the denial was not based on a good faith interpretation, the interim regulations provide that the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than March 9, 2001. If the opportunity is presented within the first plan year beginning on or after the effective date of the statutory HIPAA nondiscrimination rules, the enrollment must be effective within that plan year. If this enrollment opportunity is presented after such plan year, the individual must be given an option to have coverage effective either (1) prospectively from the date the plan receives a request for enrollment in connection with the enrollment opportunity or (2) retroactively to the first day of the first plan year beginning on HIPAA's effective date for the plan (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan).

The reason for giving the individual the opportunity to elect retroactive coverage is to make the individual whole; that is, to put the individual in the same financial condition that the individual would have been in had the individual not been denied enrollment. Thus, if the individual elects retroactive coverage, the plan or issuer may require the individual to pay premiums or contributions for the retroactive

period (but the plan or issuer cannot charge interest on that amount).

The rule differs for situations where coverage was denied to individuals based on one or more health factors but where the denial was based on a good faith interpretation of the statute or the Departments' prior published guidance. In those situations, these interim regulations require plans and issuers to give the individuals an opportunity to enroll that continues for at least 30 days and with coverage effective not later than July 1, 2001.

In both situations (whether the denial of coverage was or was not based on a good faith interpretation), the interim regulations also clarify that, once enrolled, these individuals cannot be treated as late enrollees. The individual's enrollment date under the plan is the effective date of HIPAA (or, if later, the date the individual would have otherwise been eligible to enroll). In addition, any period between an individual's enrollment date and the effective date of coverage is treated as a waiting period. Thus, for example, with respect to a calendar year plan that is not collectively bargained, an individual who was previously denied late enrollment due to a health factor before the effective date of HIPAA has an enrollment date of January 1, 1998 (HIPAA's effective date for that plan) and a waiting period that begins on that date. Moreover, because any waiting period must begin on the individual's enrollment date, January 1, 1998, and the maximum preexisting exclusion period that can be applied is 12 months, individuals who enroll in the plan on July 1, 2001 cannot be subject to any preexisting condition exclusion period.

Special Transitional Rule for Self-Funded Non-Federal Governmental Plans Exempted under 45 CFR 146.180

The sponsor of a self-funded non-Federal governmental plan may elect under section 2721(b)(2) of the PHS Act and 45 CFR 146.180 to exempt its group health plan from the nondiscrimination requirements of section 2702 of the PHS Act and 45 CFR 146.121. If the plan sponsor subsequently chooses to bring the plan into compliance with these nondiscrimination requirements, the plan must provide notice to that effect to individuals who were denied enrollment based on one or more health factors, and afford those

individuals an opportunity, that continues for at least 30 days, to enroll in the plan. (An individual is considered to have been denied coverage if he or she failed to apply for coverage because, given an exemption election under 45 CFR 146.180, it was reasonable to believe that an application for coverage would have been denied based on a health factor.) The notice must specify the effective date of compliance, and inform the individual regarding any enrollment restrictions that may apply under the terms of the plan once the plan comes into compliance. The plan may not treat the individual as a late enrollee or a special enrollee. Coverage must be effective no later than the date the exemption election under 45 CFR 146.180 (with regard to these nondiscrimination requirements) no

longer applies, or July 1, 2001 (if later) and the plan was acting in accordance with a good faith interpretation of the statutory HIPAA nondiscrimination provisions and guidance published by the Health Care Financing Administration.

III. Format of Regulations

Final and Temporary Treasury Regulations

The Department of the Treasury is issuing a portion of these regulations as final regulations and a portion as temporary and cross-referencing proposed regulations. The April 1997 interim rules were originally issued by Treasury in the form of temporary and cross-referencing proposed regulations. Under section 7805(e)(2) of the Code, however, any

temporary regulation issued under the Code expires within three years after the date issued. Treasury is issuing final regulations that restate the rules relating to the HIPAA nondiscrimination requirements from the April 1997 regulations without significant modification. The final regulations apply March 9, 2001. Table 1 identifies which paragraphs of the final regulation issued today correspond to which paragraphs of the April 1997 regulation. New guidance being published today by Treasury is being issued as temporary and cross-referencing proposed regulations. This guidance will apply to group health plans beginning with the first plan year on or after July 1, 2001. (These new temporary regulations will also expire after three years pursuant to section 7805(e) of the Code.)

Table 1
Comparison of Treasury's April 1997 Regulations with Treasury's Final Regulations

April 1997 Regulations	Final Regulation under §9802
§54.9802-1T(a)(1)	§54.9802-1(a)(1),(2); (b)(1)
§54.9802-1T(a)(2)(i)	§54.9802-1(b)(2)(i)(A)
§54.9802-1T(a)(3)	[The corresponding provision is in the new temporary regulations.]
§54.9802-1T(a)(4)	§54.9802-1(b)(1)(iii)
§54.9802-1T(b)(1)	§54.9802-1(c)(1)(i)
§54.9802-1T(b)(2)(i)	§54.9802-1(c)(2)(i)
§54.9802-1T(b)(2)(ii)	§54.9802-1(b)(2)(i); (c)(3)
§54.9802-1T(b)(3)	[The corresponding provision is in the new proposed regulations for wellness programs.]

Interim Final Labor and HHS Regulations

The guidance issued by the Departments of Labor (Labor) and Health and Human Services (HHS) in April 1997

is not subject to a statutory expiration date. Accordingly, the Labor and HHS guidance is being published as interim final regulations. These regulations contain two applicability dates that parallel the two separate applicability dates in the

Treasury guidance. Table 2 identifies which paragraphs of the interim final regulation issued today are applicable on March 9, 2001 and which paragraphs take effect on or after July 1, 2001.

Table 2
Applicability Dates for the Interim Final Regulations

Subject	Paragraph of the Interim Final Regulations	Applies March 9, 2001	Applies plan years beginning on or after 7/1/2001
Health factors	(a)(1)	✓	
<i>Health factors - Evidence of insurability - Conditions arising out of an act of domestic violence</i>	(a)(2)(i)	✓	

Subject	Paragraph of the Interim Final Regulations	Applies March 9, 2001	Applies plan years beginning on or after 7/1/2001
<i>Health factors - Evidence of insurability - Participation in certain activities</i>	(a)(2)(ii)		✓
<i>Health factors - The decision whether health coverage is elected</i>	(a)(3)		✓
<i>Prohibited discrimination in rules for eligibility - General rule</i>	(b)(1)(i)	✓	
<i>Prohibited discrimination in rules for eligibility - Rules for eligibility described</i>	(b)(1)(ii)		✓
<i>Prohibited discrimination in eligibility - General rule - Example 1</i>	(b)(1)(iii) Example 1	✓	
<i>Prohibited discrimination in eligibility - General rule - Examples 2 through 4</i>	(b)(1)(iii) Examples 2 through 4		✓
<i>Prohibited discrimination in eligibility - Application to benefits - No benefits mandated</i>	(b)(2)(i)(A)	✓	
<i>Prohibited discrimination in eligibility - Application to benefits - Nondiscriminatory benefit restrictions permitted</i>	(b)(2)(i)(B), (C), & (D)		✓
<i>Prohibited discrimination in eligibility - Application to benefits - Certain cost-sharing mechanisms</i>	(b)(2)(ii)	✓	
<i>Prohibited discrimination in eligibility - Application to benefits - Source-of-injury exclusions</i>	(b)(2)(iii)		✓
<i>Prohibited discrimination in eligibility - Application to benefits - Relationship to HIPAA preexisting condition exclusion rules</i>	(b)(3)		✓
<i>Prohibited discrimination in premiums or contributions - General rule</i>	(c)(1)(i)	✓	
<i>Prohibited discrimination in premiums or contributions - Determining an individual's premium rate</i>	(c)(1)(ii)		✓
<i>Prohibited discrimination in premiums or contributions - Group rating on health factors not restricted</i>	(c)(2)(i)	✓	
<i>Prohibited discrimination in premiums or contributions - List billing based on a health factor prohibited</i>	(c)(2)(ii) & (iii)		✓
<i>Prohibited discrimination in premiums or contributions - Exception for bona fide wellness programs</i>	(c)(3)	✓	
Similarly situated individuals	(d)		✓
Nonconfinement and actively-at-work provisions	(e)		✓
Bona fide wellness programs	(f) [Reserved.]		See proposed regulations published elsewhere in this Bulletin.

Subject	Paragraph of the Interim Final Regulations	Applies March 9, 2001	Applies plan years beginning on or after 7/1/2001
More favorable treatment of individuals with adverse health factors permitted	(g)		✓
No effect on other laws	(h)		✓

IV. Interim Final Regulations with Request for Comments

The principal purpose of these interim final regulations is to provide additional guidance on how to comply with the HIPAA nondiscrimination provisions contained in section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act. Code section 9833, ERISA section 734, and PHS Act section 2792 authorize the Secretaries of the Treasury, Labor, and HHS to issue any interim final rules as the Secretaries deem are appropriate to carry out certain provisions of HIPAA, including the nondiscrimination provisions. As explained below, the Secretaries have determined that these regulations should be issued as interim final rules with requests for comments.

HIPAA was enacted in August of 1996. The Secretaries first issued interim final rules providing guidance on HIPAA's nondiscrimination provisions in April of 1997. In publishing this guidance, the Secretaries relied on the authority granted in section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act, as well as other authority including section 101(g)(4) of HIPAA and section 505 of ERISA. As part of the April 1997 rulemaking, the Secretaries requested comments on whether additional guidance was needed concerning the extent to which the statutory HIPAA nondiscrimination provisions prohibit discrimination against individuals in eligibility for particular benefits; the extent to which the statute may permit benefit limitations based on the source of an injury; the permissible standards for defining groups of similarly situated individuals; the application of the prohibitions on discrimination between groups of similarly situated individuals; and the permissible standards for determining bona fide wellness programs. Numerous comments were received in response to this request.

After evaluating all of the comments, and after speaking with various interest-

ed parties in the course of an extensive educational outreach campaign, the Departments have developed these comprehensive regulations. Among other things, the comments reflected the need for more comprehensive guidance on the application of the nondiscrimination provisions. In the period since HIPAA was enacted and the April 1997 regulations were issued, numerous issues have arisen concerning how plans and issuers should apply the nondiscrimination provisions. In addition, the number of comments and the breadth of issues raised demonstrates that these regulations should go into effect on an interim basis pending receipt of further comments. This need to act on an interim basis is also supported by the General Accounting Office's request that the Departments "promptly complete regulations related to HIPAA's non-discrimination provisions" (GAO/HEHS 00-85). Therefore, the Departments have determined that it is appropriate to issue the guidance on an interim final basis, with the exception of the bona fide wellness program provisions.¹³ With respect to these last provisions, the Departments would like to better develop the administrative record before any provisions regarding such programs go into effect.

The Secretaries believe that this period of interim effectiveness will provide ample opportunity for the regulated community to comment specifically on this comprehensive guidance, providing a sound basis for developing final rules. The Departments are seeking comments from all those affected by these regulations, and the Departments will consider such comments and will reevaluate these regulations following the comment period in the same way that it would if the regulations had been published in proposed form. Based on such comments and other

¹³ See proposed rules relating to bona fide wellness programs published elsewhere in this issue of the Bulletin.

information obtained through the administration of the nondiscrimination requirements, the Departments will make any necessary modifications to the regulations when they are issued in final form.

V. Economic Impact and Paperwork Burden

Summary - Department of Labor and Department of Health and Human Services

HIPAA's nondiscrimination provisions generally prohibit group health plans and group health plan issuers from discriminating against individuals in eligibility or premium on the basis of health status factors. The Departments crafted this regulation to secure these protections as intended by Congress in as economically efficient a manner as possible, and believe that the economic benefits of the regulation outweigh its costs.

The primary economic benefits associated with securing HIPAA's nondiscrimination provisions derive from increased access to affordable group health plan coverage for individuals with health problems. Increased access benefits both newly covered individuals and society at large. It fosters expanded insurance coverage, timelier and fuller medical care, better health outcomes, and improved productivity and quality of life. This is especially true for the individuals most affected by HIPAA's nondiscrimination provisions — those with adverse health conditions. Denied insurance, individuals in poorer health are more likely to suffer economic hardship, to forgo badly needed care for financial reasons, and to suffer adverse health outcomes as a result. For them, gaining insurance is more likely to mean gaining economic security, receiving timely, quality care, and living healthier, more productive lives.

Additional economic benefits derive directly from the improved clarity provided by the regulation. The regulation will

reduce uncertainty and costly disputes and promote confidence in health benefits' value, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans.

The Departments estimate that the cost to plans to implement amendments in order to comply with this regulation, revise materials accordingly, and provide notices of opportunities to enroll as required by the regulation will amount to less than \$19 million. This is a one-time cost distinguishable from the transfer that will result from the self-implementing requirements of HIPAA's nondiscrimination provisions and the discretion exercised by the Departments in this regulation.

Such a transfer occurs when resources are redistributed without any direct change in aggregate social welfare. In this instance, the premium and claims cost incurred by group health plans to provide coverage under HIPAA's statutory nondiscrimination provisions to individuals previously denied coverage or offered restricted coverage based on health factors are offset by the commensurate or greater benefits realized by the newly eligible participants on whose behalf the premiums or claims are paid. Although the Departments are not aware of any published estimates of transfers attributable to HIPAA's statutory nondiscrimination provisions, a rough attempt to gauge the order of magnitude of this transfer suggests that it may amount to more than \$400 million annually, which is a small fraction of 1 percent of total expenditures by group plans. The regulation clarifies at the margin exactly what practices are permitted or prohibited by these provisions, and may have the effect of slightly increasing the amount of this transfer.

Executive Order 12866 - Department of Labor and Department of Health and Human Services

Under Executive Order 12866, the Departments must determine whether a regulatory action is "significant" and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a "significant regulatory action" as an action that is likely to result in a rule (1) having an annual effect on the econo-

my of \$100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, it has been determined that this action raises novel policy issues arising out of legal mandates. In addition, the magnitude of the transfer that arises from the implementation of HIPAA's statutory nondiscrimination provisions is estimated to exceed \$100 million. Therefore, this notice is "significant" and subject to OMB review under Sections 3(f)(1) and 3(f)(4) of the Executive Order. Consistent with the Executive Order, the Departments have assessed the costs and benefits of this regulatory action. The Departments' assessment, and the analysis underlying that assessment, is detailed below. The Departments performed a comprehensive, unified analysis to estimate the costs and benefits attributable to the interim regulation for purposes of compliance with the Executive Order 12866, the Regulatory Flexibility Act, and the Paperwork Reduction Act.

1. Statement of Need for Proposed Action

These interim regulations are needed to clarify and interpret the HIPAA nondiscrimination provisions (prohibiting discrimination against individual participants and beneficiaries based on health status) under section 702 of the Employee Retirement Income Security Act of 1974 (ERISA), section 2702 of the Public Health Service Act, and section 9802 of the Internal Revenue Code of 1986. The provisions are needed to ensure that group health plans and group health insurers and issuers do not discriminate against individuals, participants, and beneficiaries based on any health factors with respect to

health care coverage and premiums. Additional guidance was required to explain the application of the statute to benefits, clarify the relationship between the HIPAA nondiscrimination provisions and the HIPAA preexisting condition exclusion limitations, explain the applications of these provisions to premiums, describe similarly situated individuals, explain the application of the provisions to actively-at-work and nonconfinement clauses, clarify that more favorable treatment of individuals with medical needs generally is permitted, and describe plans' and issuers' obligations with respect to plan amendments.

2. Costs and Benefits

The primary economic benefits associated with the HIPAA nondiscrimination provisions derive from increased access to affordable group health plan coverage for individuals with health problems. Expanding access benefits both newly covered individuals and society at large by fostering expanded insurance coverage, timelier and fuller medical care, better health outcomes, and improved productivity and quality of life. Additional economic benefits derive directly from the improved clarity provided by the regulation. By clarifying employees' rights and plan sponsors' obligations under HIPAA's nondiscrimination provisions, the regulation will reduce uncertainty and costly disputes and promote confidence in health benefits' value, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans.

The Departments estimate that the cost to plans to implement amendments in order to comply with this regulation, revise materials accordingly, and provide notices of opportunities to enroll as required by the regulation will amount to less than \$19 million. This is a one-time cost distinguishable from the transfer that will result from the self-implementing requirements of HIPAA's nondiscrimination provisions and the discretion exercised by the Departments in this regulation.

Such a transfer occurs when resources are redistributed without any direct change in aggregate social welfare. In this instance, the premium and claims cost incurred by group health plans to provide

coverage under HIPAA's statutory nondiscrimination provisions to individuals previously denied coverage or offered restricted coverage based on health factors are offset by the commensurate or greater benefits realized by the newly eligible participants on whose behalf the premiums or claims are paid. Although the Departments are not aware of any published estimates of transfers attributable to HIPAA's statutory nondiscrimination provisions, a rough attempt to gauge the order of magnitude of this transfer suggests that it may amount to more than \$400 million annually. The regulation clarifies at the margin exactly what practices are permitted or prohibited by these provisions, and may have the effect of slightly increasing the amount of this transfer. The Departments note that this transfer is the direct reflection of the intent and beneficial effect of HIPAA's nondiscrimination provisions: increasing access to affordable group health plan coverage for individuals with health problems. They also note that even the full transfer to plans attributable to HIPAA's statutory nondiscrimination provisions probably amounts to a small fraction of 1 percent of total expenditures by these plans.

The Departments believe that the benefits of the regulation outweigh its costs.

A fuller discussion of the Departments assessment of the costs and benefits of this regulation is provided below.

Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rule making describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small

businesses, organizations, and governmental jurisdictions.

Because these rules are being issued as interim final rules and not as a notice of proposed rule making, the RFA does not apply and the Departments are not required to either certify that the rule will not have a significant impact on a substantial number of small businesses or conduct a regulatory flexibility analysis. The Departments nonetheless crafted this regulation in careful consideration of its effects on small entities, and have conducted an analysis of the likely impact of the rules on small entities.

For purposes of this discussion, the Departments consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis of this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. The Departments believe that assessing the impact of this interim final rule on small plans is an appropriate substitute for evaluating the effect on small entities as that term is defined in the RFA.

Small plans in particular will benefit from the regulations' provisions that affirm and clarify the flexibility available to plans under HIPAA's nondiscrimination requirements. Consideration of small plans' needs and circumstances played an important part in the development these provisions. These provisions are discussed in more detail below.

The Departments estimate that plans with 100 or fewer participants will incur costs of \$4 million on aggregate to amend their provisions to comply with the regulation and revise their materials accordingly. These costs generally will fall directly to issuers who supply small group insurance products and stop-loss insurers who provide services to small self-insured plans, who will spread those costs across the much larger number of small plans that buy them. These same small plans will incur costs of \$10 million to prepare and distribute notices of enrollment opportunities as required by the regulation, the Departments estimate. The total economic cost to small plans to comply with this regulation is estimated to be \$14 million. This is a one-time cost distinguishable from the transfer that will result

from the self-implementing requirements of HIPAA's nondiscrimination provisions and the discretion exercised by the Departments in this regulation

Such a transfer occurs when resources are redistributed without any direct change in aggregate social welfare. In this instance, the premium and claims cost incurred by group health plans to provide coverage under HIPAA's statutory nondiscrimination provisions to individuals previously denied coverage or offered restricted coverage based on health factors are offset by the commensurate or greater benefits realized by the newly eligible participants on whose behalf the premiums or claims are paid. The Departments note that transfers to small plans attributable to HIPAA's statutory nondiscrimination provisions may amount to approximately \$110 million. The regulation clarifies at the margin exactly what practices are permitted or prohibited by these provisions, and may have the effect of slightly increasing the amount of this transfer. The Departments note that this transfer is the direct reflection of the intent and beneficial effect of HIPAA's nondiscrimination provisions: increasing access to affordable group health plan coverage for individuals with health problems. They also note that even the full transfer to small plans attributable to HIPAA's statutory nondiscrimination provisions amounts to a small fraction of total expenditures by these plans.

Paperwork Reduction Act - Department of Labor and Department of the Treasury

1. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA 95), 44 U.S.C. 3506(c)(2)(A). This helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed.

Currently, the Pension and Welfare Benefits Administration (PWBA) is soliciting comments concerning the proposed information collection request (ICR) included in the Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market.

The Department has submitted this ICR using emergency review procedures to the Office of Management and Budget (OMB) for its review and clearance in accordance with PRA 95. OMB approval has been requested by March 9, 2001. The Department and OMB are particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of the responses.

Comments on the collection of information should be sent to the Office of Information and Regulatory Affairs, **Office of Management and Budget**, Room 10235, New Executive Office Building, Washington, DC 20503; Attention: Desk Officer for the Pension and Welfare Benefits Administration. Although comments may be submitted through March 9, 2001, OMB requests that comments be received by February 7, 2001, to ensure their consideration in OMB's review of the request for emergency approval. All comments will be shared among the Departments.

Requests for copies of the ICR may be addressed to: Gerald B. Lindrew, Office of Policy and Research, U.S. Department

of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, NW, Room N-5647, Washington, D.C., 20210. Telephone: (202) 219-4782; Fax: (202) 219-4745 (these are not toll-free numbers).

2. Department of the Treasury

The collection of information is in 26 CFR 54.9802-1T(i)(3)(ii) and (iii). This information is required to be provided so that participants who have been denied group health plan coverage based on a health status factor may be made aware of the opportunity to enroll in the plan. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are mandatory for affected group health plans.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC, 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, W:CAR:MP:FP:S:O, Washington, DC 20224. Comments on the collection of information should be received by February 7, 2001. In light of the request for OMB clearance by March 9, 2001, the early submission of comments is encouraged to ensure their consideration. Comments are specifically requested concerning:

- Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;
- How to enhance the quality, utility, and clarity of the information to be collected;
- How to minimize the burden of complying with the proposed collection of information, including

the application of automated collection techniques or other forms of information technology; and

- Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

3. Description of Collection of Information

29 CFR 2590.702(i)(3)(ii) and (iii) and 26 CFR 54.9802-1T(i)(3)(ii) and (iii) of these interim rules include information collection requests. Paragraphs (i)(3)(ii) and (iii) describe the requirement that individuals previously denied coverage under a group health plan be provided with an opportunity to enroll in the plan, and a notice concerning this opportunity. Pursuant to paragraph (i)(3)(ii), where coverage denials were not based on a good faith interpretation of section 702 of the ERISA and section 9802 of the Code, notices of the opportunity for individuals previously denied coverage to enroll are required to be provided within 60 days of publication of this interim final rule. Where coverage was denied based on a good faith interpretation of section 702 of ERISA and section 9802 of the Code, the plan or issuer must provide notice of the opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001.

The method of estimating the hour and cost burdens of the information collection request is described in the section of this preamble appearing below entitled *Costs and Benefits of the Regulation*. Generally, the Departments have conservatively estimated that all group health plans that excluded individuals on the basis of health status factors prior to HIPAA's enactment will provide a notice of the opportunity to enroll to all participants. The total burden of providing notices to participants of private employers is divided equally between the Departments of Labor and Treasury.

Paragraph (h), *No effect on other laws*, is not considered to include an information collection request because the provision makes no substantive or material change to the Department of Labor's existing information collection request for the Summary Plan Description and Summary of Material Modifications cur-

rently approved under OMB control number 1210-0039.

Type of Review: New

Agency: Pension and Welfare Benefits Administration, Department of Labor; U.S. Department of the Treasury, Internal Revenue Service

Title: Notice of Opportunity To Enroll
OMB Number: 1210-0NEW; 1545-0NEW

Affected Public: Individuals or households; Business or other for-profit institutions; Not-for-profit institutions

Total Respondents: 120,000

Frequency of Response: One time

Total Responses: 2.0 million

Estimated Burden Hours: 5,950 (Pension and Welfare Benefits Administration); 5,950 (Internal Revenue Service)

Estimated Annual Costs (Operating and Maintenance): \$5.1 million (Pension and Welfare Benefits Administration); \$5.1 million (Internal Revenue Service)

Estimated Total Annual Costs: \$5.1 million (Pension and Welfare Benefits Administration); \$5.1 million (Internal Revenue Service)

Comments submitted in response to the information collection provisions of these Interim Final, final, and temporary rules will be shared among the Departments and summarized and/or included in the request for continuing OMB approval of the information collection request; they will also become a matter of public record.

Paperwork Reduction Act - Department of Health and Human Services

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the OMB for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;

- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are, however, requesting an emergency review of this interim final rule with comment period. In compliance with section 3506(c)(2)(A) of the PRA, we are submitting to OMB the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR Part 1320, to ensure compliance with section 2702 of the PHS Act. This section generally prohibits group health plans and group health insurance issuers from discriminating against individual participants or beneficiaries based on any health factor of such participants or beneficiaries. We cannot reasonably comply with normal clearance procedures because public harm is likely to result if the agency cannot enforce the requirements of this section 2702 of the PHS Act in order to ensure that individual participants or beneficiaries are not subject to unfair discrimination.

HCFA is requesting OMB review and approval of this collection 60 working days after the publication of this rule, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below within 30 working days after the publication of this rule.

During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval.

We are soliciting public comment on each of the issues for the provisions summarized below that contain information collection requirements:

Section 146.121 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(h) *No effect on other laws* Although this section generally does not impose new

disclosure obligations on plans and issuers, this paragraph (h) states that this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation. Therefore, plan documents (including, for example, group health insurance policies and certificates of insurance) must be amended if they do not accurately reflect the requirements set forth in this section, by the applicability date of this section.

The revisions to the plan documents are intended to eliminate provisions that do not comply with the HIPAA nondiscrimination statute and regulations. In particular, it is anticipated that changes will be required to the majority of actively-at-work provisions and nonconfinement clauses found in plan documents. The modifications are to be made by the applicability date of the regulation and the requirements do not impose any on-going burden. The revisions are anticipated to take 100 hours for state governmental plans and 4,900 hours for local governmental plans. The changes are expected to involve one hour of an attorney's time at a \$72 hourly rate. The corresponding plan amendment cost to be performed by service providers who are acting on behalf of the plans, is \$32,000 for State governmental plans and \$1,311,000 for local governmental plans.

(i) *Special transitional rule for self-funded non-Federal governmental plans exempted under 45 CFR 146.180.* Paragraph (4)(i) requires that if coverage has been denied to any individual because the sponsor of a self-funded non-Federal governmental plan has elected under § 146.180 of this part to exempt the plan from the requirements of this section, and the plan sponsor subsequently chooses to bring the plan into compliance with the requirements of this section, the plan must: notify the individual that the plan will be coming into compliance with the requirements of this section; afford the individual an opportunity that continues for at least 30 days, specify the effective date of compliance; and inform the individual regarding any enrollment restrictions that may apply under the terms of the plan once the plan is in compliance with this section (as a matter of administrative convenience; the notice may be disseminated to all employees).

The regulation clarifies that self-funded non-Federal governmental plans are required to give individuals who were previously discriminated against an opportunity to enroll, including notice of an opportunity to enroll. The development of the number of plans that are required to notify individuals were conservatively arrived at by assuming that all plans which have excluded individuals must notify all individuals who are eligible to participate in the plan. Development of the transitional notices are estimated to take 0 hours for State governmental plans and 200 hours for local governmental plans. The corresponding burden for work performed by service providers is anticipated to be \$1,000 for State governmental plans and \$535,000 for local governmental plans. The Department estimates that the burden to distribute transitional notices will require State governmental plans 800 hours and 1,400 hours for local governmental plans. The corresponding distribution burden performed by service providers is \$72,000 for State governmental plans and \$158,000 for local governmental plans.

The above costs will be reduced to the extent that State and local governmental plans have elected to opt out of the HIPAA requirements. As of the date of publishing, approximately 600 plans have opted out of the HIPAA statutory and regulatory requirements.

We have submitted a copy of this rule to OMB for its review of the information collection requirements. These requirements are not effective until they have been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Health Care Financing Administration,
Office of Information Services,
Information Technology Investment
Management Group,
Division of HCFA Enterprise Standards,
Room C2-26-17,
7500 Security Boulevard,
Baltimore, MD 21244-1850,
Attn: John Burke HCFA-2022,
and

Office of Information and Regulatory
Affairs,
Office of Management and Budget,
Room 10235, New Executive Office
Building,
Washington, DC 20503,
Attn.: Allison Herron Eydt, HCFA-
2022.

Small Business Regulatory Enforcement Fairness Act

This interim final rule is subject to the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and is being transmitted to Congress and the Comptroller General for review. The interim final rule is a “major rule,” as that term is defined in 5 U.S.C. 804, because it is likely to result in an annual effect on the economy of \$100 million or more. As such, this interim final rule is being transmitted to Congress and the Comptroller General for review.

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), as well as Executive Order 12875, this interim final rule does not include any Federal mandate that may result in expenditures by State, local, or tribal governments, nor does it include mandates which may impose an annual burden of \$100 million or more on the private sector.

Federalism Statement - Department of Labor and Department of Health and Human Services

Executive Order 13132 (August 4, 1999) outlines fundamental principles of federalism, and requires the adherence to specific criteria by federal agencies in the process of their formulation and implementation of policies that have substantial direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments’ view, these interim final regulations do not have federalism implications, because they do not have substantial direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. This is largely because, with respect to health insurance issuers, the vast majority of States have enacted laws which meet or exceed the federal standards in HIPAA prohibiting discrimination based on health factors. Therefore, the regulations are not likely to require substantial additional oversight of States by the Department of Health and Human Services.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, HIPAA added a new preemption provision to ERISA (as well as to the PHS Act) preserving the applicability of State laws establishing requirements for issuers of group health insurance coverage, except to the extent that these requirements prevent the application of the portability, access, and renewability requirements of HIPAA. The nondiscrimination provisions that are the subject of this rulemaking are included among those requirements.

In enacting these new preemption provisions, Congress indicated its intent to establish a preemption of State insurance requirements only to the extent that those requirements prevent the application of the basic protections set forth in HIPAA. HIPAA’s Conference Report states that the conferees intended the narrowest preemption of State laws with regard to health insurance issuers. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 205 (1996). Consequently, under the statute and the Conference Report, State insurance laws that are more stringent than the federal requirements are unlikely to “prevent the application of” the HIPAA nondiscrimination provisions.

Accordingly, States are given significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law. In many

cases, the federal law imposes minimum requirements which States are free to exceed. Guidance conveying this interpretation was published in the **Federal Register** on April 8, 1997, and these regulations do not reduce the discretion given to the States by the statute. It is the Departments' understanding that the vast majority of States have in fact implemented provisions which meet or exceed the minimum requirements of the HIPAA non-discrimination provisions.

HIPAA provides that the States may enforce the provisions of HIPAA as they pertain to issuers, but that the Secretary of Health and Human Services must enforce any provisions that a State fails to substantially enforce. When exercising its responsibility to enforce the provisions of HIPAA, HCFA works cooperatively with the States for the purpose of addressing State concerns and avoiding conflicts with the exercise of State authority.¹⁴ HCFA has developed procedures to implement its enforcement responsibilities, and to afford the States the maximum opportunity to enforce HIPAA's requirements in the first instance. HCFA's procedures address the handling of reports that States may not be enforcing HIPAA's requirements, and the mechanism for allocating enforcement responsibility between the States and HCFA. To date, HCFA has had occasion to enforce the HIPAA non-discrimination provisions in only two States.

Although the Departments conclude that these interim final rules do not have federalism implications, in keeping with the spirit of the Executive Order that agencies closely examine any policies that may have federalism implications or limit the policy making discretion of the States, the Department of Labor and HCFA have

engaged in numerous efforts to consult with and work cooperatively with affected State and local officials.

For example, the Departments were aware that some States commented on the way the federal provisions should be interpreted. Therefore, the Departments have sought and received input from State insurance regulators and the National Association of Insurance Commissioners (NAIC). The NAIC is a non-profit corporation established by the insurance commissioners of the 50 States, the District of Columbia, and the four U.S. territories, that among other things provides a forum for the development of uniform policy when uniformity is appropriate. Its members meet, discuss, and offer solutions to mutual problems. The NAIC sponsors quarterly meetings to provide a forum for the exchange of ideas, and in-depth consideration of insurance issues by regulators, industry representatives, and consumers. HCFA and Department of Labor staff have attended the quarterly meetings consistently to listen to the concerns of the State Insurance Departments regarding HIPAA issues, including the nondiscrimination provisions. In addition to the general discussions, committee meetings and task groups, the NAIC sponsors the following two standing HIPAA meetings for members during the quarterly conferences:

- HCFA/DOL Meeting on HIPAA Issues (This meeting provides HCFA and Labor the opportunity to provide updates on regulations, bulletins, enforcement actions and outreach efforts regarding HIPAA.)
- The NAIC/HCFA Liaison Meeting (This meeting provides HCFA and the NAIC the opportunity to discuss HIPAA and other health care programs.)

In addition, in developing these interim final regulations, the Departments consulted with the NAIC and requested their assistance to obtain information from the State Insurance Departments. Specifically, we sought and received their input on certain insurance rating practices and late enrollment issues. The Departments employed the States' insights on insurance rating practices in developing the provisions prohibiting "list-billing," and their experience with late enrollment in

crafting the regulatory provision clarifying the relationship between the nondiscrimination provisions and late enrollment. Specifically, the regulations clarify that while late enrollment, if offered by a plan, must be available to all similarly situated individuals regardless of any health factor, an individual's status as a late enrollee is not itself within the scope of any health factor.

The Departments also cooperate with the States in several ongoing outreach initiatives, through which information on HIPAA is shared among federal regulators, State regulators, and the regulated community. In particular, the Department of Labor has established a Health Benefits Education Campaign with more than 70 partners, including HCFA, NAIC and many business and consumer groups. HCFA has sponsored four conferences with the States - the Consumer Outreach and Advocacy conferences in March 1999 and June 2000, the Implementation and Enforcement of HIPAA National State-Federal Conferences in August 1999 and 2000. Furthermore, both the Department of Labor and HCFA websites offer links to important State websites and other resources, facilitating coordination between the State and federal regulators and the regulated community.

In conclusion, throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HIPAA, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress's intent to provide uniform minimum protections to consumers in every State.

Unified Analysis of Costs and Benefits

1. Introduction

HIPAA's nondiscrimination provisions generally prohibit group health plans and group health plan issuers from discriminating against individuals on the basis of health status factors. The primary effect and intent of the provision is to increase access to affordable group health coverage for individuals with health problems. This effect, and the economic costs, benefits, and transfers attendant to it, generally flow directly from the HIPAA's statutory provisions, which are largely self-implementing. However, the statute

¹⁴ This authority applies to insurance issued with respect to group health plans generally, including plans covering employees of church organizations. Thus, this discussion of federalism applies to all group health insurance coverage that is subject to the PHS Act, including those church plans that provide coverage through a health insurance issuer (but not to church plans that do not provide coverage through a health insurance issuer). For additional information relating to the application of these nondiscrimination rules to church plans, see the preamble to regulations being proposed elsewhere in this issue of the Bulletin regarding section 9802(c) of the Code relating to church plans.

alone leaves room for varying interpretations of exactly which practices are prohibited or permitted at the margin. This regulation draws on the Departments' authority to clarify and interpret HIPAA's statutory nondiscrimination provisions in order to secure the protections intended by Congress for plan participants and beneficiaries. The Departments crafted it to satisfy this mandate in as economically efficient a manner as possible, and believe that the economic benefits of the regulation outweigh its costs. The analysis underlying this conclusion takes into account both the effect of the statute and the impact of the discretion exercised in the regulation.

The nondiscrimination provisions of the HIPAA statute and of this regulation generally apply to both group health plans and to issuers of group health plan policies. Economic theory predicts that issuers will pass their costs of compliance back to plans, and that plans may pass some or all of issuers' and their own costs of compliance to participants. This analysis is carried out in light of this prediction.

2. Costs and Benefits of HIPAA's Statutory Nondiscrimination Provisions

As noted above, HIPAA's statutory nondiscrimination provisions are largely self-implementing even in the absence of interpretive guidance. It is the Departments' policy where practicable to evaluate such impacts separately from the impact of discretion exercised in regulation. The Departments provide qualitative assessments of the nature of the costs, benefits, and transfers that are expected to derive from statutory provisions, and provide summaries of any credible, empirical estimates of these effects that are available.

To the Departments' knowledge, there is no publicly available work that quantifies the magnitude or presents the nature of these benefits, costs, and transfers. In its initial scoring of the statute, the Congressional Budget Office did not separately quantify the costs of the nondiscrimination provisions. Therefore, this analysis considers the nature of anticipated costs, benefits, and transfers, and offers a basis for estimating separately the impacts of the statute and regulatory discretion, but does not present a detailed description of any other quantitative

analysis of the statute's impact.

HIPAA's statutory nondiscrimination provisions entail new economic costs and benefits, as well as transfers of health care costs among plan sponsors and participants.

The primary statutory economic benefits associated with the HIPAA nondiscrimination provisions derive from increased access to affordable group health plan coverage for individuals with certain health status-related factors. Expanding access benefits both newly covered individuals and society at large. Individuals without health insurance are less likely to get preventive care and less likely to have a regular source of care.¹⁵ A lack of health insurance generally increases the likelihood that needed medical treatment will be forgone or delayed. Forgoing or delaying care increases the risk of adverse health outcomes. These adverse outcomes in turn spawn higher medical costs which are often shifted to public funding sources (and therefore to taxpayers) or to other payers. They also erode productivity and the quality of life. Improved access to affordable group health coverage for individuals with health problems under HIPAA's nondiscrimination provisions will lead to more insurance coverage, timelier and fuller medical care, better health outcomes, and improved productivity and quality of life. This is especially true for the individuals most affected by HIPAA's nondiscrimination provisions — those with adverse health conditions. Denied insurance, individuals in poorer health are more likely to suffer economic hardship, to forgo badly needed care for financial reasons, and to suffer adverse health outcomes as a result. For them, gaining insurance is more likely to mean gaining economic security, receiving timely, quality care, and living healthier, more productive lives.

Plans and issuers will incur economic costs as a result of the law. These are generally limited to administrative costs, such as those incurred to change plan design and pricing structures and update plan materials.

The premiums and claims costs incurred by group health plans to provide coverage

to individuals who were previously denied coverage or offered restricted coverage based on health factors are offset by the commensurate or greater benefits realized by the newly eligible participants on whose behalf the premiums or claims are paid. As such, these premiums and claims costs are properly characterized as transfers rather than as new economic costs. These transfers shift the burden of health care costs from one party to another without any direct change in aggregate social welfare. For example, as individuals' insurance status changes from insured through an individual policy to insured through an employment based group health plan, health care costs are transferred from these individuals to their employers. Similarly, as individuals' insurance status changes from uninsured to insured through a group health plan, health care costs are transferred from the individuals and public funding sources to employers.

The HIPAA nondiscrimination statutory transfer is likely to be substantial. Annual per-participant group health plan costs average more than \$4,000¹⁶, and it is likely that average costs would be higher for individuals who had faced discrimination due to health status factors. Prior to HIPAA's enactment approximately 106,000 employees were denied employment based coverage because of health factors.¹⁷ A simple assessment suggests that the total cost of coverage for such employees could exceed \$400 million. However, this potential statutory transfer is small relative to the overall cost of employment-based health coverage. Group health plans will spend about \$431 billion this year to cover approximately 77 million participants and their dependents. Transfers under HIPAA's nondiscrimination provision will represent a very small fraction of one percent of total group health plan expenditures.

3. Costs and Benefits of the Regulation

Prohibiting Discrimination — Many of the provisions of this regulation serve to specify more precisely than the statute

¹⁶ Gabel, Jon R. *Job-based Health Insurance, 1977-1998: The Accidental System Under Scrutiny. Health Affairs.* November / December 1999. Volume 18, Number 6.

¹⁷ February 1997 Current Population Survey, Contingent Worker Supplement.

¹⁵ Kaiser Family Foundation and *The NewsHour*, "NewsHour/Kaiser Spotlights Misconceptions About the Medically Uninsured: Survey Examines Difficulties Faced by Those Without Health Coverage," News Release, May 16, 2000.

alone exactly what practices are prohibited by HIPAA as unlawful discrimination in eligibility or employee premium among similarly situated employees. For example, under the regulation eligibility generally may not be restricted based on an individuals' participation in risky activities, confinement to an institution or absence from work on enrollment day due to illness, or status as a late enrollee. The regulation provides that various plan features including waiting periods and eligibility for certain benefits constitute rules for eligibility which may not vary across similarly situated employees based on health status factors. It provides that individuals who were previously denied eligibility based on health status factors (or who failed to enroll in anticipation of such denial) must be given an opportunity to enroll. It provides that plans may not reclassify employees based on health status factors in order to create separate groups of similarly situated employees among which discrimination would be permitted.

All of these provisions have the effect of clarifying and ensuring certain participants' right to freedom from discrimination in eligibility and premium amounts, thereby securing their access to affordable group health plan coverage. The costs and benefits attributable to these provisions resemble those attendant to HIPAA's statutory nondiscrimination provisions. Securing participants' access to affordable group coverage provides economic benefits by reducing uninsurance and thereby improving health outcomes. It entails transfers of costs from the employees whose rights are secured (and/or from other parties who would otherwise pay for their health care) to plan sponsors (or to other plan participants if sponsors pass those costs back evenly to them). And it imposes economic costs in the form of administrative burdens to design and implement necessary plan amendments.

The Departments lack any basis on which to distinguish these benefits, costs, and transfers from those of the statute itself. It is unclear how many plans might be engaging in the discriminatory practices targeted for prohibition by these regulatory provisions. Because these provisions operate largely at the margin of the statutory requirements, it is likely that the effects of these provisions will be far

smaller than the similar statutory effects. The Departments are confident, however, that by securing employees' access to affordable coverage at the margin, the regulation, like the statute, will yield benefits in excess of costs.

Clarifying Requirements — Additional economic benefits derive directly from the improved clarity provided by the regulation. The regulation provides clarity through both its provisions and its examples of how those provisions apply in various circumstances. By clarifying employees' rights and plan sponsors' obligations under HIPAA's nondiscrimination provisions, the regulation will reduce uncertainty and costly disputes over these rights and obligations. It will promote employers' and employees' common understanding of the value of group health plan benefits and confidence in the security and predictability of those benefits, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans by employers.¹⁸

¹⁸ The voluntary nature of the employment-based health benefit system in conjunction with the open and dynamic character of labor markets make explicit as well as implicit negotiations on compensation a key determinant of the prevalence of employee benefits coverage. It is likely that 80% to 100% of the cost of employee benefits is borne by workers through reduced wages (see for example Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," *Tax Policy and Economy* (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, Vol. 84 (June 1994), pp. 622-641; Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review*, Vol. 79, No. 2 (May 1989); Louise Sheiner, "Health Care Costs, Wages, and Aging," Federal Reserve Board of Governors working paper, April 1999; and Edward Montgomery, Kathryn Shaw, and Mary Ellen Benedict, "Pensions and Wages: An Hedonic Price Theory Approach," *International Economic Review*, Vol. 33 No. 1, Feb. 1992.) The prevalence of benefits is therefore largely dependent on the efficacy of this exchange. If workers perceive that there is the potential for inappropriate denial of benefits, they will discount their value to adjust for this risk. This discount drives a wedge in the compensation negotiation, limiting its efficiency. With workers unwilling to bear the full cost of the benefit, fewer benefits will be provided. The extent to which workers perceive a federal regulation supported by enforcement authority to improve the security and quality of benefits, the differential between the employers costs and workers willingness to accept wage offsets is minimized.

Amending Plans — The regulation is expected to entail some new economic costs, in the form of two new administrative burdens, which are distinguishable from those attributable to the statute. First, it is likely that some of the regulation's nondiscrimination provisions will effectively require some plans to amend their terms and revise plan materials. Second, as noted above, the regulation requires that individuals who were previously denied eligibility based on health status factors (or who failed to enroll in anticipation of such denial) must be given an opportunity to enroll. It also requires that plans notify such individuals of their right of enroll. Providing notices under these requirements will entail new administrative costs.

Plans that, prior to HIPAA's effective date, included provisions since prohibited by HIPAA's nondiscrimination requirements, were effectively required by HIPAA to implement conforming amendments and to revise plan materials accordingly. The costs associated with these actions generally are attributable to the HIPAA statute and not to this regulation. However, it is likely that some of the regulation's nondiscrimination provisions will effectively require some plans to amend their terms and revise their materials. For example, the Departments understand that plans commonly require employees to be actively at work on a designated enrollment day in order to qualify for enrollment. It is possible that some plans failed to interpret HIPAA's statutory provisions to prohibit this practice. Such plans will need to amend their terms and materials to provide that employees will not be denied enrollment solely because they were absent due to a health status factor. Such plans will incur administrative costs.

The Departments have no basis for estimating how many plans might need to implement amendments beyond those implemented in response to the HIPAA's statutory nondiscrimination provisions in order to comply with the regulation's corresponding provisions. They adopted conservative assumptions in order to develop an upper bound estimate of the cost to amend plans and materials to conform with the regulation. They assumed that all plans will require at least some amendments to conform with this regulation.

A large majority of fully insured plans do not have unique eligibility and

employee premium provisions but instead choose from a relatively small menu of standardized products offered by issuers. The Departments accordingly assumed that issuers will amend their standardized group insurance products, passing the associated cost back to the plans that buy them. They estimate that a total of approximately 33,000 group insurance products will be so amended, and that the cost of these amendments will be spread across a universe of approximately 2.6 million fully insured plans. The Departments assumed that small self-insured plans (which generally fall outside state regulation of insurance products) choose from a much larger menu of products and that large self-insured plans each have unique eligibility rules will need to be amended independently. This implies a total of approximately 76,000 self-insured plan configurations requiring amendment.

Assuming that each affected group insurance product and self-insured plan configuration would require 1 hour of professional time billed at \$72 per hour to design and implement amendments, the aggregate cost to amend plans would be \$8 million.

Separate from the cost to design and implement plan amendments is the cost to revise plan materials to reflect the amendments. The Departments note that the cost to revise plan materials can generally be attributed to legal requirements other than the HIPAA statute or this regulation. It is the policy of the Department of Labor to attribute the cost of revising private-sector group health plan materials to its regulation implementing ERISA's Summary Plan Description requirements.

Various state laws compel issuers to provide accurate materials, and the Departments believe that State and local governmental plan sponsors and private plan sponsors routinely update plan materials as a matter of either law or compensation and employment policy.

Notifying Employees of Enrollment Opportunities — In estimating the costs associated with the notification requirements, the Departments separately considered the cost of preparing notices and the cost of distributing them.

Based on a 1993 Robert Wood Johnson Foundation survey of employers, the Departments estimate that 128,000 group health plans excluded individuals on the basis of health status factors prior to HIPAA's enactment and will therefore be required by the regulation to prepare and distribute notices. The Departments assumed that preparing the notice will require one hour of time billed at a \$72 hourly rate. The cost to develop notices is therefore estimated to be \$9 million.

The Departments assumed that plans will distribute notices to all individuals who are eligible for coverage under the plan. It might be necessary to notify individuals who are currently enrolled because such individuals may have dependents for whom eligibility was denied based on a health status factor or may have failed to enroll dependents because they expected that eligibility would be so denied for them. This assumption probably results in an overestimate of the true cost. Some affected plans may already have notified affected individuals of their right to enroll under HIPAA. Others may have historical records of plan enrollment that are suffi-

ciently detailed to allow for the notification of only specific individuals. Based on the 1997 Robert Wood Johnson Foundation survey, the Departments estimate that a total of 2.3 million employees are eligible for coverage under the 128,000 plans that are required to provide notices. The Departments assumed that distributing each notice costs \$0.37 for mailing and materials plus 2 minutes of photocopying and mailing billed at a \$15 per hour clerical rate for a total per-notice distribution cost of \$0.87. The cost to distribute notices is therefore estimated to be \$2 million.

The estimated combined cost to prepare and distribute notices therefore amounts to \$11 million. The Departments note that this is a one-time cost which will be incurred concurrent with the regulation's applicability date.

The Department's note that the provision of notices will benefit employees who newly learn of opportunities to enroll themselves or their dependents. The result will be fuller realization of HIPAA's intent and employees' associated rights, as well as improved access to affordable group coverage and reduced rates of uninsurance for affected employees.

4. Summary of Cost Estimates

The cost estimates presented here are compiled in the table below. Upper bound cost estimates attributable to the regulation include \$8 million to amend plans and revise documents and \$11 million to prepare and distribute notices of enrollment opportunities, or a total of \$19 million.

Source of cost	\$MM	Explanatory notes
Amending plans and revising materials	\$8	Upper bound of new economic cost incurred as plans are amended to comply with the regulation. One-time cost.
Notifying employees of enrollment opportunities	\$11	Upper bound of new economic cost to prepare and distribute notices. One-time cost.
Prohibiting discrimination	>\$400	Transfer attributable to HIPAA's statutory nondiscriminatory provisions. Transfers attributable to the regulation were not estimated but are expected to be a very small fraction of this amount. Ongoing annual level.

5. Assessment of Likelihood of Adverse Secondary Effects

The Departments considered whether employers might reduce or eliminate health insurance benefits for all employees as a result of this regulation. They believe that this is highly unlikely because the regulation affirms and clarifies plan sponsors' flexibility and because its costs will be very small relative to group health plan expenditures.

The regulation affirms plan sponsors' flexibility to design plans and control plan costs in many ways. It affirms and clarifies plans' flexibility under HIPAA to exclude from coverage or limit coverage for certain conditions or services, to require employees to perform services before coverage becomes effective, and to provide different benefits or charge different premiums for employees in different bona fide employment classes. It also clarifies that more favorable treatment of individuals with adverse health factors is permitted, thereby allowing employers to assist employees and their families dealing with disabilities, medical conditions, or other health factors by extending coverage or lowering premiums.

Both the transfer of health insurance costs and the administrative costs generated by this regulation will be very small relative to total group health plan expenditures. The \$19 million economic cost estimate attributed to this regulation amounts to a tiny fraction of one percent of the \$431 billion that group health plans will spend this year. Even the more than \$400 million transfer of cost attributed to HIPAA's statutory nondiscrimination provisions amount to a very small fraction of one percent of that spending. Plan sponsors wishing to do so generally can pass these costs back to participants with small, across the board changes to employee premiums or benefits.

Statutory Authority

The Department of the Treasury final and temporary rules are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code (26 U.S.C. 7805, 9833).

The Department of Labor interim final rule is adopted pursuant to the authority contained in sections 107, 209, 505, 701-703, 711-713, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135,

1171-1173, 1181, 1182, and 1191-1194), as amended by HIPAA (Public Law 104-191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104-204, 110 Stat. 2935), and WHCRA (Public Law 105-277, 112 Stat. 2681-436), section 101(g)(4) of HIPAA, and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

The Department of HHS interim final rule is adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended by HIPAA (Public Law 104-191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104-204, 110 Stat. 2935), and WHCRA (Public Law 105-277, 112 Stat. 2681-436).

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Adoption of Amendments to the Regulations

Internal Revenue Service
26 CFR Chapter I

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54 — PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Section 54.9802-1T is removed.

Par. 3. Section 54.9802-1 is added to read as follows:

§54.9802-1 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) *Health factors.* (1) The term *health factor* means, in relation to an individual, any of the following health status-related factors:

- (i) Health status;
- (ii) Medical condition (including both physical and mental illnesses);
- (iii) Claims experience;
- (iv) Receipt of health care;
- (v) Medical history;
- (vi) Genetic information;
- (vii) Evidence of insurability; or
- (viii) Disability.

(2) Evidence of insurability includes —

- (i) Conditions arising out of acts of domestic violence; and

(ii) **[Reserved]** For further guidance, see §54.9802-1T(a)(2)(ii).

(b) *Prohibited discrimination in rules for eligibility* — (1) *In general* — (i) A group health plan may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (b)(3) of this section (allowing plans to impose certain preexisting condition exclusions), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to bona fide wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) **[Reserved]** For further guidance, see §54.9802-1T(b)(1)(ii).

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion.* In this *Example 1*, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. **[Reserved]**

(2) *Application to benefits* — (i) *General rule* — (A) Under this section, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) **[Reserved]** For further guidance, see §54.9802-1T(b)(2)(i)(B).

(C) **[Reserved]** For further guidance, see §54.9802-1T(b)(2)(i)(C).

(D) **[Reserved]** For further guidance, see §54.9802-1T(b)(2)(i)(D).

(ii) *Cost-sharing mechanisms and wellness programs.* A group health plan with a cost-sharing mechanism (such as a deductible, copayment, or coinsurance) that requires a higher payment from an individual, based on a health factor of that

individual or a dependent of that individual, than for a similarly situated individual under the plan (and thus does not apply uniformly to all similarly situated individuals) does not violate the requirements of this paragraph (b)(2) if the payment differential is based on whether an individual has complied with the requirements of a bona fide wellness program.

(iii) *Specific rule relating to source-of-injury exclusions.* [Reserved] For further guidance, see §54.9802-1T(b)(2)(iii).

(3) *Relationship to section 9801(a), (b), and (d).* [Reserved] For further guidance, see §54.9802-1T(b)(3).

(c) *Prohibited discrimination in premiums or contributions* — (1) *In general* — (i) A group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.

(ii) [Reserved] For further guidance, see §54.9802-1T(c)(1)(ii).

(2) *Rules relating to premium rates* — (i) *Group rating based on health factors not restricted under this section.* Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) *List billing based on a health factor prohibited.* [Reserved] For further guidance, see §54.9802-1T(c)(2)(ii).

(3) *Exception for bona fide wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

(d) *Similarly situated individuals.* [Reserved] For further guidance, see §54.9802-1T(d).

(e) *Nonconfinement and actively-at-work provisions.* [Reserved] For further guidance, see §54.9802-1T(e).

(f) *Bona fide wellness programs.* [Reserved]

(g) *Benign discrimination permitted.* [Reserved] For further guidance, see §54.9802-1T(g).

(h) *No effect on other laws.* [Reserved] For further guidance, see §54.9802-1T(h).

(i) *Effective dates* — (1) *Final rules apply March 9, 2001.* This section applies March 9, 2001.

(2) *Cross-reference to temporary rules applicable for plan years beginning on or after July 1, 2001.* See §54.9802-1T(i)(2), which makes the rules of that section applicable for plan years beginning on or after July 1, 2001.

(3) *Cross-reference to temporary transitional rules for individuals previously denied coverage based on a health factor.* See §54.9802-1T(i)(3) for transitional rules that apply with respect to individuals previously denied coverage under a group health plan based on a health factor.

Par. 4. Section 54.9802-1T is added to read as follows:

§54.9802-1T Prohibiting discrimination against participants and beneficiaries based on a health factor (temporary).

(a) *Health factors.* (1) [Reserved] For further guidance, see §54.9802-1(a).

(2) Evidence of insurability includes —

(i) [Reserved] For further guidance, see §54.9802-1(a)(2)(i).

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under section 9801(f) a plan must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility* — (1) *In general* — (i) [Reserved] For further guidance, see §54.9802-1(b)(1)(i).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to —

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

(E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as

described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. [Reserved] For further guidance, see §54.9802-1(b)(1)(iii), *Example 1.*

Example 2. (i) *Facts.* Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion.* In this *Example 2*, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts.* Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion.* In this *Example 3*, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts.* A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual A is an employee of the employer maintaining the plan. A and A's dependents have a history of high health claims. Based on the information about A and A's dependents, the issuer excludes A and A's dependents from the group policy it offers to the employer.

(ii) *Conclusion.* See *Example 4* in 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) for a conclusion that the exclusion by the issuer of A and A's dependents from coverage is a rule for eligibility that discriminates based on one or more health factors and violates rules under 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) similar to the rules under this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not

provide equivalent coverage for A and A's dependents through other means, the plan will also violate this paragraph (b)(1).

(2) *Application to benefits* — (i) *General rule* — (A) **[Reserved]** For further guidance, see §54.9802–1(b)(2)(i)(A).

(B) However, benefits provided under a plan must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan may impose annual, lifetime, or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also paragraph (b)(2)(ii) of this section, which permits variances in the application of a cost-sharing mechanism made available under a bona fide wellness program. (Whether any plan provision or practice with respect to benefits complies with this paragraph (b)(2)(i) does not affect whether the provision or practice is permitted under any other provision of the Code, the Americans with Disabilities Act, or any other law, whether State or federal.)

(C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the

plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan applies a \$500,000 lifetime limit on all benefits to each participant or beneficiary covered under the plan. The limit is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, the limit does not violate this paragraph (b)(2)(i) because \$500,000 of benefits are available uniformly to each participant and beneficiary under the plan and because the limit is applied uniformly to all participants and beneficiaries and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* A group health plan has a \$2 million lifetime limit on all benefits (and no other lifetime limits) for participants covered under the plan. Participant *B* files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a \$10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

(ii) *Conclusion.* Under the facts of this *Example 2*, the plan violates this paragraph (b)(2)(i) because the plan modification is directed at *B* based on *B*'s claim.

Example 3. (i) A group health plan applies for a group health policy offered by an issuer. Individual *C* is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about *C*'s adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that *C* has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for *C* for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion.* See *Example 3* in 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) for a conclusion that the issuer violates rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) similar to the rules under this paragraph (b)(2)(i) because the rider excluding benefits for the condition that *C* has is directed at *C* even though it applies by its terms to all participants and beneficiaries under the plan.

Example 4. (i) *Facts.* A group health plan has a \$2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because \$2000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed

at individual participants or beneficiaries.

Example 5. (i) *Facts.* A group health plan applies a \$2 million lifetime limit on all benefits. However, the \$2 million lifetime limit is reduced to \$10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

(ii) *Conclusion.* In this *Example 5*, the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan's lifetime limit on benefits does not apply uniformly to all similarly situated individuals.

Example 6. (i) *Facts.* A group health plan limits its benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 6*, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) *Facts.* Under a group health plan, doctor visits are generally subject to a \$250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 7*, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Cost-sharing mechanisms and wellness programs.* **[Reserved]** For further guidance, see §54.9802–1(b)(2)(ii).

(iii) *Specific rule relating to source-of-injury exclusions* — (A) If a group health plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

(B) The rules of this paragraph (b)(2)(iii) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Individual *D* suffers from depression and attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the

injuries. Pursuant to the exclusion, the plan denies D benefits for treatment of the injuries.

(ii) *Conclusion.* In this *Example 1*, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of D's injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts.* A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant E sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for E's head injury.

(ii) *Conclusion.* In this *Example 2*, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow E to enroll in the plan (or applied different rules for eligibility to E) because E frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

(3) *Relationship to section 9801(a), (b), and (d).* (i) A preexisting condition exclusion is permitted under this section if it —

(A) Complies with section 9801(a), (b), and (d);

(B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and

(C) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an indi-

vidual's creditable coverage in accordance with section 9801(a). There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with section 9801(a), (b), and (d) (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2. (i) *Facts.* A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.

(ii) *Conclusion.* In this *Example 2*, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(c) *Prohibited discrimination in premiums or contributions* — (1) *In general* — (i) **[Reserved]** For further guidance, see §54.9802-1(c)(1)(i).

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates* — (i) *Group rating based on health factors not restricted under this section.* **[Reserved]** For further guidance, see §54.9802-1(c)(2)(i).

(ii) *List billing based on a health factor prohibited.* However, a group health plan may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(ii) *Examples.* The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual F had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of F's claims experience.

(ii) *Conclusion.* See *Example 1* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer does not violate the provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for F than for a similarly situated individual based on F's claims experience.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the issuer quotes the employer a higher premium rate for F, because of F's claims experience, than for a similarly situated individual.

(ii) *Conclusion.* See *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer violates provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for F than for a similarly situated individual, see *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer would still violate 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for bona fide wellness programs.* **[Reserved]** For further guidance, see §54.9802-1(c)(3).

(d) *Similarly situated individuals.* The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants.* Subject to paragraph (d)(3) of this section, a plan may treat participants as two or more distinct groups of

similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries* — (i) Subject to paragraph (d)(3) of this section, a plan may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (e.g., as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of beneficiaries with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals*. Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or cover-

age classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

(4) *Examples*. The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) *Facts*. An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's usual business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts*. Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 if the child is continuously enrolled full-time in an institution of higher learning (full-time students)). There is no evidence to suggest that these classifications are directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 2*, treating spouses and dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent children is permitted under paragraph (d)(2) of this section and is not prohibited under paragraph (d)(3) of this section because it is not directed at individual participants or beneficiaries. It is also permissible to treat dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 or older if they are not full-time students) because the classification is permitted under paragraph (d)(2) of this section and is not directed at individual participants or beneficiaries.

Example 3. (i) *Facts*. A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 3*, the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4. (i) *Facts*. An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 4*, imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

Example 5. (i) *Facts*. An employer sponsors a group health plan that provides the same benefit package to all seven employees of the employer. Six of the seven employees have the same job title and responsibilities, but Employee *G* has a different job title and different responsibilities. After *G* files an expensive claim for benefits under the plan, coverage under the plan is modified so that employees with *G*'s job title receive a different benefit package that includes a lower lifetime dollar limit than in the benefit package made available to the other six employees.

(ii) *Conclusion*. Under the facts of this *Example 5*, changing the coverage classification for *G* based on the existing employment classification for *G* is not permitted under this paragraph (d) because the creation of the new coverage classification for *G* is directed at *G* based on one or more health factors.

(e) *Nonconfinement and actively-at-work provisions* — (1) *Nonconfinement provisions* — (i) *General rule*. Under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under para-

graphs (e)(2)(ii) and (3) of this section (permitting plans, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples.* The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) Facts. Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) *Conclusion.* In this *Example 1*, the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) Facts. In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M*. However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer *N*. Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion.* See *Example 2* in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for a conclusion that Issuer *N* violates provisions of 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) similar to the provisions of this paragraph (e)(1) because Issuer *N* restricts benefits based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits from a previous issuer.

(2) *Actively-at-work and continuous service provisions* — (i) *General rule* — (A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work in paragraph (e)(2)(ii) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) Facts. Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion.* In this *Example 1*, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) Facts. Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(ii) *Conclusion.* In this *Example 2*, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service.

(ii) *Exception for the first day of work* — (A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) Facts. Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion.* In this *Example 1*, the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) Facts. Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion.* In this *Example 2*, the plan provision does not violate this section. However, as in

Example 1, if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals* —

(i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) Facts. Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as annual, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion.* In this *Example 1*, the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on annual leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) Facts. To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual partici-

pants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2*, the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 3*, the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

Example 4. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 4*, the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *Bona fide wellness programs.*
[Reserved]

(g) *More favorable treatment of individuals with adverse health factors permitted* — (1) *In rules for eligibility* — (i) Nothing in this section prevents a group health plan from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit

premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 23. However, dependent children who are disabled are eligible for coverage beyond age 23.

(ii) *Conclusion.* In this *Example 1*, the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2. (i) *Facts.* An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees \$50 per month for employee-only coverage and \$125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee \$100 per month for employee-only coverage and \$250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 2*, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion.* In this *Example 3*, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individu-

als pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions* — (i) Nothing in this section prevents a group health plan from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

(ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example. (i) *Facts.* Under a group health plan, employees are generally required to pay \$50 per month for employee-only coverage and \$125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion.* In this *Example*, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws.* Compliance with this section is not determinative of compliance with any other provision of the Code (including the COBRA continuation provisions) or any other State or federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) *Effective dates* — (1) *Final rules apply March 9, 2001.* **[Reserved]** For further guidance, see §54.9802-1(i)(1).

(2) *This section applies for plan years beginning on or after July 1, 2001.* Except as provided in paragraph (i)(3) of this section, this section applies for plan years beginning on or after July 1, 2001.

Except as provided in paragraph (i)(3) of this section, with respect to efforts to comply with section 9802 before the first plan year beginning on or after July 1, 2001, the Secretary will not take any enforcement action against a plan that has sought to comply in good faith with section 9802.

(3) *Transitional rules for individuals previously denied coverage based on a health factor.* This paragraph (i)(3) provides rules relating to individuals previously denied coverage under a group health plan based on a health factor of the individual. Paragraph (i)(3)(i) clarifies what constitutes a denial of coverage under this paragraph (i)(3). Paragraph (i)(3)(ii) of this section applies with respect to any individual who was denied coverage if the denial was not based on a good faith interpretation of section 9802 or the Secretary's published guidance. Under that paragraph, such an individual must be allowed to enroll retroactively to the effective date of section 9802, or, if later, the date the individual meets eligibility criteria under the plan that do not discriminate based on any health factor. Paragraph (i)(3)(iii) of this section applies with respect to any individual who was denied coverage based on a good faith interpretation of section 9802 or the Secretary's published guidance. Under that paragraph, such an individual must be given an opportunity to enroll effective July 1, 2001. In either event, whether under paragraph (i)(3)(ii) or (iii) of this section, the Secretary will not take any enforcement action with respect to denials of coverage addressed in this paragraph (i)(3) if the plan has complied with the transitional rules of this paragraph (i)(3).

(i) *Denial of coverage clarified.* For purposes of this paragraph (i)(3), an individual is considered to have been denied coverage if the individual —

(A) Failed to apply for coverage because it was reasonable to believe that an application for coverage would have been futile due to a plan provision that discriminated based on a health factor; or

(B) Was not offered an opportunity to enroll in the plan and the failure to give such an opportunity violates this section.

(ii) *Individuals denied coverage without a good faith interpretation of the law — (A) Opportunity to enroll required.* If a plan has denied coverage to any indi-

vidual based on a health factor and that denial was not based on a good faith interpretation of section 9802 or any guidance published by the Secretary, the plan is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than March 9, 2001.

(1) If this enrollment opportunity was presented before or within the first plan year beginning on or after July 1, 1997 (or in the case of a collectively bargained plan, before or within the first plan year beginning on the effective date for the plan described in section 401(c)(3) of the Health Insurance Portability and Accountability Act of 1996), the coverage must be effective within that first plan year.

(2) If this enrollment opportunity is presented after such plan year, the individual must be given the choice of having the coverage effective on either of the following two dates —

(i) The date the plan receives a request for enrollment in connection with the enrollment opportunity; or

(ii) Retroactively to the first day of the first plan year beginning on the effective date for the plan described in section 401(c)(1) or (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). If an individual elects retroactive coverage, the plan is required to provide the benefits it would have provided if the individual had been enrolled for coverage during that period (irrespective of any otherwise applicable plan provisions governing timing for the submission of claims). The plan may require the individual to pay whatever additional amount the individual would have been required to pay for the coverage (but the plan cannot charge interest on that amount).

(B) *Relation to preexisting condition rules.* For purposes of Chapter 100 of Subtitle K, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in section 401(c)(1) or (3) of the Health Insurance Portability and

Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan), even if the individual chooses under paragraph (i)(3)(ii)(A) of this section to have coverage effective only prospectively. In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Examples.* The rules of this paragraph (i)(3)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer X maintains a group health plan with a plan year beginning October 1 and ending September 30. Individual F was hired by Employer X before the effective date of section 9802. Before the effective date of section 9802 for this plan (October 1, 1997), the terms of the plan allowed employees and their dependents to enroll when the employee was first hired, and on each January 1 thereafter, but in either case, only if the individual could pass a physical examination. F's application to enroll when first hired was denied because F could not pass a physical examination. Upon the effective date of section 9802 for this plan (October 1, 1997), the plan is amended to delete the requirement to pass a physical examination. In November of 1997, the plan gives F an opportunity to enroll in the plan (including notice of the opportunity to enroll) without passing a physical examination, with coverage effective January 1, 1998.

(ii) *Conclusion.* In this *Example 1*, the plan complies with the requirements of this paragraph (i)(3)(ii).

Example 2. (i) *Facts.* The plan year of a group health plan begins January 1 and ends December 31. Under the plan, a dependent who is unable to engage in normal life activities on the date coverage would otherwise become effective is not enrolled until the dependent is able to engage in normal life activities. Individual G is a dependent who is otherwise eligible for coverage, but is unable to engage in normal life activities. The plan has not allowed G to enroll for coverage.

(ii) *Conclusion.* In this *Example 2*, beginning on the effective date of section 9802 for the plan (January 1, 1998), the plan provision is not permitted under any good faith interpretation of section 9802 or any guidance published by the Secretary. Therefore, the plan is required, not later than March 9, 2001, to give G an opportunity to enroll (including notice of the opportunity to enroll), with coverage effective, at G's option, either retroactively from January 1, 1998 or prospectively from the date G's request for enrollment is received by the plan. If G elects coverage to be effective beginning January 1, 1998, the plan can require G to pay employee premiums for the retroactive coverage.

(iii) *Individuals denied coverage based on a good faith interpretation of the law — (A) Opportunity to enroll required.* If a plan has denied coverage to any individual before the first day of the first plan year beginning on or after

July 1, 2001 based in part on a health factor and that denial was based on a good faith interpretation of section 9802 or guidance published by the Secretary, the plan is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days, with coverage effective no later than July 1, 2001. Individuals required to be offered an opportunity to enroll include individuals previously offered enrollment without regard to a health factor but subsequently denied enrollment due to a health factor.

(B) *Relation to preexisting condition rules.* For purposes of Chapter 100 of Subtitle K, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date under the plan is the effective date for the plan described in section 401(c)(1) or (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Example.* The rules of this paragraph (i)(3)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *H* was hired by Employer *Y* on May 3, 1995. *Y* maintains a group health plan with a plan year beginning on February 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired (without a requirement to pass a physical examination), and on each February 1 thereafter if the individual can pass a physical examination. *H* chose not to enroll for coverage when hired in May of 1995. On February 1, 1997, *H* tried to enroll for coverage under the plan. However, *H* was denied coverage for failure to pass a physical examination. Shortly thereafter, *Y*'s plan eliminated late enrollment, and *H* was not given another opportunity to enroll in the plan. There is no evidence to suggest that *Y*'s plan was acting in bad faith in denying coverage under the plan beginning on the effective date of section 9802 (February 1, 1998).

(ii) *Conclusion.* In this *Example*, because coverage previously had been made available with respect to *H* without regard to any health factor of *H* and because *Y*'s plan was acting in accordance with a good faith interpretation of section 9802 (and guidance published by the Secretary), the failure of *Y*'s plan to allow *H* to enroll effective February 1, 1998 was permissible on that date. However, under the transitional rules of this paragraph (i)(3)(iii), *Y*'s plan must give *H* an opportunity to enroll that continues for at least 30 days, with coverage effective no later

than July 1, 2001. (In addition, February 1, 1998 is *H*'s enrollment date under the plan and the period between February 1, 1998 and July 1, 2001 is treated as a waiting period. Accordingly, any preexisting condition exclusion period permitted under section 9801 will have expired before July 1, 2001.)

Robert E. Wenzel,
*Deputy Commissioner
of Internal Revenue.*

Approved August 8, 2000.

Jonathan Talisman,
*Acting Assistant Secretary
of the Treasury.*

For the reasons set forth above, 29 CFR Part 2590 is amended as follows:

PART 2590 [AMENDED] — RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

1. The authority citation for Part 2590 is revised to read as follows:

Authority: Secs. 107, 209, 505, 701-703, 711-713, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171-1173, 1181-1183, and 1191-1194), as amended by HIPAA (Public Law 104-191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104-204, 110 Stat. 2935), and WHCRA (Public Law 105-277, 112 Stat. 2681-436), section 101(g)(4) of HIPAA, and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

2. **Section § 2590.702 is revised to read as follows:**

§ 2590.702 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) *Health factors.* (1) The term *health factor* means, in relation to an individual, any of the following health status-related factors:

- (i) Health status;
- (ii) Medical condition (including both physical and mental illnesses), as defined in § 2590.701-2;
- (iii) Claims experience;
- (iv) Receipt of health care;
- (v) Medical history;
- (vi) Genetic information, as defined in § 2590.701-2;
- (vii) Evidence of insurability; or
- (viii) Disability.

(2) Evidence of insurability includes —

(i) Conditions arising out of acts of domestic violence; and

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under § 2590.701-6, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility* — (1) *In general* — (i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (b)(3) of this section (allowing plans to impose certain preexisting condition exclusions), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to bona fide wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to —

- (A) Enrollment;
- (B) The effective date of coverage;
- (C) Waiting (or affiliation) periods;
- (D) Late and special enrollment;
- (E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);
- (F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion.* In this *Example 1*, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. (i) *Facts.* Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion.* In this *Example 2*, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts.* Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion.* In this *Example 3*, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts.* A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual *A* is an employee of the employer maintaining the plan. *A* and *A*'s dependents have a history of high health claims. Based on the information about *A* and *A*'s dependents, the issuer excludes *A* and *A*'s dependents from the group policy it offers to the employer.

(ii) *Conclusion.* In this *Example 4*, the issuer's exclusion of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors, and thus violates this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a

guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for *A* and *A*'s dependents through other means, the plan will also violate this paragraph (b)(1).

(2) *Application to benefits* — (i) *General rule* — (A) Under this section, a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan or through group health insurance coverage must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan or issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan or issuer may impose annual, lifetime, or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also paragraph (b)(2)(ii) of this section, which permits variances in the application of a cost-sharing mechanism made available under a bona fide wellness program. (Whether any plan provision or practice with respect to benefits complies with this paragraph (b)(2)(i) does not affect whether the provision or practice is permitted under any other provision of the

Act, the Americans with Disabilities Act, or any other law, whether State or federal.)

(C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan applies a \$500,000 lifetime limit on all benefits to each participant or beneficiary covered under the plan. The limit is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, the limit does not violate this paragraph (b)(2)(i) because \$500,000 of benefits are available uniformly to each participant and beneficiary under the plan and because the limit is applied uniformly to all participants and beneficiaries and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* A group health plan has a \$2 million lifetime limit on all benefits (and no other lifetime limits) for participants covered under the plan. Participant *B* files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a \$10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

(ii) *Conclusion.* Under the facts of this *Example 2*, the plan violates this paragraph (b)(2)(i) because the plan modification is directed at *B* based on *B*'s claim.

Example 3. (i) A group health plan applies for a group health policy offered by an issuer. Individual *C* is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about *C*'s adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that *C* has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for *C* for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion.* In this *Example 3*, the issuer violates this paragraph (b)(2)(i) because benefits for *C*'s condition are available to other individuals in the group of similarly situated individuals that includes *C* but are not available to *C*. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates this paragraph (b)(2)(i).

Example 4. (i) *Facts.* A group health plan has a \$2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is

applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because \$2000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 5. (i) *Facts.* A group health plan applies a \$2 million lifetime limit on all benefits. However, the \$2 million lifetime limit is reduced to \$10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

(ii) *Conclusion.* In this *Example 5*, the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan's lifetime limit on benefits does not apply uniformly to all similarly situated individuals.

Example 6. (i) *Facts.* A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 6*, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) *Facts.* Under a group health plan, doctor visits are generally subject to a \$250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 7*, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Cost-sharing mechanisms and wellness programs.* A group health plan or group health insurance coverage with a cost-sharing mechanism (such as a deductible, copayment, or coinsurance) that requires a higher payment from an individual, based on a health factor of that individual or a dependent of that individual, than for a similarly situated individual under the plan (and thus does not apply uniformly to all similarly situated individuals) does not violate the requirements of this paragraph (b)(2) if the payment dif-

ferential is based on whether an individual has complied with the requirements of a bona fide wellness program.

(iii) *Specific rule relating to source-of-injury exclusions* — (A) If a group health plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

(B) The rules of this paragraph (b)(2)(iii) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Individual *D* suffers from depression and attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Pursuant to the exclusion, the plan denies *D* benefits for treatment of the injuries.

(ii) *Conclusion.* In this *Example 1*, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of *D*'s injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts.* A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant *E* sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for *E*'s head injury.

(ii) *Conclusion.* In this *Example 2*, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow *E* to enroll in the plan (or applied different rules for eligibility to *E*) because *E* frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

(3) *Relationship to § 2590.701–3.* (i) A preexisting condition exclusion is permitted under this section if it —

- (A) Complies with § 2590.701–3;
- (B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and
- (C) Is not directed at individual participants or beneficiaries based on any health

factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with § 2590.701–3. There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with § 2590.701–3 (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2. (i) *Facts.* A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.

(ii) *Conclusion.* In this *Example 2*, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(c) *Prohibited discrimination in premiums or contributions* — (1) *In general* — (i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group

health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan or group health insurance coverage based on any health factor that relates to the individual or a dependent of the individual.

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates* — (i) *Group rating based on health factors not restricted under this section.* Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) *List billing based on a health factor prohibited.* However, a group health insurance issuer, or a group health plan, may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(iii) *Examples.* The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual F had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of F's claims experience.

(ii) *Conclusion.* In this *Example 1*, the issuer does not violate the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for F than for a similarly situated individual based on F's claims experience.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the issuer quotes the employer a higher premium rate for F, because of F's claims experience, than for a similarly situated individual.

(ii) *Conclusion.* In this *Example 2*, the issuer violates this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did

not require a higher participant contribution for F than for a similarly situated individual, the issuer would still violate this paragraph (c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for bona fide wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

(d) *Similarly situated individuals.* The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan or issuer may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants.* Subject to paragraph (d)(3) of this section, a plan or issuer may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different

occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries* — (i) Subject to paragraph (d)(3) of this section, a plan or issuer may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (e.g., as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of individuals with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals.* Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

(4) *Examples.* The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's usual business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 if the child is continuously enrolled full-time in an institution of higher learning (full-time students)). There is no evidence to suggest that these classifications are directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2*, treating spouses and dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent children is permitted under paragraph (d)(2) of this section and is not prohibited under paragraph (d)(3) of this section because it is not directed at individual participants or beneficiaries. It is also permissible to treat dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 or older if they are not full-time students) because the classification is permitted under paragraph (d)(2) of this section and is not directed at individual participants or beneficiaries.

Example 3. (i) *Facts.* A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 3*, the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4. (i) *Facts.* An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4*, imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who

do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

Example 5. (i) *Facts.* An employer sponsors a group health plan that provides the same benefit package to all seven employees of the employer. Six of the seven employees have the same job title and responsibilities, but Employee *G* has a different job title and different responsibilities. After *G* files an expensive claim for benefits under the plan, coverage under the plan is modified so that employees with *G*'s job title receive a different benefit package that includes a lower lifetime dollar limit than in the benefit package made available to the other six employees.

(ii) *Conclusion.* Under the facts of this *Example 5*, changing the coverage classification for *G* based on the existing employment classification for *G* is not permitted under this paragraph (d) because the creation of the new coverage classification for *G* is directed at *G* based on one or more health factors.

(e) *Nonconfinement and actively-at-work provisions* — (1) *Nonconfinement provisions* — (i) *General rule.* Under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans and issuers, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples.* The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) *Conclusion.* In this *Example 1*, the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) *Facts.* In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M*. However, for the current year, the plan provides coverage through a group health insurance policy

offered by Issuer *N*. Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion.* In this *Example 2*, Issuer *N* violates this paragraph (e)(1) because the group health insurance coverage restricts benefits (a rule for eligibility under paragraph (b)(1)) based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits clause from a previous issuer. This section does not affect any obligation Issuer *M* may have under applicable State law to provide any extension of benefits and does not affect any State law governing coordination of benefits.

(2) *Actively-at-work and continuous service provisions* — (i) *General rule* — (A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work described in paragraph (e)(2)(ii) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion.* In this *Example 1*, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) *Facts.* Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(ii) *Conclusion.* In this *Example 2*, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service.

(ii) *Exception for the first day of work* — (A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan or issuer may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) Facts. Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion.* In this *Example 1*, the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) Facts. Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion.* In this *Example 2*, the plan provision does not violate this section. However, as in *Example 1*, if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals* —

(i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan or issuer may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan or issuer may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other federal or

State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) Facts. Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion.* In this *Example 1*, the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on vacation leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) Facts. To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2*, the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) Facts. Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 3*, the plan provision terminating *B*'s coverage upon *B*'s termina-

tion of employment does not violate this section.

Example 4. (i) Facts. Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 4*, the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *Bona fide wellness programs.*
[Reserved.]

(g) *More favorable treatment of individuals with adverse health factors permitted* — (1) *In rules for eligibility* — (i) Nothing in this section prevents a group health plan or group health insurance issuer from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan or issuer from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1. (i) Facts. An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 23. However, dependent children who are disabled are eligible for coverage beyond age 23.

(ii) *Conclusion.* In this *Example 1*, the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2. (i) Facts. An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees \$50 per month for employee-only coverage and \$125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee \$100 per

month for employee-only coverage and \$250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 2*, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion.* In this *Example 3*, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions* — (i) Nothing in this section prevents a group health plan or group health insurance issuer from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

(ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example. (i) *Facts.* Under a group health plan, employees are generally required to pay \$50 per month for employee-only coverage and \$125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion.* In this *Example*, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws.* Compliance with this section is not deter-

minative of compliance with any other provision of the Act (including the COBRA continuation provisions) or any other State or federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans and issuers, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) *Applicability dates* — (1) *Paragraphs applicable March 9, 2001.* Paragraphs (a)(1), (a)(2)(i), (b)(1)(i), (b)(1)(iii) *Example 1*, (b)(2)(i)(A), (b)(2)(ii), (c)(1)(i), (c)(2)(i), and (c)(3) of this section and this paragraph (i)(1) apply to group health plans and health insurance issuers offering group health insurance coverage March 9, 2001.

(2) *Paragraphs applicable for plan years beginning on or after July 1, 2001.* Except as provided in paragraph (i)(3) of this section, the provisions of this section not listed in paragraph (i)(1) of this section apply to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after July 1, 2001. Except as provided in paragraph (i)(3) of this section, with respect to efforts to comply with section 702 of the Act before the first plan year beginning on or after July 1, 2001, the Secretary will not take any enforcement action against a plan that has sought to comply in good faith with section 702 of the Act.

(3) *Transitional rules for individuals previously denied coverage based on a health factor.* This paragraph (i)(3) provides rules relating to individuals previously denied coverage under a group health plan or group health insurance coverage based on a health factor of the individual. Paragraph (i)(3)(i) clarifies what constitutes a denial of coverage under this

paragraph (i)(3). Paragraph (i)(3)(ii) of this section applies with respect to any individual who was denied coverage if the denial was not based on a good faith interpretation of section 702 of the Act or the Secretary's published guidance. Under that paragraph, such an individual must be allowed to enroll retroactively to the effective date of section 702 of the Act, or, if later, the date the individual meets eligibility criteria under the plan that do not discriminate based on any health factor. Paragraph (i)(3)(iii) of this section applies with respect to any individual who was denied coverage based on a good faith interpretation of section 702 of the Act or the Secretary's published guidance. Under that paragraph, such an individual must be given an opportunity to enroll effective July 1, 2001. In either event, whether under paragraph (i)(3)(ii) or (iii) of this section, the Secretary will not take any enforcement action with respect to denials of coverage addressed in this paragraph (i)(3) if the plan has complied with the transitional rules of this paragraph (i)(3).

(i) *Denial of coverage clarified.* For purposes of this paragraph (i)(3), an individual is considered to have been denied coverage if the individual —

(A) Failed to apply for coverage because it was reasonable to believe that an application for coverage would have been futile due to a plan provision that discriminated based on a health factor; or

(B) Was not offered an opportunity to enroll in the plan and the failure to give such an opportunity violates this section.

(ii) *Individuals denied coverage without a good faith interpretation of the law* — (A) *Opportunity to enroll required.* If a plan or issuer has denied coverage to any individual based on a health factor and that denial was not based on a good faith interpretation of section 702 of the Act or any guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than March 9, 2001.

(I) If this enrollment opportunity was presented before or within the first plan year beginning on or after July 1, 1997 (or in the case of a collectively bargained plan, before or within the first plan year beginning on the effective date for the

plan described in section 101(g)(3) of the Health Insurance Portability and Accountability Act of 1996), the coverage must be effective within that first plan year.

(2) If this enrollment opportunity is presented after such plan year, the individual must be given the choice of having the coverage effective on either of the following two dates —

(i) The date the plan receives a request for enrollment in connection with the enrollment opportunity; or

(ii) Retroactively to the first day of the first plan year beginning on the effective date for the plan described in sections 101(g)(1) and (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). If an individual elects retroactive coverage, the plan or issuer is required to provide the benefits it would have provided if the individual had been enrolled for coverage during that period (irrespective of any otherwise applicable plan provisions governing timing for the submission of claims). The plan or issuer may require the individual to pay whatever additional amount the individual would have been required to pay for the coverage (but the plan or issuer cannot charge interest on that amount).

(B) *Relation to preexisting condition rules.* For purposes of Part 7 of Subtitle B of Title I of the Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 101(g)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan), even if the individual chooses under paragraph (i)(3)(ii)(A) of this section to have coverage effective only prospectively. In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Examples.* The rules of this paragraph (i)(3)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer X maintains a group health plan with a plan year beginning October 1 and ending September 30. Individual F

was hired by Employer X before the effective date of section 702 of the Act. Before the effective date of section 702 of the Act for this plan (October 1, 1997), the terms of the plan allowed employees and their dependents to enroll when the employee was first hired, and on each January 1 thereafter, but in either case, only if the individual could pass a physical examination. F's application to enroll when first hired was denied because F had diabetes and could not pass a physical examination. Upon the effective date of section 702 of the Act for this plan (October 1, 1997), the plan is amended to delete the requirement to pass a physical examination. In November of 1997, the plan gives F an opportunity to enroll in the plan (including notice of the opportunity to enroll) without passing a physical examination, with coverage effective January 1, 1998.

(ii) *Conclusion.* In this *Example 1*, the plan complies with the requirements of this paragraph (i)(3)(ii).

Example 2. (i) *Facts.* The plan year of a group health plan begins January 1 and ends December 31. Under the plan, a dependent who is unable to engage in normal life activities on the date coverage would otherwise become effective is not enrolled until the dependent is able to engage in normal life activities. Individual G is a dependent who is otherwise eligible for coverage, but is unable to engage in normal life activities. The plan has not allowed G to enroll for coverage.

(ii) *Conclusion.* In this *Example 2*, beginning on the effective date of section 702 of the Act for the plan (January 1, 1998), the plan provision is not permitted under any good faith interpretation of section 702 of the Act or any guidance published by the Secretary. Therefore, the plan is required, not later than March 9, 2001, to give G an opportunity to enroll (including notice of the opportunity to enroll), with coverage effective, at G's option, either retroactively from January 1, 1998 or prospectively from the date G's request for enrollment is received by the plan. If G elects coverage to be effective beginning January 1, 1998, the plan can require G to pay any required employee premiums for the retroactive coverage.

(iii) *Individuals denied coverage based on a good faith interpretation of the law* — (A) *Opportunity to enroll required.* If a plan or issuer has denied coverage to any individual before the first day of the first plan year beginning on or after July 1, 2001 based in part on a health factor and that denial was based on a good faith interpretation of section 702 of the Act or guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days, with coverage effective no later than July 1, 2001. Individuals required to be offered an opportunity to enroll include individuals previously offered enrollment without regard to a health factor but subsequently denied enrollment due to a health factor.

(B) *Relation to preexisting condition rules.* For purposes of Part 7 of Subtitle B

of Title I of the Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 101(g)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Example.* The rules of this paragraph (i)(3)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual H was hired by Employer Y on May 3, 1995. Y maintains a group health plan with a plan year beginning on February 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired (without a requirement to pass a physical examination), and on each February 1 thereafter if the individual can pass a physical examination. H chose not to enroll for coverage when hired in May of 1995. On February 1, 1997, H tried to enroll for coverage under the plan. However, H was denied coverage for failure to pass a physical examination. Shortly thereafter, Y's plan eliminated late enrollment, and H was not given another opportunity to enroll in the plan. There is no evidence to suggest that Y's plan was acting in bad faith in denying coverage under the plan beginning on the effective date of section 702 of the Act (February 1, 1998).

(ii) *Conclusion.* In this *Example*, because coverage previously had been made available with respect to H without regard to any health factor of H and because Y's plan was acting in accordance with a good faith interpretation of section 702 (and guidance published by the Secretary), the failure of Y's plan to allow H to enroll effective February 1, 1998 was permissible on that date. However, under the transitional rules of this paragraph (i)(3)(iii), Y's plan must give H an opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (In addition, February 1, 1998 is H's enrollment date under the plan and the period between February 1, 1998 and July 1, 2001 is treated as a waiting period. Accordingly, any preexisting condition exclusion period permitted under § 2590.701–3 will have expired before July 1, 2001.)

3. The heading, paragraph (a)(1), and the first sentence of paragraph (a)(2) of § 2590.736 of Part 2590 are revised to read as follows:

§ 2590.736 Applicability dates.

(a) *General applicability dates* — (1) *Non-collectively bargained plans.* Part 7 of Subtitle B of Title I of the Act and §§ 2590.701–1 through 2590.701–7, 2590.703, 2590.731 through 2590.734, and this section apply with respect to group

health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided in this section.

(2) *Collectively-bargained plans.* Except as otherwise provided in this section (other than in paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Part 7 of Subtitle B of Title I of the Act and §§ 2590.701–1 through 2590.701–7, 2590.703, 2590.731 through 2590.734, and this section do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). * * * *

* * * *

Signed in Washington, DC, this 28th day of December, 2000.

Leslie B. Kramerich,

Assistant Secretary, Pension and Welfare Benefits Administration
U.S. Department of Labor.

For the reasons set forth above, 45 CFR Part 146 is amended as follows:

PART 146 [AMENDED] — RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

1. The authority citation for Part 146 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791 and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92 as amended by HIPAA (Public Law 104–191, 110 Stat. 1936), MHPA and NMHPA (Public Law 104–204, 110 Stat. 2935), and WHCRA (Public Law 105–277, 112 Stat. 2681–436), and section 102(c)(4) of HIPAA.

2. **Section § 146.121 is revised to read as follows:**

§ 146.121 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) *Health factors.* (1) The term *health factor* means, in relation to an indi-

vidual, any of the following health status-related factors:

- (i) Health status;
- (ii) Medical condition (including both physical and mental illnesses), as defined in § 144.103;
- (iii) Claims experience;
- (iv) Receipt of health care;
- (v) Medical history;
- (vi) Genetic information, as defined in 45 CFR 144.103;
- (vii) Evidence of insurability; or
- (viii) Disability.

(2) Evidence of insurability includes —
(i) Conditions arising out of acts of domestic violence; and

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under § 146.117, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility* — (1) *In general* — (i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (b)(3) of this section (allowing plans to impose certain preexisting condition exclusions), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to bona fide wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to —

- (A) Enrollment;
- (B) The effective date of coverage;
- (C) Waiting (or affiliation) periods;
- (D) Late and special enrollment;
- (E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);
- (F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;
- (G) Continued eligibility; and
- (H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion.* In this *Example 1*, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. (i) *Facts.* Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion.* In this *Example 2*, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts.* Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion.* In this *Example 3*, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts.* A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual A is an employee of the employ-

or maintaining the plan. A and A's dependents have a history of high health claims. Based on the information about A and A's dependents, the issuer excludes A and A's dependents from the group policy it offers to the employer.

(ii) *Conclusion.* In this *Example 4*, the issuer's exclusion of A and A's dependents from coverage is a rule for eligibility that discriminates based on one or more health factors, and thus violates this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for A and A's dependents through other means, the plan will also violate this paragraph (b)(1).

(2) *Application to benefits* — (i) *General rule* — (A) Under this section, a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan or through group health insurance coverage must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan or issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan or issuer may impose annual, lifetime, or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the

participants or beneficiaries. In the case of a cost-sharing requirement, see also paragraph (b)(2)(ii) of this section, which permits variances in the application of a cost-sharing mechanism made available under a bona fide wellness program. (Whether any plan provision or practice with respect to benefits complies with this paragraph (b)(2)(i) does not affect whether the provision or practice is permitted under any other provision of ERISA, the Americans with Disabilities Act, or any other law, whether State or federal.)

(C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan applies a \$500,000 lifetime limit on all benefits to each participant or beneficiary covered under the plan. The limit is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, the limit does not violate this paragraph (b)(2)(i) because \$500,000 of benefits are available uniformly to each participant and beneficiary under the plan and because the limit is applied uniformly to all participants and beneficiaries and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* A group health plan has a \$2 million lifetime limit on all benefits (and no other lifetime limits) for participants covered under the plan. Participant B files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a \$10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

(ii) *Conclusion.* Under the facts of this *Example 2*, the plan violates this paragraph (b)(2)(i) because the plan modification is directed at B based on B's claim.

Example 3. (i) A group health plan applies for a group health policy offered by an issuer. Individual C is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about C's adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that C has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for C for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion.* In this *Example 3*, the issuer violates this paragraph (b)(2)(i) because benefits for

C's condition are available to other individuals in the group of similarly situated individuals that includes C but are not available to C. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates this paragraph (b)(2)(i).

Example 4. (i) *Facts.* A group health plan has a \$2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because \$2,000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 5. (i) *Facts.* A group health plan applies a \$2 million lifetime limit on all benefits. However, the \$2 million lifetime limit is reduced to \$10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

(ii) *Conclusion.* In this *Example 5*, the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan's lifetime limit on benefits does not apply uniformly to all similarly situated individuals.

Example 6. (i) *Facts.* A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 6*, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) *Facts.* Under a group health plan, doctor visits are generally subject to a \$250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 7*, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Cost-sharing mechanisms and wellness programs.* A group health plan or group health insurance coverage with a

cost-sharing mechanism (such as a deductible, copayment, or coinsurance) that requires a higher payment from an individual, based on a health factor of that individual or a dependent of that individual, than for a similarly situated individual under the plan (and thus does not apply uniformly to all similarly situated individuals) does not violate the requirements of this paragraph (b)(2) if the payment differential is based on whether an individual has complied with the requirements of a bona fide wellness program.

(iii) *Specific rule relating to source-of-injury exclusions* — (A) If a group health plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

(B) The rules of this paragraph (b)(2)(iii) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Individual *D* suffers from depression and attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Pursuant to the exclusion, the plan denies *D* benefits for treatment of the injuries.

(ii) *Conclusion.* In this *Example 1*, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of *D*'s injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts.* A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant *E* sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for *E*'s head injury.

(ii) *Conclusion.* In this *Example 2*, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow *E* to enroll in the plan (or applied different rules for eligibility to *E*) because *E* frequently participates in bungee jump-

ing, the plan would violate paragraph (b)(1) of this section.)

(3) *Relationship to § 146.111.* (i) A preexisting condition exclusion is permitted under this section if it —

(A) Complies with § 146.111;

(B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and

(C) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with § 146.111. There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with § 146.111 (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2. (i) *Facts.* A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.

(ii) *Conclusion.* In this *Example 2*, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have

medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(c) *Prohibited discrimination in premiums or contributions* — (1) *In general* —

(i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan or group health insurance coverage based on any health factor that relates to the individual or a dependent of the individual.

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates* — (i) *Group rating based on health factors not restricted under this section.* Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) *List billing based on a health factor prohibited.* However, a group health insurance issuer, or a group health plan, may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(iii) *Examples.* The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual *F* had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of *F*'s claims experience.

(ii) *Conclusion.* In this *Example 1*, the issuer does not violate the provisions of this paragraph

(c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for *F* than for a similarly situated individual based on *F*'s claims experience.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the issuer quotes the employer a higher premium rate for *F*, because of *F*'s claims experience, than for a similarly situated individual.

(ii) *Conclusion.* In this *Example 2*, the issuer violates this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for *F* than for a similarly situated individual, the issuer would still violate this paragraph (c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for bona fide wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

(d) *Similarly situated individuals.* The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan or issuer may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants.* Subject to paragraph (d)(3) of this section, a plan or issuer may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employ-

ment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries* — (i) Subject to paragraph (d)(3) of this section, a plan or issuer may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (e.g., as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of individuals with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals.* Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

(4) *Examples.* The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's usual business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 if the child is continuously enrolled full-time in an institution of higher learning (full-time students)). There is no evidence to suggest that these classifications are directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2*, treating spouses and dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent children is permitted under paragraph (d)(2) of this section and is not prohibited under paragraph (d)(3) of this section because it is not directed at individual participants or beneficiaries. It is also permissible to treat dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 or older if they are not full-time students) because the classification is permitted under paragraph (d)(2) of this section and is not directed at individual participants or beneficiaries.

Example 3. (i) *Facts.* A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 3*, the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4. (i) *Facts.* An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4*, imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

Example 5. (i) *Facts.* An employer sponsors a group health plan that provides the same benefit package to all seven employees of the employer. Six of the seven employees have the same job title and responsibilities, but Employee *G* has a different job title and different responsibilities. After *G* files an expensive claim for benefits under the plan, coverage under the plan is modified so that employees with *G*'s job title receive a different benefit package that includes a lower lifetime dollar limit than in the benefit package made available to the other six employees.

(ii) *Conclusion.* Under the facts of this *Example 5*, changing the coverage classification for *G* based on the existing employment classification for *G* is not permitted under this paragraph (d) because the creation of the new coverage classification for *G* is directed at *G* based on one or more health factors.

(e) *Nonconfinement and actively-at-work provisions* — (1) *Nonconfinement provisions* — (i) *General rule.* Under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans and issuers, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples.* The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution

does not become effective until the confinement ends.

(ii) *Conclusion.* In this *Example 1*, the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) *Facts.* In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M*. However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer *N*. Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion.* In this *Example 2*, Issuer *N* violates this paragraph (e)(1) because the group health insurance coverage restricts benefits (a rule for eligibility under paragraph (b)(1)) based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits clause from a previous issuer. This section does not affect any obligation Issuer *M* may have under applicable State law to provide any extension of benefits and does not affect any State law governing coordination of benefits.

(2) *Actively-at-work and continuous service provisions* — (i) *General rule* — (A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work described in paragraph (e)(2)(ii) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion.* In this *Example 1*, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) *Facts.* Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is

absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(ii) *Conclusion.* In this *Example 2*, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service.

(ii) *Exception for the first day of work* — (A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan or issuer may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion.* In this *Example 1*, the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) *Facts.* Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion.* In this *Example 2*, the plan provision does not violate this section. However, as in *Example 1*, if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals* — (i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan

or issuer may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan or issuer may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion.* In this *Example 1*, the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on vacation leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) *Facts.* To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2*, the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours

in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 3*, the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

Example 4. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 4*, the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *Bona fide wellness programs.*
[Reserved.]

(g) *More favorable treatment of individuals with adverse health factors permitted* — (1) *In rules for eligibility* — (i) Nothing in this section prevents a group health plan or group health insurance issuer from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan or issuer from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 23. However, dependent children who are disabled are eligible for coverage beyond age 23.

(ii) *Conclusion.* In this *Example 1*, the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2. (i) *Facts.* An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees \$50 per month for employee-only coverage and \$125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee \$100 per month for employee-only coverage and \$250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 2*, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion.* In this *Example 3*, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions* — (i) Nothing in this section prevents a group health plan or group health insurance issuer from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an

adverse health factor, such as disability.

(ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example. (i) *Facts.* Under a group health plan, employees are generally required to pay \$50 per month for employee-only coverage and \$125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion.* In this *Example*, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws.*

Compliance with this section is not determinative of compliance with any other provision of the PHS Act (including the COBRA continuation provisions) or any other State or federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans and issuers, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) *Applicability dates* — (1) *Paragraphs applicable March 9, 2001.* Paragraphs (a)(1), (a)(2)(i), (b)(1)(i), (b)(1)(iii) *Example 1*, (b)(2)(i)(A), (b)(2)(ii), (c)(1)(i), (c)(2)(i), and (c)(3) of this section and this paragraph (i)(1) apply to group health plans and health insurance issuers offering group health insurance coverage March 9, 2001.

(2) *Paragraphs applicable for plan years beginning on or after July 1, 2001.* Except as provided in paragraph (i)(3) or (i)(4) of this section, the provisions of this section not listed in paragraph (i)(1) of this section apply to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after July 1, 2001. Except as provided in paragraph (i)(3) or

(i)(4) of this section, with respect to efforts to comply with section 2702 of the PHS Act before the first plan year beginning on or after July 1, 2001, the Secretary will not take any enforcement action against an issuer or plan that has sought to comply in good faith with section 2702 of the PHS Act.

(3) *Transitional rules for individuals previously denied coverage based on a health factor.* This paragraph (i)(3) provides rules relating to individuals previously denied coverage under a group health plan or group health insurance coverage based on a health factor of the individual. Paragraph (i)(3)(i) clarifies what constitutes a denial of coverage under this paragraph (i)(3). Paragraph (i)(3)(ii) of this section applies with respect to any individual who was denied coverage if the denial was not based on a good faith interpretation of section 2702 of the PHS Act or the Secretary's published guidance. Under that paragraph, such an individual must be allowed to enroll retroactively to the effective date of section 2702 of the PHS Act, or, if later, the date the individual meets eligibility criteria under the plan that do not discriminate based on any health factor. Paragraph (i)(3)(iii) of this section applies with respect to any individual who was denied coverage based on a good faith interpretation of section 2702 of the PHS Act or the Secretary's published guidance. Under that paragraph, such an individual must be given an opportunity to enroll effective July 1, 2001. In either event, whether under paragraph (i)(3)(ii) or (iii) of this section, the Secretary will not take any enforcement action with respect to denials of coverage addressed in this paragraph (i)(3) if the issuer or plan has complied with the transitional rules of this paragraph (i)(3).

(i) *Denial of coverage clarified.* For purposes of this paragraph (i)(3), an individual is considered to have been denied coverage if the individual —

(A) Failed to apply for coverage because it was reasonable to believe that an application for coverage would have been futile due to a plan provision that discriminated based on a health factor; or

(B) Was not offered an opportunity to enroll in the plan and the failure to give

such an opportunity violates this section.

(ii) *Individuals denied coverage without a good faith interpretation of the law* — (A) *Opportunity to enroll required.* If a plan or issuer has denied coverage to any individual based on a health factor and that denial was not based on a good faith interpretation of section 2702 of the PHS Act or any guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than March 9, 2001.

(1) If this enrollment opportunity was presented before or within the first plan year beginning on or after July 1, 1997 (or in the case of a collectively bargained plan, before or within the first plan year beginning on the effective date for the plan described in section 102(c)(3) of the Health Insurance Portability and Accountability Act of 1996), the coverage must be effective within that first plan year.

(2) If this enrollment opportunity is presented after such plan year, the individual must be given the choice of having the coverage effective on either of the following two dates —

(i) The date the plan receives a request for enrollment in connection with the enrollment opportunity; or

(ii) Retroactively to the first day of the first plan year beginning on the effective date for the plan described in sections 102(c)(1) and (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). If an individual elects retroactive coverage, the plan or issuer is required to provide the benefits it would have provided if the individual had been enrolled for coverage during that period (irrespective of any otherwise applicable plan provisions governing timing for the submission of claims). The plan or issuer may require the individual to pay whatever additional amount the individual would have been required to pay for the coverage (but the plan or issuer cannot charge interest on that amount).

(B) *Relation to preexisting condition rules.* For purposes of section 2701 of the PHS Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 102(c)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan), even if the individual chooses under paragraph (i)(3)(ii)(A) of this section to have coverage effective only prospectively. In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Examples.* The rules of this paragraph (i)(3)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer X maintains a group health plan with a plan year beginning October 1 and ending September 30. Individual F was hired by Employer X before the effective date of section 2702 of the PHS Act. Before the effective date of section 2702 of the PHS Act for this plan (October 1, 1997), the terms of the plan allowed employees and their dependents to enroll when the employee was first hired, and on each January 1 thereafter, but in either case, only if the individual could pass a physical examination. F's application to enroll when first hired was denied because F had diabetes and could not pass a physical examination. Upon the effective date of section 2702 of the PHS Act for this plan (October 1, 1997), the plan is amended to delete the requirement to pass a physical examination. In November of 1997, the plan gives F an opportunity to enroll in the plan (including notice of the opportunity to enroll) without passing a physical examination, with coverage effective January 1, 1998.

(ii) *Conclusion.* In this *Example 1*, the plan complies with the requirements of this paragraph (i)(3)(ii).

Example 2. (i) *Facts.* The plan year of a group health plan begins January 1 and ends December 31. Under the plan, a dependent who is unable to engage in normal life activities on the date coverage would otherwise become effective is not enrolled until the dependent is able to engage in normal life activities. Individual G is a dependent who is otherwise eligible for coverage, but is unable to engage in normal life activities. The plan has not allowed G to enroll for coverage.

(ii) *Conclusion.* In this *Example 2*, beginning on the effective date of section 2702 of the PHS Act for the plan (January 1, 1998), the plan provision is not permitted under any good faith interpretation of section 2702 of the PHS Act or any guidance published by the Secretary. Therefore, the plan is required, not later than March 9, 2001, to give G an opportunity to enroll (including notice of the opportunity to enroll), with coverage effective, at G's option, either retroac-

tively from January 1, 1998 or prospectively from the date G's request for enrollment is received by the plan. If G elects coverage to be effective beginning January 1, 1998, the plan can require G to pay any required employee premiums for the retroactive coverage.

(iii) *Individuals denied coverage based on a good faith interpretation of the law* — (A) *Opportunity to enroll required.* If a plan or issuer has denied coverage to any individual before the first day of the first plan year beginning on or after July 1, 2001, based in part on a health factor and that denial was based on a good faith interpretation of section 2702 of the PHS Act or guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days, with coverage effective no later than July 1, 2001. Individuals required to be offered an opportunity to enroll include individuals previously offered enrollment without regard to a health factor but subsequently denied enrollment due to a health factor.

(B) *Relation to preexisting condition rules.* For purposes of section 2701 of the PHS Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 102(c)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Example.* The rules of this paragraph (i)(3)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual H was hired by Employer Y on May 3, 1995. Y maintains a group health plan with a plan year beginning on February 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired (without a requirement to pass a physical examination), and on each February 1 thereafter if the individual can pass a physical examination. H chose not to enroll for coverage when hired in May of 1995. On February 1, 1997, H tried to enroll for coverage under the plan. However, H was denied coverage for failure to pass a physical examination. Shortly thereafter, Y's plan eliminated late enrollment, and H was not given another opportunity to enroll in the plan. There is no evidence to suggest that Y's plan was acting in

bad faith in denying coverage under the plan beginning on the effective date of section 2702 of the PHS Act (February 1, 1998).

(ii) *Conclusion.* In this *Example*, because coverage previously had been made available with respect to H without regard to any health factor of H and because Y's plan was acting in accordance with a good faith interpretation of section 2702 of the PHS Act (and guidance published by the Secretary), the failure of Y's plan to allow H to enroll effective February 1, 1998 was permissible on that date. However, under the transitional rules of this paragraph (i)(3)(iii), Y's plan must give H an opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (In addition, February 1, 1998 is H's enrollment date under the plan and the period between February 1, 1998 and July 1, 2001 is treated as a waiting period. Accordingly, any preexisting condition exclusion period permitted under § 146.111 will have expired before July 1, 2001.)

(4) *Special transitional rule for self-funded non-Federal governmental plans exempted under 45 CFR 146.180* — (i) If coverage has been denied to any individual because the sponsor of a self-funded non-Federal governmental plan has elected under § 146.180 to exempt the plan from the requirements of this section, and the plan sponsor subsequently chooses to bring the plan into compliance with the requirements of this section, the plan —

(A) Must notify the individual that the plan will be coming into compliance with the requirements of this section, specify the effective date of compliance, and inform the individual regarding any enrollment restrictions that may apply under the terms of the plan once the plan is in compliance with this section (as a matter of administrative convenience, the notice may be disseminated to all employees);

(B) Must give the individual an opportunity to enroll that continues for at least 30 days;

(C) Must permit coverage to be effective as of the first day of plan coverage for which an exemption election under § 146.180 (with regard to this section) is no longer in effect (or July 1, 2001, if later, and the plan was acting in accordance with a good faith interpretation of section 2702 of the PHS Act and guidance published by HCFA); and

(D) May not treat the individual as a late enrollee or a special enrollee.

(ii) For purposes of this paragraph (i)(4), an individual is considered to have been denied coverage if the individual failed to apply for coverage because, given an exemption election under

§ 146.180, it was reasonable to believe that an application for coverage would have been denied based on a health factor.

(iii) The rules of this paragraph (i)(4) are illustrated by the following examples:

Example 1. (i) Facts. Individual *D* was hired by a non-Federal governmental employer in June 1996. The employer maintains a self-funded group health plan with a plan year beginning on October 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired without regard to any health factor. If an individual declines to enroll when first eligible, the individual may enroll effective October 1 of any plan year if the individual can pass a physical examination. The plan sponsor elected under § 146.180 of this part to exempt the plan from the requirements of this section for the plan year beginning October 1, 1997, and renewed the exemption election for the plan year beginning October 1, 1998. That is, the plan sponsor elected to retain the evidence of good health requirement for late enrollees which, absent an exemption election under § 146.180 of this part, would have been in violation of this section as of October 1, 1997. *D* chose not to enroll for coverage when first hired. In February of 1998, *D* was treated for skin cancer but did not apply for coverage under the plan for the plan year beginning October 1, 1998, because *D* assumed *D* could not meet the evidence of good health requirement. With the plan year beginning October 1, 1999, the plan sponsor chose not to renew its exemption election and brought the plan into compliance with this section. However, the terms of the plan, effective October 1, 1999, were amended to permit enrollment only during the initial 30-day period of employment. The plan no longer permits late enrollment under any circumstances, including with respect to current employees not enrolled in the plan. Therefore, *D* was not given another opportunity to enroll in the plan. There is no evidence to suggest that the plan was acting in bad faith in denying *D* coverage under the plan beginning on the effective date of § 146.121 for the plan (October 1, 1999).

(ii) *Conclusion.* In this *Example 1*, because the plan under § 146.180 was previously excluded from the requirements of § 146.121 and thereafter was acting in accordance with a good faith interpretation of § 146.121 and guidance published by HCFA, the failure of the plan to give *D* an opportunity to enroll effective October 1, 1999 was permissible on that date. However, under the transitional rules of this paragraph (i)(4), the plan must give *D* an opportuni-

ty to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (Additionally, October 1, 1999 is *D*'s enrollment date under the plan and the period between October 1, 1999 and July 1, 2001 is treated as a waiting period. Furthermore, if the plan sponsor has not elected to exempt the plan from limitations on preexisting condition exclusion periods, any preexisting condition exclusion period must be administered in accordance with § 146.111. Accordingly, any preexisting condition exclusion period permitted under § 146.111 will have expired before July 1, 2001.)

Example 2. (i) Facts. Individual *E* was hired by a non-Federal governmental employer in February 1995. The employer maintains a self-funded group health plan with a plan year beginning on September 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired without regard to any health factor. If an individual declines to enroll when first eligible, the individual may enroll effective September 1 of any plan year if the individual can pass a physical examination. All enrollees are subject to a 12-month preexisting condition exclusion period. The plan sponsor elected under § 146.180 of this part to exempt the plan from the requirements of this section and § 146.111 (limitations on preexisting condition exclusion periods) for the plan year beginning September 1, 1997, and renews the exemption election for the plan years beginning September 1, 1998, September 1, 1999, and September 1, 2000. *E* chose not to enroll for coverage when first hired. In June of 2001, *E* is diagnosed as having multiple sclerosis (MS). With the plan year beginning September 1, 2001, the plan sponsor chooses to bring the plan into compliance with this section, but renews its exemption election with regard to limitations on preexisting condition exclusion periods. The plan affords *E* an opportunity to enroll, without a physical examination, effective September 1, 2001. *E* is subject to a 12-month preexisting condition exclusion period with respect to any treatment *E* receives that is related to *E*'s MS, without regard to any prior creditable coverage *E* may have. Beginning September 1, 2002, the plan will cover treatment of *E*'s MS.

(ii) *Conclusion.* In this *Example 2*, the plan complies with the requirements of this section. (The plan is not required to comply with the requirements of § 146.111 because the plan continues to be exempted from those requirements in accordance with the plan sponsor's election under § 146.180.)

3. The heading, paragraph (a)(1), and the first sentence of paragraph (a)(2) of § 146.125 are revised to read as follows:

§ 146.125 Applicability dates.

(a) *General applicability dates* — (1) *Non-collectively bargained plans.* Part A of title XXVII of the PHS Act and §§146.101 through 146.119, § 146.143, §146.145, 45 CFR part 150, and this section apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided in this section.

(2) *Collectively-bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Part A of Title XXVII of the PHS Act and §§ 146.101 through 146.119, § 146.143, § 146.145, 45 CFR part 150, and this section do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). * * *

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Dated June 22, 2000.

Nancy-Ann Min DeParle,
*Administrator, Health Care
Financing Administration.*

Approved August 29, 2000.

Donna E. Shalala,
Secretary.

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