

§ 146.119

(ii) In this *Example*, *B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) (even though this date is also a regular enrollment date under the plan).

(Approved by the Office of Management and Budget under control number 0938-0702.)

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§ 146.119 HMO affiliation period as alternative to preexisting condition exclusion.

(a) *General*. A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the requirements in paragraph (b) of this section is satisfied.

(b) *Requirements for affiliation period*.

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is applied uniformly without regard to any health status-related factors.

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(c) *Alternatives to affiliation period*. An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. Nothing in this section requires a State to receive proposals for or approve alternatives to affiliation periods.

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

(a) *In eligibility to enroll*—(1) *General*. Subject to paragraph (a)(2) of this section, a group health plan, and a health insurance issuer offering group health

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insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(i) Health status.

(ii) Medical condition (including both physical and mental illnesses), as defined in 45 CFR 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 (including conditions arising out of acts of domestic violence).

(viii) Disability.

(2) *No application to benefits or exclusions*. To the extent consistent with section 2701 of the Act and § 146.111, paragraph (a)(1) of this section shall not be construed—

(i) To require a group health plan, or a health insurance issuer offering group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage; or

(ii) To prevent such a plan or issuer from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) *Construction*. For purposes of paragraph (a)(1) of this section, rules for eligibility to enroll include rules defining any applicable waiting (or affiliation) periods for such enrollment and rules relating to late and special enrollment.

4. *Example*. The following example illustrates the requirements of this paragraph (a):

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

(ii) In this *Example*, the plan discriminates on the basis of one or more health status-related factors.