(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.)

[62 FR 16958, Apr. 8, 1997; 62 FR 31694, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 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 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.

(b) *In premiums or contributions*—(1) *General.* 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) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor, in relation to the individual or a dependent of the individual.

(2) *Construction.* Nothing in paragraph (b)(1) of this section can be construed—

(i) To restrict the amount that an employer may be charged by an issuer for coverage under a group health plan; or

(ii) To prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to a bona fide wellness program. For purposes of this section, a bona fide wellness program is a program of health promotion and disease prevention.

(3) *Example:* The following example illustrates the requirements of this paragraph (b):

Example. (i) Plan *X* offers a premium discount to participants who adhere to a cholesterol-reduction wellness program. Enrollees are expected to keep a diary of their food intake over 6 weeks. They periodically submit the diary to the plan physician who responds with suggested diet modifications. Enrollees are to modify their diets in accordance with the physician's recommendations. At the end of the 6 weeks, enrollees are given a cholesterol test and those who achieve a count under 200 receive a premium discount.

(ii) In this *Example,* because enrollees who otherwise comply with the program may be unable to achieve a cholesterol count under 200 due to a health status-related factor, this is not a bona fide wellness program and such discounts would discriminate impermissibly based on one or more health status-related factors. However, if, instead, individuals covered by the plan were entitled to receive the discount for complying with the diary and dietary requirements and were not required to pass a cholesterol test, the program would be a bona fide wellness program.

[62 FR 16958, Apr. 8, 1997; 62 FR 31694, June 10, 1997]

§ 146.125 Effective dates.

(a) *General effective dates*—(1) *Non-collectively-bargained plans.* Except as otherwise provided in this section, part A of title XXVII of the PHS Act and this part apply with respect to group health plans, including health insurance issuers offering health insurance coverage in connection with group health plans, for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1)), in the case of a group health plan maintained under 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 this part 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). For these purposes, any plan amendment made under a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such part, is not treated as a termination of the collective bargaining agreement.

(3) *Preexisting condition exclusion periods for current employees.* (i) *General rule.* Any preexisting condition exclusion period permitted under § 146.111 is measured from the individual's enrollment date in the plan. This exclusion period, as limited under § 146.111, may be completed before the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to part A of title XXVII of the PHS Act, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation in § 146.111. For an individual who has not completed the permitted exclusion period under HIPAA, upon the effective date for his or her plan, the individual