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 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 provision of ERISA (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 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) *Applicability dates.* This section applies for plan years beginning on or after July 1, 2007.

Mark E. Matthews,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: June 22, 2006.

Eric Solomon,

Acting Deputy Assistant Secretary of the Treasury (Tax Policy).

Employee Benefits Security Administration

29 CFR Chapter XXV

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

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. The authority citation for Part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c, sec. 101(g), Public Law 104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); Secretary of Labor's Order 1–2003, 68 FR 5374 (Feb. 3, 2003).

■ 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 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 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.* The facts of this *Example 2* strongly suggest that the plan modification is directed at *B* based on *B*'s claim. Absent outweighing evidence to the contrary, the plan violates this paragraph (b)(2)(i).

Example 3. (i) *Facts.* 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. 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).

With respect to these benefit rules, the Departments received many inquiries about HRAs and one comment about nondiscrimination requirements under other laws. Under HRAs, employees are reimbursed for medical expenses up to a maximum amount for a period, based on the employer's contribution to the plan. These plans may or may not be funded. Another common feature is that the plans typically allow amounts remaining available at the end of the period to be used to reimburse medical expenses in later periods. Because the maximum reimbursement available under a plan to an employee in any single period may vary based on the claims experience of the employee, concerns have arisen about the application of the HIPAA nondiscrimination rules to these plans.

To address these concerns, these final regulations include an example under which the carryforward of unused employer-provided medical care reimbursement amounts to later years does not violate the HIPAA nondiscrimination requirements, even though the maximum reimbursement amount for a year varies among employees within the same group of similarly situated individuals based on prior claims experience. In the example, an employer sponsors a group health plan under which medical care expenses are reimbursed up to an annual maximum amount. The maximum reimbursement amount with respect to an employee for a year is a uniform amount multiplied by the number of years the employee has participated in the plan, reduced by the total reimbursements for prior years. Because employees who have participated in the plan for the same length of time are eligible for the same total benefit over that length of time, the example concludes that the arrangement does not violate the HIPAA nondiscrimination requirements.

The Equal Employment Opportunity Commission (EEOC) asked the Departments to clarify that certain plan practices or provisions permitted under the benefits paragraphs of the 2001 interim rules may violate the Americans with Disabilities Act of 1990 (ADA) or Title VII of the Civil Rights Act of 1964 (Title VII). Specifically, the 2001 interim rules allow plans to exclude or limit benefits for certain types of conditions or treatments. The EEOC commented that, if such a benefit limit were applied to AIDS, it would be a disability-based distinction that violates the ADA (unless it is permitted under section 501(c) of the ADA). In addition, the EEOC commented that an exclusion from coverage of prescription contraceptives, but not of other preventive treatments, would violate Title VII because prescription contraceptives are used exclusively by women.

Paragraph (h) of the 2001 interim rules and these final regulations is entitled "No effect on other laws." This section clarifies that compliance with the nondiscrimination rules is not determinative of compliance with any other provision of ERISA, or any other State or Federal law, including the ADA. Moreover, in paragraph (b) of the 2001 interim rules and these final regulations, the general rule governing the application of the nondiscrimination rules to benefits clarifies that whether any plan provision or practice with respect to benefits complies with these rules does not affect whether the provision or practice is permitted under any other provision of the Code, ERISA, or the PHS Act, the Americans with Disabilities Act, or any other law, whether State or Federal.

Many other laws may regulate plans and issuers in their provision of benefits to participants and beneficiaries. These laws include the ADA, Title VII, the Family and Medical Leave Act, ERISA's fiduciary provisions, and State law. The Departments have not attempted to summarize the requirements of those laws in the HIPAA nondiscrimination rules. Instead, these rules clarify the application of the HIPAA nondiscrimination rules to group health plans, which may permit certain practices that other laws prohibit. Nonetheless, to avoid misleading plans and issuers as to the permissibility of any plan provision under other laws, the Departments included, in both paragraph (h) and paragraph (b) of the regulations, references to the potential applicability of other laws. Employers, plans, issuers, and other service providers should consider the applicability of these laws to their coverage and contact legal counsel or other government agencies such as the EEOC and State insurance departments if they have questions under those laws.

Source-of-Injury Exclusions

Some plans and issuers, while generally providing coverage for the treatment of an injury, deny benefits if the injury arose from a specified cause or activity. These kinds of exclusions are known as source-of-injury exclusions. Under the 2001 interim rules, if a plan or issuer provides benefits for a particular injury, it may not deny benefits otherwise provided for treatment of the injury due to the fact that the injury results from a medical condition or an act of domestic violence. Two examples in the 2001 interim rules illustrate the application of this rule, to injuries resulting from an attempted suicide due to depression and to injuries resulting from bungee jumping.

These final regulations retain the provisions in the 2001 interim rules and add a clarification. Some people have inquired if a suicide exclusion can apply if an individual had not been diagnosed with a medical condition such as depression before the suicide attempt. These final regulations clarify that benefits may not be denied for injuries resulting from a medical condition even if the medical condition was not diagnosed before the injury.

Some comments expressed concern that the discussion of the source-of-injury rule in the 2001 interim rules might be used to support the use of vague language to identify plan benefit exclusions, especially to identify source-of-injury exclusions. Requirements for plan benefit descriptions are generally outside of the scope of these regulations. Nonetheless, Department of Labor regulations at 29 CFR 2520.102–2(b) provide, "The format of the summary plan description must not have the effect of misleading, misinforming or failing to inform participants and beneficiaries. Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant * * * The advantages and disadvantages of the plan shall be presented without either exaggerating the benefits or minimizing the limitations." State laws governing group insurance or nonfederal governmental plans may provide additional protections.

The Departments received thousands of comments protesting that the source-of-injury provisions in the 2001 interim rules would generally permit plans or issuers to exclude benefits for the treatment of injuries sustained in the activities listed in the conference report to HIPAA (motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities). Many comments requested that the source-of-injury rule be amended to provide that a source-of-injury exclusion could not apply if the

elected under § 146.180 of this part to exempt the plan from the requirements of this section for the plan year beginning October 1, 2005, and renewed the exemption election for the plan year beginning October 1, 2006. Under the terms of the plan while the exemption was in effect, employees and their dependents were allowed to enroll when the employee was first hired without regard to any health factor. If an individual declines to enroll when first eligible, the individual could enroll effective October 1 of any plan year if the individual could pass a physical examination. The evidence-of-good-health requirement for late enrollees, absent an exemption election under § 146.180 of this part, would have been in violation of this section. *D* chose not to enroll for coverage when first hired. In February of 2006, *D* was treated for skin cancer but did not apply for coverage under the plan for the plan year beginning October 1, 2006, because *D* assumed *D* could not meet the evidence-of-good-health requirement. With the plan year beginning October 1, 2007 the plan sponsor chose not to renew its exemption election and brought the plan into compliance with this section. The plan notifies individual *D* (and all other employees) that it will be coming into compliance with the requirements of this section. The notice specifies that the effective date of compliance will be October 1, 2007, explains the applicable enrollment restrictions that will apply under the plan, states that individuals will have at least 30 days to enroll, and explains that coverage for those who choose to enroll will be effective as of October 1, 2007. Individual *D* timely requests enrollment in the plan, and coverage commences under the plan on October 1, 2007.

(ii) *Conclusion.* In this *Example 1*, the plan complies with this paragraph (i)(2).

Example 2. (i) *Facts.* Individual *E* was hired by a nonfederal governmental employer in February 1999. The employer maintains a self-funded group health plan with a plan year beginning on September 1. 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, 2002, and renews the exemption election for the plan years beginning September 1, 2003, September 1, 2004, September 1, 2005, and September 1, 2006. Under the terms of the plan while the exemption was in effect, employees and their dependents were allowed to enroll when the employee was first hired without regard to any health factor. If an individual declined to enroll when first eligible, the individual could enroll effective September 1 of any plan year if the individual could pass a physical examination. Also under the terms of the plan, all enrollees were subject to a 12-month preexisting condition exclusion period, regardless of whether they had creditable coverage. *E* chose not to enroll for coverage when first hired. In June of 2006, *E* is diagnosed as having multiple sclerosis (MS). With the plan year beginning September 1, 2007, 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 notifies *E* of her opportunity to enroll, without a physical examination, effective September 1, 2007. The plan gives *E* 30 days to enroll. *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, 2008, 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.)

Editorial Note: This document was received at the Office of the Federal Register on December 1, 2006.

Dated: July 16, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 28, 2005.

Michael O. Leavitt,

Secretary, Department of Health and Human Services.

[FR Doc. 06–9557 Filed 12–12–06; 8:45 am]

BILLING CODE 4830–01–P; 4510–29–P; 4120–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[TD 9299]

RIN 1545–AY33

Exception to the HIPAA Nondiscrimination Requirements for Certain Grandfathered Church Plans

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations that provide guidance under section 9802(c) of the Internal Revenue Code relating to the exception for certain grandfathered church plans from the nondiscrimination requirements applicable to group health plans under section 9802(a) and (b). Final regulations relating to the nondiscrimination requirements under section 9802(a) and (b) are being published elsewhere in this issue of the **Federal Register**. The regulations will generally affect sponsors of and participants in certain self-funded church plans that are group health plans, and the regulations provide plan sponsors and plan administrators with guidance necessary to comply with the law.

DATES: *Effective Date:* These regulations are effective February 12, 2007.

Applicability Date: These regulations apply for plan years beginning on or after July 1, 2007.

FOR FURTHER INFORMATION CONTACT: Russ Weinheimer at 202–622–6080 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains amendments to the Miscellaneous Excise Tax Regulations (26 CFR part 54) relating to the exception for certain grandfathered church plans from the nondiscrimination requirements applicable to group health plans. The nondiscrimination requirements applicable to group health plans were added to the Internal Revenue Code (Code), in section 9802, by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191 (110 Stat. 1936). HIPAA also added similar nondiscrimination provisions applicable to group health plans and health insurance issuers (such as health insurance companies and health maintenance organizations) under the Employee Retirement Income Security Act of 1974 (ERISA), administered by the U.S. Department of Labor, and the Public Health Service Act (PHS Act), administered by the U.S. Department of Health and Human Services.

Final regulations relating to the HIPAA nondiscrimination requirements in paragraphs (a) and (b) of section 9802 of the Code are being published elsewhere in this issue of the **Federal Register**. Those regulations are similar to, and have been developed in coordination with, final regulations also being published today by the Departments of Labor and of Health and Human Services. Guidance under the HIPAA nondiscrimination requirements is summarized in a joint preamble to the final regulations.

The exception for certain grandfathered church plans was added to section 9802, in subsection (c), by section 1532 of the Taxpayer Relief Act of 1997, Public Law 105–34 (111 Stat. 788). A notice of proposed rulemaking on the exception for certain grandfathered church plans and a request for comments (REG–114083–00) was published in the **Federal Register** of January 8, 2001. Two written comments were received. After consideration of the comments, the proposed regulations are adopted as amended by this Treasury decision.

work clauses are generally prohibited, unless individuals who are absent from work due to any health factor are treated, for purposes of health coverage, as if they are actively at work. Nonetheless, a plan or issuer may distinguish between groups of similarly situated individuals (provided the distinction is not directed at individual participants or beneficiaries based on a health factor). Examples in the regulations 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).

Several members of the regulated community have asked the Departments to clarify the applicability of the actively-at-work rules to various plan provisions that require an individual to perform a minimum amount of service per week in order to be eligible for coverage. It is the Departments' experience that much of the complexity in applying these rules derives from the myriad variations in the operation of employers' leave policies. The Departments believe that the 2001 interim rules provide adequate principles for applying the actively-at-work provisions to different types of eligibility provisions. In order to comply with these rules, a plan or issuer should apply the plan's service requirements consistently to all similarly situated employees eligible for coverage under the plan without regard to whether an employee is seeking eligibility to enroll in the plan or continued eligibility to remain in the plan. Accordingly, if a plan imposes a 30-hour-per-week requirement and treats employees on paid leave (including sick leave and vacation leave) who are already in the plan as if they are actively-at-work, the plan generally is required to credit time on paid leave towards satisfying the 30-hour-per-week requirement for employees seeking enrollment in the plan. Similarly, if a plan allowed employees to continue eligibility under the plan while on paid leave and for an additional period of 30 days while on unpaid leave, the plan is generally required to credit these same periods for employees seeking enrollment in the plan.[1] To help ensure consistency in application, plans and issuers may wish to clarify, in writing, how employees on various types of leave are treated for purposes of interpreting a service requirement. Without clear plan rules, plans and issuers might slip into inconsistent applications of their rules, which could lead to violations of the actively-at-work provisions.

Wellness Programs

The HIPAA nondiscrimination provisions do not prevent a plan or issuer from establishing discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. The 1997 interim rules refer to these programs as "bona fide wellness programs." In the preamble to the 1997 interim rules, the Departments invited comments on whether additional guidance was needed concerning, among other things, the permissible standards for determining bona fide wellness programs. The Departments also stated their intent to issue further regulations on the nondiscrimination requirements 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 publication of additional guidance. The preambles to the 2001 interim final and proposed rules noted that the period for nonenforcement in cases of good faith compliance with the HIPAA nondiscrimination provisions generally ended on the applicability date of those regulations but continued with respect to wellness programs until the issuance of further guidance. Accordingly, the nonenforcement policy of the Departments ends upon the applicability date of these final regulations for cases in which a plan or issuer fails to comply with the regulations but complies in good faith with an otherwise reasonable interpretation of the statute.

The HIPAA nondiscrimination provisions generally prohibit a plan or issuer from charging similarly situated individuals different premiums or contributions based on a health factor. These final regulations also generally prohibit a plan or issuer from requiring similarly situated individuals to satisfy differing deductible, copayment, or other cost-sharing requirements. However, 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.

Both the 1997 interim rules and the 2001 proposed regulations refer to programs of health promotion and disease prevention allowed under this exception as "bona fide wellness programs." These regulations generally adopt the provisions in the 2001 proposed rules. However, as more fully explained below, the final regulations no longer use the term "bona fide" in connection with wellness programs, add a description of wellness programs that do not have to satisfy additional requirements in order to comply with the nondiscrimination requirements, reorganize the four requirements from the proposed rules into five requirements, provide that the reward for a wellness program—coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor—must not exceed 20% of the total cost of coverage under the plan, and add examples and make other changes to more accurately describe how the requirements apply.

The term "wellness program". Comments suggested that the use of the term "bona fide" with respect to wellness programs was confusing because, under the proposed rules, some wellness programs that are not "bona fide" within the narrow meaning of that term in the proposed rules nonetheless satisfy the HIPAA nondiscrimination requirements. To address this concern, these final regulations do not use the term "bona fide wellness program." Instead the final regulations treat all programs of health promotion or disease prevention as wellness programs and specify which of those wellness programs must satisfy additional standards to comply with the nondiscrimination requirements.

Programs not subject to additional standards. The preamble to the 2001 proposed rules described a number of wellness programs that comply with the HIPAA nondiscrimination requirements without having to satisfy any additional standards. However, the text of the regulation did not make such a distinction. The Departments have received many comments and inquiries about whether programs like those described in the 2001 preamble would have to satisfy the additional standards in the proposed rules. As a result, a paragraph has been added to the final regulations defining and illustrating programs that comply with the nondiscrimination requirements without having to satisfy any additional

[1] These nondiscrimination rules do not address the applicability of the Family and Medical Leave Act to employers or group health coverage.

individuals and is not directed at individual participants or beneficiaries. (This example does not address whether the plan provision is permissible under the Americans with Disabilities Act or any other applicable law.)

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.

Example 8. (i) *Facts.* An employer sponsors a group health plan that is available to all current employees. Under the plan, the medical care expenses of each employee (and the employee's dependents) are reimbursed up to an annual maximum amount. The maximum reimbursement amount with respect to an employee for a year is $1500 multiplied by the number of years the employee has participated in the plan, reduced by the total reimbursements for prior years.

(ii) *Conclusion.* In this *Example 8*, the variable annual limit does not violate this paragraph (b)(2)(i). Although the maximum reimbursement amount for a year varies among employees within the same group of similarly situated individuals based on prior claims experience, employees who have participated in the plan for the same length of time are eligible for the same total benefit over that length of time (and the restriction on the maximum reimbursement amount is not directed at any individual participants or beneficiaries based on any health factor).

(ii) *Exception for wellness programs.* A group health plan or group health insurance issuer may vary benefits, including cost-sharing mechanisms (such as a deductible, copayment, or coinsurance), based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(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). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.

(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. Because of depression, Individual *D* attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Under 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 wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan or issuer may vary the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(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 (for example, 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. State law cannot change the obligation of Issuer *N* under this section. However, under State law Issuer *M* may also be responsible for providing benefits to such a dependent. In a case in which Issuer *N* has an obligation under this section to provide benefits and Issuer *M* has an obligation under State law to provide benefits, any State laws designed to prevent more than 100% reimbursement, such as State coordination-of-benefits laws, continue to apply.

(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.

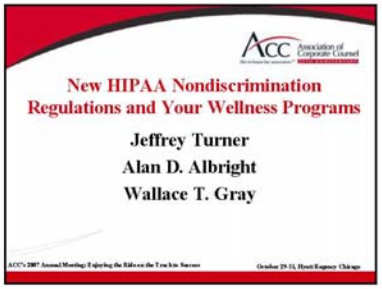
Example 3. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from 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.)

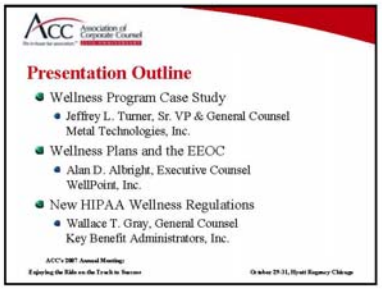
(ii) *Conclusion.* In this *Example 3*, the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

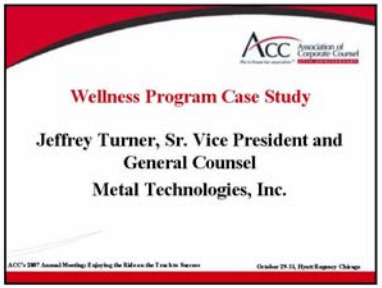
Example 4. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *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) *Wellness programs.* A wellness program is any program designed to promote health or prevent disease. Paragraphs (b)(2)(ii) and (c)(3) of this section provide exceptions to the general prohibitions against discrimination based on a health factor for plan provisions that vary benefits (including cost-sharing mechanisms) or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of this paragraph (f). If none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, paragraph (f)(1) of this







Why Encourage Wellness?

- **Lifestyle-related problems account for 25% of all medical costs**
  - Smoking and obesity make up the lion's share
- **Smoking is a leading contributor to healthcare costs**
  - 20% of adults smoke
  - The lower the wage, the higher the smoking rate (up to 50%)
  - Diabetes risk is triple among smokers
  - Smokers' healthcare EXCEEDS that for AIDS, accidents, suicide, homicide, alcoholism, drug abuse, breast cancer, prostate cancer COMBINED!

What Does a Wellness Program Look Like?

A. Prevention
B. Early Detection
C. Tertiary Prevention
D. Incentives for Wellness
E. A Wellness Environment
F. A Wellness Culture

Why Encourage Wellness?

- **Obesity is the second leading cause of healthcare costs**
  - 64% of American adults are overweight
  - Half of these (30%) are obese (BMI > 30)
  - Getting worse – average daily caloric intake from 1971 – 2000:
    - Men went from 2450 to 2618
    - Women from 1542 to 1877
  - That's an extra pound of weight EVERY 2 ½ weeks!!
  - McDonald's All American meal (1970) = 590 calories
    McDonald's Super-sized meal (2007) 1550 calories

What does a Wellness Program Look Like?

A. Prevention:
- Exercise
- Immunizations
- Condoms
- Stress management
- Seat belts/helmets
- Company policies (cell phone use, alcohol use, etc.)
- Weight Control Classes

Why Encourage Wellness?

- **Workers with risk factors are less productive and absent more**
- **Turnover rate is higher among less healthy**

What does a Wellness Program Look Like?

B. Early Detection
- Screening for cancer
- BMI measurement
- Blood pressure screening
- Cholesterol screening
- Diabetes/blood glucose screening
- Intervention:
  Examples: pre-natal care; referrals based on screening results; EAP mental health or substance abuse counseling

What does a Wellness Program Look Like?

C. Tertiary Prevention:

- Halting established disease/dependency
  - Smoking cessation classes and medication
  - Disease management
  - Disability management
  - Large case management

What does a Wellness Program Look Like?

F. A Wellness Culture

- Top management support – active participation
- Benefits literature during annual enrollment and year round
- Stretch breaks during meetings
- Company Sponsored Walks/Runs
- Physical activity "Boot Camps" with leader participation
- Weight loss contest

What does a Wellness Program Look Like?

D. Incentives for Wellness

- Cash
- Flexible Spending Accounts
- Points convertible to cash
- Subsidies of health clubs/YMCA's
- Travel
- Health insurance premium differentials
- Low cost premium gifts (t-shirts, mugs, etc.)

Do Wellness Plans Work?

- Many studies conclude 3 – 5 years before payback
- Wisconsin Public Health and Policies Institute reports savings of $1.81 to $6.15 for every dollar invested

What does a Wellness Program Look Like?

E. A Wellness Environment

- Smoke-free campus
- On-site Fitness Center
- Fitness groups/company sponsored trainer
- Encourage Stairs vs. elevators
- Walking trails mapped
- Walk or bike-to-work
- Healthy snack machines
- Healthy food in meetings
- Posters, e-mails, mailings

The Sample Company Wellness Plan

- Local hospital coordinated Health Risk Assessment (HRA) screening
- Measured 5 Health Factors*:

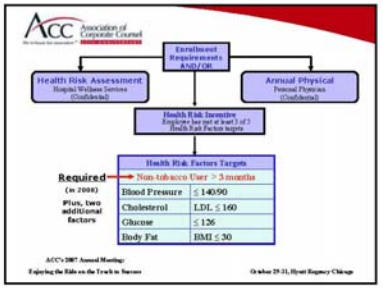
Non-Smoking:	At least 3 months
Cholesterol:	LDL ≤ 160
Blood Glucose:	≤126
Blood Pressure:	≤140/90
Body Fat:	BMI ≤ 30 (females) or25 (males)

*Alternative available if medically inadvisable to meet.

The Sample Company Wellness Plan

- Voluntary HRA or doctor's report required for discount
- Employee received appraisal report that included:

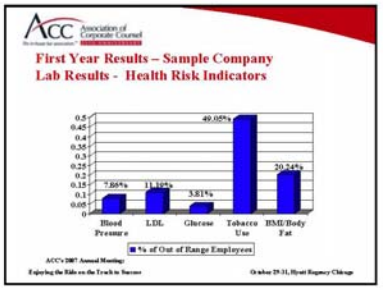
Health Risk Analysis Overview	Personal Health and Safety
Health Risk Age (actual age vs. health age)	Exercise
Body Composition	Non-controllable Risks
Coronary Risk	Osteoporosis Risk
Cancer Risk	Arthritis Risk
Nutrition	Diabetes Risk
Lifestyle Analysis	Hypertension Risk



The Sample Company Wellness Plan

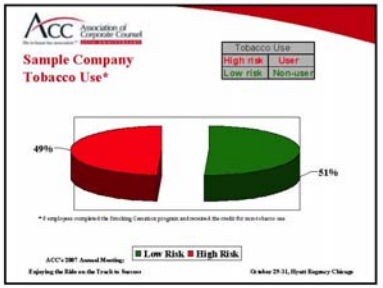
- Premium reductions:

	Non-Participant Premiums	Participant Premiums	Discounted Premiums
Employee	$110	$35	$31
Employee/Child	$125	$50	$44
Employee/Spouse	$150	$78	$69
Family	$170	$100	$87

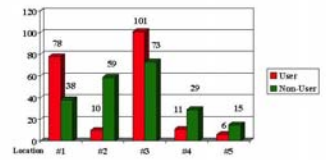


The Sample Company Wellness Plan

- **Confidentiality:** Company did not receive HRA results. Hospital only reported whether employee qualified for additional discount
- Additional support:
  - On-line resources through our health insurance TPA
  - Fitness center and personal trainer at corporate center (include families)
  - Daily e-mail wellness lesson
  - Periodic healthy lunches for office personnel
  - Posters/flyers
  - Planning a fitness "Boot Camp" for corporate office
  - Fruit/healthy snacks during annual enrollment as reminder
  - Quarterly wellness newsletter



Sample Company - Tobacco Use by Location



Sample Company - Second Year Plan Changes:

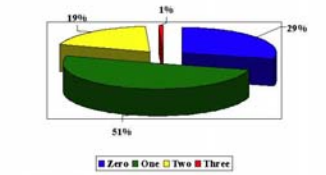
- MUST participate in HRA to qualify for health insurance
- REQUIRE either non-smoking or smoking cessation class
- Add $750 lifetime prescription coverage for smoking cessation
- Allow qualifying for discount at any time during plan year

Sample Company BMI/Body Fat

Possible Future Changes:

- Gradually increase Health Factor levels
- Increased discount for spouse and family plans
- Increased support, such as:
  - Fitness training
  - Classes
  - Nutrition events

Sample Company - % of Risk Indicator Failure



New HIPAA Wellness Regulations

Alan D. Albright, Executive Counsel
WellPoint, Inc.