

One comment requested that the final regulations set forth one or more safe harbors that would demonstrate compliance with the "reasonably designed" standard. The examples in the proposed and final regulations present a range of wellness programs that are well within the borders of what is considered reasonably designed to promote health or prevent disease. The examples serve as safe harbors, so that a plan or issuer could adopt a program identical to one described as satisfying the wellness program requirements in the examples and be assured of satisfying the requirements in the regulations. Wellness programs similar to the examples also would satisfy the "reasonably designed" requirement. The Departments, though, do not want plans or issuers to feel constrained by the relatively narrow range of programs described by the examples but want plans and issuers to feel free to consider innovative programs for motivating individuals to make efforts to improve their health.

**Reasonable alternative standard.** Under the 2001 proposed rules and these final regulations, a wellness program that provides a reward requiring satisfaction of a standard related to a health factor must provide a reasonable alternative standard for obtaining the reward for certain individuals. This alternative standard must be available for individuals for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard, or for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard. A program does not need to establish the specific reasonable alternative standard before the program commences. It is sufficient to determine a reasonable alternative standard once a participant informs the plan that it is unreasonably difficult for the participant due to a medical condition to satisfy the general standard (or that it is medically inadvisable for the participant to attempt to achieve the general standard) under the program.

Some comments suggested that the requirement to devise and offer such a reasonable alternative standard potentially creates a significant burden on plans and issuers. Comments also suggested that the Departments should define a "safe harbor" for what constitutes a reasonable alternative standard, and that plans and issuers should be permitted to establish a single alternative standard, rather than having to tailor a standard for each individual for whom a reasonable alternative standard must be offered.

The Departments understand that, in devising wellness programs, plans and issuers strive to improve the health of participating individuals in a way that is not administratively burdensome or expensive. Under the proposed and final rules, it is permissible for a plan or issuer to devise a reasonable alternative standard by lowering the threshold of the existing health-factor-related standard, substituting a different standard, or waiving the standard. (For the alternative standard to be reasonable, the individual must be able to satisfy it without regard to any health factor.) To address the concern regarding the potential burden of this requirement, the final regulations explicitly provide that a plan or issuer can waive the health-factor-related standard for all individuals for whom a reasonable alternative standard must be offered. Additionally, the final regulations include an example demonstrating that a reasonable alternative standard could include following the recommendations of an individual's physician regarding the health factor at issue. Thus, a plan or issuer need not assume the burden of designing a discrete alternative standard for each individual for whom an alternative standard must be offered. An example also illustrates that if an alternative standard is health-factor-related (*i.e.*, walking three days a week for 20 minutes a day), the wellness program must provide an additional alternative standard (*i.e.*, following the individual's physician's recommendations regarding the health factor at issue) to the appropriate individuals.

The 2001 proposed rules included an example illustrating a smoking cessation program. Comments expressed concern that, under the proposed regulations, individuals addicted to nicotine who comply with a reasonable alternative standard year after year would always be entitled to the reward even if they did not quit using tobacco. Comments questioned whether this result is consistent with the goal of promoting wellness. The final regulations retain the example from the proposed rules. Comments noted that overcoming an addiction sometimes requires a cycle of failure and renewed effort. For those individuals for whom it remains unreasonably difficult due to an addiction, a reasonable alternative standard must continue to be offered. Plans and issuers can accommodate this health factor by continuing to offer the same or a new reasonable alternative standard. For example, a plan or issuer using a smoking cessation class might

use different classes from year to year or might change from using a class to providing nicotine replacement therapy. These final regulations provide an additional example of a reasonable alternative standard of viewing, over a period of 12 months, a 12-hour video series on health problems associated with tobacco use.

Concern has been expressed that individuals might claim that it would be unreasonably difficult or medically inadvisable to meet the wellness program standard, when in fact the individual could meet the standard. The final rules clarify that plans may seek verification, such as a statement from a physician, that a health factor makes it unreasonably difficult or medically inadvisable for an individual to meet a standard.

**Disclosure requirements.** The fifth requirement for a wellness program that provides a reward requiring satisfaction of a standard related to a health factor is that all plan materials describing the terms of the program must disclose the availability of a reasonable alternative standard. This requirement is unchanged from the proposed rules. The 2001 proposed rules and these final regulations include the same model language that can be used to satisfy this requirement; examples also illustrate substantially similar language that would satisfy the requirement.

The final regulations retain the two clarifications of this requirement. First, plan materials are not required to describe specific reasonable alternative standards. It is sufficient to disclose that some reasonable alternative standard will be made available. Second, any plan materials that describe the general standard would also have to disclose the availability of a reasonable alternative standard. However, if the program is merely mentioned (and does not describe the general standard), disclosure of the availability of a reasonable alternative standard is not required.

**Special Rule for Self-Funded Nonfederal Governmental Plans Exempted Under 45 CFR 146.180**

The sponsor of a self-funded nonfederal governmental plan may elect under section 2721(b)(2) of the PHS Act and 45 CFR 146.180 to exempt its group health plan from the nondiscrimination requirements of section 2702 of the PHS Act and 45 CFR 146.121. Under the interim final nondiscrimination rules, if the plan sponsor subsequently chooses to bring the plan into compliance with the nondiscrimination requirements, the plan must provide notice to that effect to individuals who were denied

enrollment based on one or more health factors, and afford those individuals an opportunity, that continues for at least 30 days, to enroll in the plan. (An individual is considered to have been denied coverage if he or she failed to apply for coverage because, given an exemption election under 45 CFR 146.180, it was reasonable to believe that an application for coverage would have been denied based on a health factor). The notice must specify the effective date of compliance, and inform the individual regarding any enrollment restrictions that may apply under the terms of the plan once the plan comes into compliance. The plan may not treat the individual as a late enrollee or a special enrollee. These final regulations retain this transitional rule, and state that the plan must permit coverage to be effective as of the first day of plan coverage for which an exemption election under 45 CFR 146.180 (with regard to the nondiscrimination requirements) is no longer in effect. (These final regulations delete the reference giving the plan the option of having the coverage start July 1, 2001, because that option implicated the expired transitional rules regarding individuals who were denied coverage based on a health factor prior to the applicability of the 2001 interim rules. As previously stated, those transitional rules have not been republished in these final regulations.) Additionally, the examples illustrating how the special rule for nonfederal governmental plans operates have been revised slightly.

#### Applicability Date

These regulations apply for plan years beginning on or after July 1, 2007. Until the applicability date for this regulation, plans and issuers are required to comply with the corresponding sections of the regulations previously published in the **Federal Register** (66 FR 1378) and other applicable regulations.

#### III. Economic Impact and Paperwork Burden

**Summary—Department of Labor and Department of Health and Human Services**

HIPAA's nondiscrimination provisions generally prohibit group health plans and group health insurance issuers from discriminating against individuals in eligibility or premiums on the basis of health factors. The Departments have crafted these regulations to secure the protections from discrimination as intended by Congress in as economically efficient a manner as possible, and believe that the

economic benefits of the regulations justify their costs.

The primary economic benefits associated with securing HIPAA's nondiscrimination provisions derive from increased access to affordable group health plan coverage for individuals with health problems. Increased access benefits both newly-covered individuals and society at large. It fosters expanded health coverage, timelier and more complete medical care, better health outcomes, and improved productivity and quality of life. This is especially true for the individuals most affected by HIPAA's nondiscrimination provisions—those with adverse health conditions. Denied health coverage, individuals in poorer health are more likely to suffer economic hardship, to forego badly needed care for financial reasons, and to suffer adverse health outcomes as a result. For them, gaining health coverage is more likely to mean gaining economic security, receiving timely, quality care, and living healthier, more productive lives. Similarly, participation by these individuals in wellness programs fosters better health outcomes, increases productivity and quality of life, and has the same outcome in terms of overall gains in economic security. The wellness provisions of these regulations will result in fewer instances in which wellness programs shift costs to high-risk individuals, and more instances in which these individuals succeed at improving health habits and health.

Additional economic benefits derive directly from the improved clarity provided by the regulations. The regulations will reduce uncertainty and costly disputes and promote confidence in health benefits' value, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans and their wellness program provisions.

The Departments estimate that the dollar value of the expanded coverage attributable to HIPAA's nondiscrimination provisions is approximately \$850 million annually. The Departments believe that the cost of HIPAA's nondiscrimination provisions is borne by covered workers. Costs can be shifted to workers through increases in employee premium shares or reductions (or smaller increases) in pay or other components of compensation, by increases in deductibles or other cost sharing, or by reducing the richness of health benefits. Whereas the benefits of the nondiscrimination provisions are concentrated in a relatively small population, the costs are distributed broadly across plans and enrollees.

The proposed rules on wellness programs impose certain requirements on wellness programs providing rewards that would otherwise discriminate based on a health factor in order to ensure that the exception for wellness programs does not eviscerate the general rule contained in HIPAA's nondiscrimination provisions. Costs associated with the wellness program provisions are justified by the benefits received by those individuals now able, through alternative standards, to participate in such programs. Because the new provisions limit rewards for wellness programs that require an individual to satisfy a standard related to a health factor to 20 percent of the cost of single coverage (with additional provisions related to rewards that apply also to classes of dependents), some rewards will be reduced and this reduction might compel some individuals to decline coverage. The number of individuals affected, however, is thought to be small. Moreover, the Departments estimate that the cost of the reduction in rewards that would exceed the limit will amount to only \$6 million. Establishing reasonable alternative standards, which should increase coverage for those now eligible for discounts as well as their participation in programs designed to promote health or prevent disease, is expected to cost between \$2 million to \$9 million. The total costs should therefore fall within a range between \$8 million and \$15 million annually.

New economic costs may be also incurred in connection with the wellness provisions if reductions in rewards result in the reduction of wellness programs' effectiveness, but this effect is expected to be very small. Other new economic costs may be incurred by plan sponsors to make available reasonable alternative standards where required. The Departments are unable to estimate these costs due to the variety of options available to plan sponsors for bringing wellness programs into compliance with these rules.

**Executive Order 12866—Department of Labor and Department of Health and Human Services**

Under Executive Order 12866, the Departments must determine whether a regulatory action is "significant" and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a "significant regulatory action" as an action that is likely to result in a rule (1) having an annual effect on the economy of \$100 million

the application, the issuer receives health information about the individuals to be covered, including information about C's adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that C has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for C for that condition. The exclusionary rider is made effective the first day of the next plan year.

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

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

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

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

(A) Complies with § 146.111;

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

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

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

*Example 1. (i) Facts.* A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-

month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with § 146.111. There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.

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

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

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

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

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into

account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates—(i) Group rating based on health factors not restricted under this section.*

Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

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

(iii) *List billing.* 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 (c)(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 (d)(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 (e)(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

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section clarifies that the wellness program does not violate this section if participation in the program is made available to all similarly situated individuals. If any 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, the wellness program does not violate this section if the requirements of paragraph (f)(2) of this section are met.

(1) *Wellness programs not subject to requirements.* If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program does not violate this section, if participation in the program is made available to all similarly situated individuals. Thus, for example, the following programs need not satisfy the requirements of paragraph (f)(2) of this section, if participation in the program is made available to all similarly situated individuals:

(i) A program that reimburses all or part of the cost for memberships in a fitness center.

(ii) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(iii) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.

(iv) A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.

(v) A program that provides a reward to employees for attending a monthly health education seminar.

(2) *Wellness programs subject to requirements.* If any 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, the wellness program does not violate this section if the requirements of this paragraph (f)(2) are met.

(i) The reward for the 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 percent of the cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses or spouses and dependent children) may participate in the wellness program, the reward must not

exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(2), the cost of coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

(ii) The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of or preventing disease in participating individuals and is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(iii) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(iv) The reward under the program must be available to all similarly situated individuals.

(A) A reward is not available to all similarly situated individuals for all similarly situated individuals for all similarly situated individuals—

(1) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(2) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(B) A plan or issuer may seek verification, such as a statement from an individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(v)(A) The plan or issuer must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under paragraph (f)(2)(iv) of this section. However, if plan materials merely

mention that a program is available, without describing its terms, this disclosure is not required.

(B) The following language, or substantially similar language, can be used to satisfy the requirement of this paragraph (f)(2)(v): "If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward." In addition, other examples of language that would satisfy this requirement are set forth in Examples 3, 4, and 5 of paragraph (f)(3) of this section.

(3) *Examples.* The rules of paragraph (f)(2) of this section are illustrated by the following examples:

*Example 1.* (i) *Facts.* An employer sponsors a group health plan. The annual premium for employee-only coverage is \$3,600 (of which the employer pays \$2,700 per year and the employee pays \$900 per year). The annual premium for family coverage is \$9,000 (of which the employer pays \$4,500 per year and the employee pays \$4,500 per year). The plan offers a wellness program with an annual premium rebate of \$360. The program is available only to employees.

(ii) *Conclusion.* In this Example 1, the program satisfies the requirements of paragraph (f)(2)(i) of this section because the reward for the wellness program, \$360, does not exceed 20 percent of the total annual cost of employee-only coverage, \$720. ( $\$3,600 \times 20\% = \$720$ .) If any class of dependents is allowed to participate in the program and the employee is enrolled in family coverage, the plan could offer the employee a reward of up to 20 percent of the cost of family coverage, \$1,800. ( $\$9,000 \times 20\% = \$1,800$ .)

*Example 2.* (i) *Facts.* A group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.

(ii) *Conclusion.* In this Example 2, the program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard or waive the cholesterol standard. (In addition, plan materials describing the program are required to disclose the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) for obtaining the premium discount. Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

*Example 3.* (i) *Facts.* Same facts as Example 2, except that the plan provides that if it is unreasonably difficult due to a medical condition for a participant to achieve the targeted cholesterol count (or if it is medically inadvisable for a participant to attempt to achieve the targeted cholesterol count) within a 60-day period, the plan will make available a reasonable alternative standard that takes the relevant medical condition into account. In addition, all plan materials describing the terms of the program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a cholesterol count under 200, or if it is medically inadvisable for you to attempt to achieve a count under 200, call us at the number below and we will work with you to develop another way to get the discount." Individual D begins a diet and exercise program but is unable to achieve a cholesterol count under 200 within the prescribed period. D's doctor determines D requires prescription medication to achieve a medically advisable cholesterol count. In addition, the doctor determines that D must be monitored through periodic blood tests to continually reevaluate D's health status. The plan accommodates D by making the discount available to D, but only if D follows the advice of D's doctor's regarding medication and blood tests.

(ii) *Conclusion.* In this Example 3, the program is a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve the targeted count (or for whom it is medically inadvisable to attempt to achieve the targeted count) in the prescribed period by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium discount does not violate this section.

*Example 4.* (i) *Facts.* A group health plan will waive the \$250 annual deductible (which is less than 20 percent of the annual cost of employee-only coverage under the plan) for the following year for participants who have a body mass index between 19 and 26, determined shortly before the beginning of the year. However, any participant for whom it is unreasonably difficult due to a medical condition to attain this standard (and any participant for whom it is medically inadvisable to attempt to achieve this standard) during the plan year is given the same discount if the participant walks for 20 minutes three days a week. Any participant for whom it is unreasonably difficult due to a medical condition to attain either standard (and any participant for whom it is medically inadvisable to attempt to achieve either standard) during the year is given the same discount if the individual satisfies an

alternative standard that is reasonable in the burden it imposes and is reasonable taking into consideration the individual's medical situation. All plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a body mass index between 19 and 26 (or if it is medically inadvisable for you to attempt to achieve this body mass index) this year, your deductible will be waived if you walk for 20 minutes three days a week. If you cannot follow the walking program, call us at the number above and we will work with you to develop another way to have your deductible waived." Due to a medical condition, Individual E is unable to achieve a BMI of between 19 and 26 and is also unable to follow the walking program. E proposes a program based on the recommendations of E's physician. The plan agrees to make the discount available to E if E follows the physician's recommendations.

(ii) *Conclusion.* In this Example 4, the program satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it generally accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve (or for whom it is medically inadvisable to attempt to achieve) the targeted body mass index by providing a reasonable alternative standard (walking) and it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt to walk by providing an alternative standard that is reasonable for the individual). Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard for every individual. Thus, the waiver of the deductible does not violate this section.

*Example 5.* (i) *Facts.* In conjunction with an annual open enrollment period, a group health plan provides a form for participants to certify that they have not used tobacco products in the preceding twelve months. Participants who do not provide the certification are assessed a surcharge that is 20 percent of the cost of employee-only coverage. However, all plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a health factor for you to meet the requirements under this program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge." It is unreasonably difficult for Individual F to stop smoking cigarettes due to an addiction to nicotine (a medical condition). The plan accommodates F by requiring F to participate in a smoking cessation program to avoid the surcharge. F can avoid the surcharge for as long as F participates in the program, regardless of

whether F stops smoking (as long as F continues to be addicted to nicotine).

(ii) *Conclusion.* In this Example 5, the premium surcharge is permissible as a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to quit using tobacco products by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium surcharge does not violate this section.

*Example 6.* (i) *Facts.* Same facts as Example 5, except the plan accommodates F by requiring F to view, over a period of 12 months, a 12-hour video series on health problems associated with tobacco use. F can avoid the surcharge by complying with this requirement.

(ii) *Conclusion.* In this Example 6, the requirement to watch the series of video tapes is a reasonable alternative method for avoiding the surcharge.

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

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

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

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

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

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

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

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

*(2) In premiums or contributions—(i)* Nothing in this section prevents a group health plan or group health insurance issuer from charging individuals a premium or contribution that is less

than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

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

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

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

*(h) No effect on other laws.* Compliance with this section is not determinative of compliance with any other provision of the Act (including the COBRA continuation provisions) or any other State or Federal law, such as the Americans with Disabilities Act.

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

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

Signed at Washington, DC this 1st day of December, 2006.

**Bradford P. Campbell,**  
Acting Assistant Secretary, Employee Benefits Security Administration, U.S. Department of Labor.

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

**PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET**

■ 1. Paragraph (b)(1)(vi) is added to § 146.101 as follows:

**§ 146.101 Basis and scope**

\* \* \* \* \*

(b) \* \* \*

(1) \* \* \*  
(vi) Prohibiting discrimination against participants and beneficiaries based on a health factor.

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

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

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

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

(2) Evidence of insurability includes—

- (i) Conditions arising out of acts of domestic violence; and
- (ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

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

(b) *Prohibited discrimination in rules for eligibility—(1) In general—(i)* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (b)(3) of this section (allowing plans to impose certain preexisting condition exclusions), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals).

paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph

(f) of this section (relating to 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 (b)(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 or 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 ERISA, the Americans with Disabilities Act, or any other law, whether State or Federal.)

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

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

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

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

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

*(ii) Conclusion.* 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)* 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

injury resulted from (in addition to an act of domestic violence or a medical condition) participation in legal recreational activities such as those listed in the conference report. Some comments expressed the concern that the rule in the 2001 interim rules would cause plans and issuers to begin excluding benefits for treatment of injuries sustained in these kinds of activities.

One comment generally supported the position in the 2001 interim rules. That comment expressed the belief that Congress intended with this issue, as with many other issues, to continue its longstanding deference to the States on the regulation of benefit design under health insurance. The comment also noted that the source-of-injury rule in the 2001 interim rules would not change the practice of plans or issuers with regard to the activities listed in the conference report and that the practice of plans and issuers in this regard would continue to be governed, as they had been before HIPAA, by market conditions and the States.

The Departments have not added the list of activities from the conference report to the source-of-injury rule in the final regulations. The statute itself is unclear about how benefits in general are affected by the nondiscrimination requirements and is silent with respect to source-of-injury exclusions in particular. The legislative history provides that the inclusion of evidence of insurability in the list of health factors is intended to ensure, among other things, that individuals are not excluded from health care coverage due to their participation in the activities listed in the conference report. This language is unclear because the term "health care coverage" could mean only eligibility to enroll for coverage under the plan, so that people who participate in the activities listed in the conference report could not be kept out of the plan but could be denied benefits for injuries sustained in those activities. Alternatively, it could mean eligibility both to enroll for coverage and for benefits, so that people who participate in those activities could not be kept out of the plan or denied benefits for injuries sustained in those activities. Without any indication in the statute and without a clear indication in the legislative history about this issue, and in light of the overall scheme of the statute, the Departments have made no changes to the regulations.

Moreover, to the extent not prohibited by State law, plans and issuers have been free to impose source-of-injury exclusions since before HIPAA. There is no reason to believe that plans and

issuers will begin to impose source-of-injury exclusions with respect to the conference report activities merely because such exclusions are not prohibited under the 2001 interim rules and these final regulations.

#### *Relationship of Prohibition on Nonconfinement Clauses to State Extension-of-Benefits Laws*

Questions have arisen about the relationship of the prohibition on nonconfinement clauses in the 2001 interim rules to State extension-of-benefits laws. Plan provisions that deny an individual benefits based on the individual's confinement to a hospital or other health care institution at the time coverage would otherwise become effective are often called nonconfinement clauses. The 2001 interim rules prohibit such nonconfinement clauses. At the same time, many States require issuers to provide benefits beyond the date on which coverage under the policy would otherwise have ended to individuals who continue to be hospitalized beyond that date. Example 2 in the 2001 interim rules illustrated that a current issuer cannot impose a nonconfinement clause that restricts benefits for an individual based on whether that individual is entitled to continued benefits from a prior issuer pursuant to a State law requirement. The final sentence in Example 2 provided that HIPAA does not affect the prior issuer's obligation under State law and does not affect any State law governing coordination of benefits.

Under the laws of some States, a prior issuer has the obligation to provide health benefits to an individual confined to a hospital beyond the nominal end of the policy only if the hospitalization is not covered by a succeeding issuer. Because HIPAA requires a succeeding issuer to provide benefits that it would otherwise provide if not for the nonconfinement clause, in such a case State law would not require the prior issuer to provide benefits for a confinement beyond the nominal end of the policy. In this context, the statement in the final sentence of Example 2—that HIPAA does not affect the prior issuer's obligation under State law—could be read to conflict with the text of the rule and the main point of Example 2 that the succeeding issuer must cover the confinement.

There has been some dispute about how this potential ambiguity should be resolved. One interpretation is that the succeeding issuer can never impose a nonconfinement clause, and if this has the effect under State law of not requiring the prior issuer to provide

benefits beyond the nominal end of the policy, then the prior issuer is not obligated to provide the extended benefits. This interpretation is consistent with the text of the nonconfinement rule and the main point of Example 2, though it could be read to conflict with the last sentence in Example 2.

Another interpretation proposed by some is that, consistent with the last sentence of Example 2, the obligation of a prior issuer is never affected by the HIPAA prohibition against nonconfinement clauses. Under this interpretation, if a State law conditions a prior issuer's obligation on there being no succeeding issuer with the obligation, then in order to leave the prior issuer's obligation unaffected under State law, the succeeding issuer could apply a nonconfinement clause and the HIPAA prohibition would not apply. This interpretation elevates a minor clarification at the end of an example to supersede not only the main point of the example but also the express text of the rule the example illustrates. This proposed interpretation is clearly contrary to the intent of the 2001 interim rules.

To avoid other interpretations, these final rules have replaced the final sentence of Example 2 in the 2001 interim rules with three sentences. The new language clarifies that: State law cannot change the succeeding issuer's obligation under HIPAA; a prior issuer may also have an obligation; and in a case in which a succeeding issuer has an obligation under HIPAA and a prior issuer has an obligation under State law to provide benefits for a confinement, any State laws designed to prevent more than 100 percent reimbursement, such as State coordination-of-benefits laws, continue to apply. Thus, under HIPAA a succeeding issuer cannot deny benefits to an individual on the basis of a nonconfinement clause. If this requirement under HIPAA has the effect under State law of removing a prior issuer's obligation to provide benefits, then the prior issuer is not obligated to provide benefits for the confinement. If under State law this requirement under HIPAA has the effect of obligating both the prior issuer and the succeeding issuer to provide benefits, then any State coordination-of-benefits law that is used to determine the order of payment and to prevent more than 100 percent reimbursement continues to apply.

#### *Actively-at-Work Rules and Employer Leave Policies*

The final regulations make no changes to the 2001 interim rules relating to actively-at-work provisions. Actively-at-

work plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

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

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

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

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

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

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

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

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

*Example 1. (i) Facts.* Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as 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 section clarifies that the wellness program does not violate this section if participation in the program is made available to all similarly situated individuals. If any 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, the wellness program does not violate this section if the requirements of paragraph (f)(2) of this section are met.

(1) *Wellness programs not subject to requirements.* If none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that are related to a health factor (or if a wellness program does not provide a reward), the wellness program does not violate this section, if participation in the program is made available to all similarly situated individuals. Thus, for example, the following programs need not satisfy the requirements of paragraph (f)(2) of this section, if participation in the program is made available to all similarly situated individuals:

(i) A program that reimburses all or part of the cost for memberships in a fitness center.

(ii) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(iii) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.

(iv) A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.

(v) A program that provides a reward to employees for attending a monthly health education seminar.

(2) *Wellness programs subject to requirements.* If any 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, the wellness program does not violate this section if the requirements of this paragraph (f)(2) are met.

(i) The reward for the 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 percent of the cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses or spouses and dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(2), the cost of coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

(ii) The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of or preventing disease in participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(iii) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(iv) The reward under the program must be available to all similarly situated individuals.

(A) A reward is not available to all similarly situated individuals for a period unless the program allows—

(1) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(2) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(B) A plan or issuer may seek verification, such as a statement from an individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(v)(A) The plan must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under paragraph (f)(2)(iv) of this section. However, if plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.

(B) The following language, or substantially similar language, can be used to satisfy the requirement of this paragraph (f)(2)(v): "If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward." In addition, other examples of language that would satisfy this requirement are set forth in Examples 3, 4, and 5 of paragraph (f)(3) of this section.

(3) *Examples.* The rules of paragraph (f)(2) of this section are illustrated by the following examples:

*Example 1.* (i) *Facts.* An employer sponsors a group health plan. The annual premium for employee-only coverage is \$3,600 (of which the employer pays \$2,700 per year and the employee pays \$900 per year). The annual premium for family coverage is \$9,000 (of which the employer pays \$4,500 per year and the employee pays \$4,500 per year). The plan offers a wellness program with an annual premium rebate of \$360. The program is available only to employees.

(ii) *Conclusion.* In this Example 1, the program satisfies the requirements of paragraph (f)(2)(i) of this section because the reward for the wellness program, \$360, does not exceed 20 percent of the total annual cost of employee-only coverage, \$720. (\$3,600 × 20% = \$720.) If any class of dependents is allowed to participate in the program and the employee is enrolled in family coverage, the plan could offer the employee a reward of up to 20 percent of the cost of family coverage, \$1,800. (\$9,000 × 20% = \$1,800.)

*Example 2.* (i) *Facts.* A group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.

(ii) *Conclusion.* In this Example 2, the program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard or waive the cholesterol standard. (In addition, plan materials describing the program are required to disclose the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) for obtaining the premium discount. Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.)

*Example 3.* (i) *Facts.* Same facts as Example 2, except that the plan provides that if it is unreasonably difficult due to a medical condition for a participant to achieve the targeted cholesterol count (or if it is medically inadvisable for a participant to attempt to achieve the targeted cholesterol count) within a 60-day period, the plan will make available a reasonable alternative standard that takes the relevant medical condition into account. In addition, all plan materials describing the terms of the program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a cholesterol count under 200, or if it is medically inadvisable for you to attempt to achieve a count under 200, call us at the number below and we will work with you to develop another way to get the discount." Individual D begins a diet and exercise program but is unable to achieve a cholesterol count under 200 within the prescribed period. D's doctor determines D requires prescription medication to achieve a medically advisable cholesterol count. In addition, the doctor determines that D must be monitored through periodic blood tests to continually reevaluate D's health status. The plan accommodates D by making the discount available to D, but only if D follows the advice of D's doctor's regarding medication and blood tests.

(ii) *Conclusion.* In this Example 3, the program is a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program

complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve the targeted count (or for whom it is medically inadvisable to attempt to achieve the targeted count) in the prescribed period by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium discount does not violate this section.

*Example 4.* (i) *Facts.* A group health plan will waive the \$250 annual deductible (which is less than 20 percent of the annual cost of employee-only coverage under the plan) for the following year for participants who have a body mass index between 19 and 26, determined shortly before the beginning of the year. However, any participant for whom it is unreasonably difficult due to a medical condition to attain this standard (and any participant for whom it is medically inadvisable to attempt to achieve this standard) during the plan year is given the same discount if the participant walks for 20 minutes three days a week. Any participant for whom it is unreasonably difficult due to a medical condition to attain either standard (and any participant for whom it is medically inadvisable to attempt to achieve either standard) during the year is given the same discount if the individual satisfies an alternative standard that is reasonable in the burden it imposes and is reasonable taking into consideration the individual's medical situation. All plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a body mass index between 19 and 26 (or if it is medically inadvisable for you to attempt to achieve this body mass index) this year, your deductible will be waived if you walk for 20 minutes three days a week. If you cannot follow the walking program, call us at the number above and we will work with you to develop another way to have your deductible waived." Due to a medical condition, individual E is unable to achieve a BMI of between 19 and 26 and is also unable to follow the walking program. E proposes a program based on the recommendations of E's physician. The plan agrees to make the discount available to E if E follows the physician's recommendations.

(ii) *Conclusion.* In this Example 4, the program satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it generally accommodates individuals for whom it is unreasonably difficult due to a

medical condition to achieve (or for whom it is medically inadvisable to attempt to achieve) the targeted body mass index by providing a reasonable alternative standard (walking) and it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt to walk by providing an alternative standard that is reasonable for the individual. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard for every individual. Thus, the waiver of the deductible does not violate this section.

*Example 5.* (i) *Facts.* In conjunction with an annual open enrollment period, a group health plan provides a form for participants to certify that they have not used tobacco products in the preceding twelve months. Participants who do not provide the certification are assessed a surcharge that is 20 percent of the cost of employee-only coverage. However, all plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a health factor for you to meet the requirements under this program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge." It is unreasonably difficult for Individual F to stop smoking cigarettes due to an addiction to nicotine (a medical condition). The plan accommodates F by requiring F to participate in a smoking cessation program to avoid the surcharge. F can avoid the surcharge for as long as F participates in the program, regardless of whether F stops smoking (as long as F continues to be addicted to nicotine).

(ii) *Conclusion.* In this Example 5, the premium surcharge is permissible as a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to quit using tobacco products by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium surcharge does not violate this section.

*Example 6.* (i) *Facts.* Same facts as Example 5, except the plan accommodates F by requiring F to view, over a period of 12 months, a 12-hour video series on health problems associated with tobacco use. F can avoid the surcharge by complying with this requirement.

(ii) *Conclusion.* In this Example 6, the requirement to watch the series of video tapes is a reasonable alternative method for avoiding the surcharge.

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

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

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

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

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

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

*Example 3.* (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage