Employment, Labor & Benefits

MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

Employment, Labor & Benefits Advisory

MARCH 4, 2014

Departments of Labor, Treasury, and Health and Human Services Issue Final and Proposed Regulations Implementing the 90-day Limit on Waiting Periods under the Affordable Care Act

BY ALDEN BIANCHI

The Affordable Care Act (the "Act") generally prevents an otherwise eligible employee (or dependent) from having to wait more than 90 days before coverage becomes effective under a group health plan. The regulation of waiting periods is part of the Act's insurance market reforms, which take the form of amendments to the Public Health Service Act that are incorporated by reference into ERISA and the Internal Revenue Code. Thus, the rules barring waiting periods that exceed 90 days apply to health insurance issuers as well as group health plans (grandfathered and non-grandfathered alike), whether fully insured or self-funded. A group health plan that runs afoul of the 90-day waiting period limit is generally subject to an excise tax of $100 per day per failure, which must be self-reported on IRS Form 8928. The 90-day waiting period limitation is effective for plan years beginning on or after January 1, 2014.

Proposed regulations issued in March 2013 looked to prior law (i.e., the Health Insurance Portability and Accountability Act, or "HIPAA") to furnish a definition of what constitutes a "waiting period." The proposed regulations also included rules addressing (i) the coordination of the 90-day waiting period rule with the look back measurement method under regulations implementing the Act's employer shared responsibly rules; (ii) the extent to which a carrier could rely on eligibility information provided by plans and employers; (iii) cumulative hour-of-service requirements; and (iv) the treatment of multiemployer plans.

On February 24th, the Departments of Labor, Treasury, and Health and Human Services (the "Departments") issued final regulations[1] implementing the 90-day waiting period rule. The final regulations preserve the basic structure of the proposed rule, which generally permits:

- Eligibility conditions based solely on the lapse of time for no more than 90 days; and
- Other conditions for eligibility, unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

The term "waiting period" for this purpose means "the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective."[2]
Plans are free to impose substantive eligibility conditions — e.g., being in an eligible job classification, achieving job-related licensure requirements, or satisfying a reasonable and bona fide employment-based orientation period) — without violating the 90-day rule. And a plan sponsor is not required to offer coverage to any particular individual or class of individuals (e.g., part-time employees).[3] Where an employee is in an eligible class, however, his or her enrollment may not be delayed beyond 90 consecutive calendar days.

Where an individual enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period. Also, nothing prevents an individual from taking additional time (beyond the end of the 90-day

waiting period) to elect coverage. And nothing *requires* a group health plan or a carrier to impose any waiting period, or prevents a plan or carrier from having a waiting period that is shorter than 90 days.

Coordination of the 90-day waiting period rule with the look back measurement method

Final regulations[4] issued under the Act's employer shared responsibility rules generally provide that, if a group health plan conditions eligibility on an employee regularly having a specified number of hours of service per period (or working full-time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full-time), the plan may take a reasonable period of time, not to exceed 12 months and beginning on any date between the employee's start date and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the plan's eligibility condition. Under the final 90-day waiting period regulations, the time period for determining whether an employee meets the plan's eligibility condition will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no later than 13 months from the employee's start date plus, if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month. Thus, the employer shared responsibility and the 90-day waiting period rules are aligned such that employers that follow the former are deemed to comply with the latter.

Cumulative service requirements

Some plans condition eligibility on an employee's having completed a number of cumulative hours of service. The final regulations sanction this approach so long as the cumulative hours-of-service requirement does not exceed 1,200 hours. Where this is the case, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation.

Rehires

A plan is permitted under the final regulations to treat an employee who has been terminated and later rehired as newly eligible upon rehire and, therefore, again required to meet the plan's eligibility criteria and waiting period only if reasonable under the circumstances. The regulations specifically note that the termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period limitation.

Special rule for health insurance issuers

A carrier is generally permitted to rely on the eligibility information reported to it by the employer or other plan sponsor and will not be considered to violate the 90-day waiting period requirement if:

- The carrier requires the plan sponsor to make a representation regarding the terms of any eligibility conditions or waiting periods imposed by the plan sponsor before an individual is eligible to become covered under the terms of the plan (and requires the plan sponsor to update this representation with any changes), and
- The carrier has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.

Multiemployer plans

As the Departments acknowledge:

"[M]ultiemployer plans maintained pursuant to collective bargaining agreements have unique operating structures and may include different eligibility conditions based on the participating employer's industry or the employee's occupation. For example, some multiemployer plans determine eligibility based on complex formulas for earnings and residuals or use 'hours banks' in which workers' excess hours from one measurement period are credited against any shortage of hours in a succeeding measurement period, functioning as buy-in provisions to prevent lapses in coverage."[5]

Following the lead of a prior set of frequently asked questions (FAQs),[6] the final regulations generally give multiemployer plans operating pursuant to an arms-length collective bargaining agreement wide berth. For example, an eligibility provision that allows employees to become eligible for coverage by working hours of covered employment across multiple contributing employers (often by aggregating hours by calendar quarter and then permitting coverage to extend for the next full calendar quarter, regardless of whether an employee has terminated employment) is expressly permitted.

Reasonable and bona fide employment-based orientation periods

Perhaps the most curious of the final regulations' provisions is a clarification of instances in which a waiting period might be delayed beyond 90 days, including where an employer imposes a "reasonable and bona fide employment-based orientation period." The final regulations do not specify the circumstances under which an orientation period would be considered "reasonable or bona fide." But a proposed regulation[7] issued contemporaneously with the final rule proposes one month as the maximum length of any orientation period.

* * *

View Mintz Levin's Employment, Labor & Benefits attorneys.

Read and subscribe to *Employment Matters* blog.

Endnotes

[1] 79 Fed. Reg. 10295, available at: http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03809.pdf.

[2] *See, e.g.,* preamble to the final regulations (79 Fed. Reg. 10295) at 10298, available at: http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03809.pdf.

[3] Of course, other provisions of the Act might require an employer to make an offer of coverage.

[4] 79 Fed. Reg. 8543 (February 12, 2014), available at: http://www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf.

[5] Preamble to the final regulations (79 Fed. Reg. 10295) at 10299, available at: http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/ 2014-03809.pdf.

[6] FAQs About the Affordable Care Act Implementation, Part XVI, Q2, issued September 4, 2013, available at: http://www.dol.gov/ebsa/faqs/faq-aca16.html.

[7] 79 Fed. Reg. 10319 at 10321, available at: http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03811.pdf.