HUMAN CAPITAL PRACTICE

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HEALTH CARE REFORM LAW

90-DAY WAITING PERIOD AND ORIENTATION PERIOD: FINAL REGULATIONS EXPLAINED

Final regulations governing the 90-day waiting period requirement under the Patient Protection and Affordable Care Act (PPACA) were issued by the Departments of Treasury, Labor and Health and Human Services on February 24, 2014. Final regulations on the orientation period were released June 20, 2014.

BACKGROUND

The PPACA prohibits a group health plan, including a health insurance issuer offering group health insurance, from applying a waiting period that exceeds 90 days. A waiting period is a period of time that must pass before coverage becomes effective for an individual who is otherwise eligible to enroll under the terms of the group health plan. If the individual is a special enrollee or late enrollee (generally as governed by HIPAA rules), however, any period before the special or late enrollment is not a waiting period.

Like the proposed regulations, the final regulations stipulate that the 90-day waiting period limitation does not require a plan or plan sponsor to offer coverage to any particular individual or class of individuals, including, for example, part-time employees.

WHAT DOES THE RULE REQUIRE?

Under the final regulations, an eligible individual cannot be required to wait more than 90 days before the individual's health coverage becomes effective. Despite requests by commentators, the waiting period remains at 90 days, not three months.

This rule applies to grandfathered and non-grandfathered plans alike, as well as to both self-insured and insured plans. All calendar days are counted towards the waiting period calculation beginning on the enrollment date, including weekends and holidays. If the 91st day falls on a weekend or holiday, a plan can make coverage effective earlier, but not later – it is not an option for coverage to be effective on the 92nd day. A plan is not considered to violate the rule if individuals take more than 90 days to elect coverage.

There is nothing in the final regulations that precludes a plan from applying different waiting periods to different groups of employees, provided no waiting period exceeds 90 days and the approach is otherwise not a subterfuge to avoid compliance with the 90-day waiting period limitation. For example, an employer could apply a 60-day waiting period to hourly employees and a 30-day waiting period to salaried employees.

A waiting period is a period of time that must pass before coverage becomes effective for an individual who is otherwise eligible to enroll under the terms of the group health plan.

Alternatively, an employer could vary the length of the waiting period based on the locations of the different employee groups. Please note, however, that such an approach would also need to be non-discriminatory under applicable law.

According to the preamble to the final regulations, state insurance laws that are more "consumer protective" than the federal requirements are unlikely to be preempted by PPACA law and therefore, states have "significant latitude" to impose requirements on health insurance issuers that are more restrictive than the PPACA law. As a result, it is permissible for a state to require insurance companies to use waiting periods that are shorter than 90 days.

To date, one state, California, has imposed a 60-day waiting period for insurance policies issued under the California Insurance Code. At present there is a bill pending in the California legislature to repeal that law. If that legislation is approved (which appears likely at this point), California employers will be allowed to include a 90-day waiting period limitation in their insured plans, although that proposed legislation does not allow California health insurers and HMOs to impose a 90-day waiting period.

HOW DOES THE RULE AFFECT PLAN ELIGIBILITY REQUIREMENTS?

The waiting period must begin as soon as an individual is otherwise eligible to enroll in a plan. An individual is considered "otherwise eligible to enroll in a plan" when the individual meets the plan's substantive eligibility conditions. The final regulations provide some examples of permissible substantive eligibility conditions, although the list is far from exhaustive – being in an eligible job classification and achieving job-related licensing requirements that are specified in the plan's terms. Other eligibility conditions that commentators have recognized as being permitted under PPACA law include, for example, full-time status, certain sales goals, a certain level of commissions or other compensation, and a fixed number of hours of service per period (like 30 hours per week or 250 hours per quarter) – any substantive eligibility requirement not based solely on the lapse of time, which is not designed to avoid compliance with the 90-day waiting period rule.

In addition, besides an eligible job classification and job-related licensing requirement the final regulations introduce a third example of a permissible substantive eligibility condition – satisfying a reasonable and bona fide employment-based orientation period. That condition is addressed with final regulations, which are discussed in a later section of this *Alert*.

To the extent a plan has an eligibility condition based solely on the lapse of a time period, the time period cannot be more than 90 days. For example, a plan that requires an employee to be employed for three consecutive calendar months before the employee's coverage becomes effective would violate the 90-day waiting period rule, because under most circumstances that eligibility condition would exceed 90 days.

If a plan conditions eligibility on completion of a number of cumulative hours of service, the hours-of-service requirement cannot exceed 1,200 hours. The 90-day waiting period must start the first day after the employee satisfies that hours-of-service requirement and cannot exceed 90 days. A plan can apply an hours-of-service eligibility requirement only once. After an employee meets a plan's hours-of service requirement, the plan cannot require the employee to meet the requirement each year or at any other time again unless the employee terminates, is rehired and must reestablish eligibility.

If a plan conditions eligibility on an employee working full-time or a specified number of hours of service per period, and the plan cannot determine that a newly-hired employee is reasonably expected to regularly work full-time or that number of hours per period (often referred to as a "variable-hour employee"), the plan can use a measurement period to determine if the employee meets the plan's eligibility condition. That measurement period must:

- Not exceed 12 months;
- Begin on any date between the employee's start date and the first day of the first calendar month following the employee's start date; and
- If the employee is determined to be eligible during the measurement period, the employee's coverage must be effective no later than 13 months from the employee's start date, plus the time remaining until the first day of the next calendar month (if the employee's start date is not the first day of a calendar month).

For insured plans, an insurance company can rely on the eligibility information reported by the employer or other plan sponsor and, in administering the plan's waiting period, the insurer will not be deemed in violation of these regulations if:

- The insurer 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 plan, and the insurer requires the plan sponsor to update that representation with any changes; and
- The insurer has no specific knowledge of the imposition of a waiting period that exceeds 90 days.

APPLICATION OF 90-DAY WAITING PERIOD RULE TO REHIRES

If an employee terminates employment and is then rehired by the same employer, the plan may require the former employee to meet the plan's eligibility criteria and satisfy the plan's waiting period again, if that is reasonable under the circumstances. As an example of what is not reasonable, the final regulations state that a termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period.

This rule also applies when an employee moves from a job that has health coverage to a job that is ineligible for coverage, and then later moves back to an eligible job classification.

ORIENTATION PERIOD

The final regulations on excessive waiting periods introduced a new element that an employer can use in complying with the 90-day waiting period requirement: the "reasonable and bona-fide employment-based orientation period." As previously noted, this requirement is another type of substantive eligibility condition that the federal agencies indicate could be used in conjunction with a waiting period of up to 90 days without violating the waiting period rule. An employer who establishes such an employment-based orientation period at the beginning of a new employee's employment can delay the start of the waiting period until after the orientation period is completed, provided that the orientation period does not exceed one month.

The federal agencies issued **final regulations** on June 20, 2014, addressing the application of this permissible substantive eligibility condition. Those final regulations describe the orientation period as a period during which the employer and employee can evaluate whether the employment situation is satisfactory for each party, and standard orientation and training processes can begin.

The maximum allowed length of a "reasonable and bona fide employment-based orientation period" is one month. That month is determined and applied in the following manner:

- Add one calendar month (using the length of the month containing the employee's start date) after the employee's start date, and then subtract one calendar day, provided the orientation period ends on or before the end of the calendar month that immediately follows the month of the employee's start date. For example, if the employee's start date is May 3, the orientation period must end on June 2. An employee whose start date is October 1 must have an orientation period ending on October 31.
- If after adding a calendar month the orientation period does not end on or before the end of the calendar month that immediately follows the month of the employee's start date, the last day of the orientation period must be the last day of the calendar month immediately following the month of the employee's start date. For example, if the employee's start date is January 30, the orientation period must end on February 28 (or February 29 in a leap year), not March 1. An employee whose start date is August 31 must have an orientation period ending on September 30, not October 1.

When a group health plan conditions eligibility on an employee completing an orientation period that meets these criteria, the maximum 90-day waiting period should begin on the first day after the orientation period ends. In effect, the orientation period provides group health plans with the opportunity to extend the time period beyond the 90-day waiting period limit that they can use as part of the new hire's probationary period or as a means to delay the start of a new hire's plan coverage until the first of the month, consistent with the common practice among group health plans. For example, if an employee establishes plan eligibility as of July 14, rather than start the waiting period on July 15, the plan can add a probationary period from July 15 through August 2 (less than 30 days) and then start a 90-day waiting period that ends October 31, with the coverage effective date on November 1.

Like the 90-day waiting period regulations, the preamble to the orientation period regulations indicates that states have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law. At this time we are not aware of any state rule that imposes such a "more restrictive" rule on insurers, but if a state chose to do so, most likely it would require an orientation period that was shorter than one month.

PENALTY

The penalty for administering a waiting period in excess of the 90-day maximum is the standard penalty for noncompliance with all of the Public Health Services Act health care reform mandates. That penalty is an excise tax of $100 per day with respect to each individual to whom the failure relates. The tax is imposed on the plan sponsor of single employer plans.

If the failure is discovered after the plan receives notice of an audit, the minimum excise tax is $2,500. For a violation that is "more than de minimis," the minimum penalty increases to $15,000. The maximum penalty for unintentional failures by a single employer plan is the lesser of 10% of the amount paid by the employer during the prior tax year for group health plans or $500,000.

The excise tax may not apply if it can be demonstrated that the failure to comply with the 90-day waiting period requirement was due to reasonable cause and not willful neglect, and the failure is corrected within 30 days after the responsible entity knew or should have known that the failure existed.

EFFECTIVE DATE AND APPLICATION

Plans are required to comply with the 90-day waiting period requirement as of the first day of the first plan year beginning on or after January 1, 2014. The final regulations are effective as of January 1, 2015. Until that date, plans can follow either the proposed regulations issued March 21, 2013 or the final regulations.

The final orientation period regulations are also effective as of January 1, 2015. Until that date, compliance with the proposed orientation period regulations is considered compliance with the final rules through the end of 2014.

According to the preamble to the final regulations, for employees who are in the middle of a waiting period when the 90-day waiting period requirement becomes effective, the waiting period must be limited to 90 days even if the rules in effect for the prior plan year require a longer waiting period. For example, if an employee participating in a calendar year plan with a prior 100 day waiting period has reached the 50th day of the employee's waiting period as of January 1, 2014, the employee's waiting period must end as of February 9, 2014 (the 40th day of the new 90-day waiting period, which is 90 days following the employee's date of hire). For an employee who had reached the 95th day of the 100-day waiting period under the plan as of January 1, 2014, the plan must make the employee's coverage effective as of January 1, 2014.

The preamble's restriction on waiting period carryover for the 2014 plan year only discusses the waiting period and does not specifically address the eligibility condition. For this reason, an employer could be aggressive and insist on using an old eligibility condition that is inconsistent with the final regulations for employees in place prior to January 1, 2014. For example, the old eligibility condition might require that the employee have six months of service (more than the 90-day limit) or 1,500 cumulative hours (more than the 1,200 hour limit) before the employee is eligible to participate in the plan. Continued application of that old eligibility condition to employees in the middle of fulfilling that condition could result in delaying the start of those employees' coverage long after their coverage would have been effective if they were hired after the start of the 2014 plan year.

There is a good chance that the federal agencies will interpret the final regulations as applying to any eligibility condition that carries over after the start of the 2014 plan year as well as to any waiting period that carries over into the 2014 plan year, by taking the view that the carryover of those eligibility conditions and waiting periods is "designed to avoid compliance with the 90-day waiting period limitation." For this reason, an employee who begins employment on October 1, 2013 with an employer whose calendar year plan includes a one year eligibility condition should cut off the eligibility condition after 90 days (as of January 28, 2014), before starting a waiting period of up to 90 days – thereby making coverage effective no later than March 19, 2014.

Likewise, if a calendar year plan imposes a 1,300 cumulative hours requirement and a new employee who started July 1, 2013 reaches 1,200 hours as of March 15, 2014, the plan should start its standard waiting period as of March 16, 2014 and make the employee's coverage effective as soon as that waiting period of up to 90 days is completed.

In summary, when implementing the 90-day waiting period guidelines employers should be careful to design both the eligibility and the waiting period aspects of their plans in order to comply with those rules as of the date those rules become effective for their plans in 2014.

Lastly, included in the final 90-day waiting period regulations is a statement indicating that compliance with those regulations does not necessarily ensure compliance with other federal laws, including the PPACA statute. A similar provision is included in the preamble to the final orientation period regulations. For employers this means that merely because their group health plan contains a waiting period or an orientation period that meets those requirements does not necessarily mean that the employer has complied with the pay or play requirements. For example, an employer could hire a full-time employee on July 7, determine that the employee is immediately eligible for coverage under the employer's health plan, and make the employee's coverage effective on November 5, after applying a one month orientation period and a 90-day waiting period. Although that arrangement would comply with the 90-day waiting period and orientation period regulations, it would leave the employer subject to a pay or play penalty, because the employee was not covered by the first day of the fourth full calendar month of the employee's employment, November 1.

CERTIFICATES OF CREDITABLE COVERAGE

Under PPACA law, a health plan cannot impose a preexisting condition exclusion for plan years beginning on or after January 1, 2014. This eliminates the need for health plans to issue certificates of creditable coverage, which are used to document a plan participant's prior period of health plan coverage and offset that period against any preexisting condition exclusionary time period under the participant's subsequent health plan. As a result, the final regulations state that health plans will no longer need to issue certificates of creditable coverage, beginning December 31, 2014.

Willis's National Legal & Research Group will continue to monitor developments and provide information as they occur.

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