The Wait Is Over—Government Issues Final Regulations on 90-Day Waiting Period

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Under the Patient Protection and Affordable Care Act (Affordable Care Act), grandfathered and non-grandfathered group health plans and health insurance issuers may not impose any waiting period that exceeds 90 days for plan years beginning after December 31, 2013. The three departments charged with administering the Affordable Care Act—Treasury, Labor, and Health and Human Services—published final regulations implementing the 90-day waiting period on February 24, 2014.

The final regulations contain rules that provide guidance on the employer mandate penalty, permit the use of an orientation period for full-time employees (FTEs) before the waiting period commences, and provide for the phase-out of HIPAA certificates of creditable coverage. This Aon Hewitt bulletin describes the changes made in the final regulations as well as the impact of the final and proposed regulations on employer group health plans.

**Prohibition on Waiting Periods Longer Than 90 Days**

The final regulations define “waiting period” as 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. The final regulations also provide that if an individual enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period.

After an individual is determined to be “otherwise eligible” for coverage under the terms of the plan, any waiting period may not extend beyond 90 days, and all calendar days are counted beginning on the enrollment date, including weekends and holidays. The “enrollment date” is defined as the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual’s enrollment date does not change.

**Eligibility Criteria**

The final regulations provide that being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period).

Eligibility conditions based solely on the lapse of a time period are permissible for no more than 90 days. Other conditions for eligibility under the terms of a group health plan are generally permissible, unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

As under the proposed regulations, if the plan’s terms allow an individual to elect coverage that becomes effective on a date that does not exceed 90 days, the coverage complies with the 90-day waiting period.
limitation, and the plan or issuer will not be considered to violate the waiting period rules merely because individuals may take additional time (beyond the end of the 90-day waiting period) to elect coverage.

Application to Variable Hour Employees
The final regulations continue to provide that a variable hour employee in a look-back measurement period (to determine FTE status for purposes of the employer mandate) will not be considered a violation of the 90-day waiting period limitation. Coverage must be 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.

Cumulative Service Requirement
If eligibility is conditioned on the completion of a number of cumulative hours of service, the hours-of-service requirement cannot exceed 1,200 hours. The preamble of the final regulations notes that this provision is a one-time eligibility requirement and that the cumulative service requirement cannot be applied to the same individual each year.

Rehired Employees
If reasonable under the circumstances, a former employee who is rehired may be treated as newly eligible for coverage and thus required to meet the plan’s eligibility criteria and waiting period again. This also applies to individuals who move into a job classification that is ineligible for coverage under the plan but then later returns to an eligible job classification.

Bona Fide Orientation Period
The final regulations provide that a requirement to successfully complete a reasonable and bona fide employment-based orientation period may be imposed as a condition for eligibility for coverage under a plan.

Proposed Regulations for Bona Fide Orientation Period—The agencies also issued proposed regulations on February 24, 2014 that specify the circumstances under which the duration of an orientation period will be considered “reasonable or bona fide.” According to the preamble of the proposed regulations, an employer and employee could, during the orientation period, evaluate whether the employment situation was satisfactory for each party, and the standard orientation and training processes would begin.

Under the proposed regulations, one month is proposed as the maximum length of any orientation period. For this purpose, one month is determined by adding one calendar month and then subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. An example in the proposed regulations shows how this would work:

**Example:** Employee begins working full time for Employer on October 16. Employer sponsors a group health plan, under which FTEs are eligible for coverage after they have successfully completed a one-month orientation period. Employee completes the orientation period on November 15. In this example, the orientation period is not considered a subterfuge for the passage of time and is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, plan coverage for Employee must begin no later than February 14, which is the 91st day after Employee completes the orientation period. (If the
At least through the end of 2014, the agencies will consider compliance with the proposed regulations to constitute a reasonable and bona fide employment-based orientation period for purposes of the 90-day waiting period limitation. If final regulations are more restrictive on plans and issuers, the final regulations or other guidance will not be effective prior to January 1, 2015, and plans and issuers will be given reasonable time to comply.

**Multiemployer Plans**

The final regulations include an example addressing the waiting period rules and certain eligibility rules for multiemployer plans that involve working for multiple employers:

**Example:** A multiemployer plan operating pursuant to an arms-length collective bargaining agreement has an eligibility provision that allows employees to become eligible for coverage by working a specified number of hours of covered employment for multiple contributing employers. The plan aggregates hours in a calendar quarter and then, if enough hours are earned, coverage begins the first day of the next calendar quarter. The plan also permits coverage to extend for the next full calendar quarter, regardless of whether an employee’s employment has terminated. In this example, these eligibility provisions are designed to accommodate a unique operating structure, and, therefore, are not considered to be designed to avoid compliance with the 90-day waiting period limitation, and the plan complies with this section.

**Insurer Reliance on Employer Information**

The final regulations allow the insurer of a fully-insured group health plan to rely on information provided by an employer or other plan sponsor if: 1) The issuer requires the plan sponsor to make a representation regarding the terms of any eligibility conditions or waiting periods imposed by the plan sponsor and requires any updates; and 2) The issuer has no specific knowledge of the imposition of a waiting period that would exceed 90 days.

**HIPAA Certificates of Creditable Coverage**

HIPAA certificates of creditable coverage will no longer be required beginning December 31, 2014. Until this time, plans and issuers must continue to issue certificates of creditable coverage in compliance with current HIPAA requirements.

**Applicability**

The final regulations are applicable to plans and issuers on plan years beginning on or after January 1, 2015. For plan years beginning in 2014, plans and issuers may comply with either the proposed regulations or these final regulations.
Next Steps
Written comments on the proposed regulations must be submitted by April 25, 2014.

Resources
The news release is available at: http://www.dol.gov/opa/media/press/ebsa/EBSA20140297.htm
The Aon Hewitt bulletin on the proposed regulations, “Proposed Regulations Implement 90-Day Waiting Period and End HIPAA Creditable Coverage Certificates” (March 2013), is available at: http://www.aon.com/human-capital-consulting/thought-leadership/leg_updates/healthcare/reports-pubs_032813_proposed_regulations_implement_90_day_waiting_period_and_end_hipaa_creditable_coverage_certificates.jsp
Aon Hewitt’s Regulatory Guidance Under the Affordable Care Act page, which provides links to Aon Hewitt bulletins on Affordable Care Act guidance and regulations, is available at: http://www.aon.com/human-capital-consulting/thought-leadership/leg_updates/healthcare/index_regulatory_guidance_affordable_care.jsp
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