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Regulations Released on 90-Day Waiting Period Limitation and Orientation Period

Recently, the Department of Health and Human Services (HHS) released final regulations on the federal maximum waiting period limitation applicable for plan years on or after January 1, 2014 as part of the Affordable Care Act. The final regulations did not include any major changes from the proposed regulations issued earlier on March 22, 2013. The proposed rules provided the following:

- A Waiting Period is defined as the period of time an already eligible employee (or dependent) must wait before their coverage is effective
- Eligibility for a plan may require an employee (or dependent) to first satisfy a plan's substantive eligibility requirements
- After an employee (or dependent) is eligible for coverage, the effective date cannot be any later than the 91st day after eligibility
- For variable or seasonal hour employees, a measurement period prior to eligibility to the plan is acceptable
- If an individual enrolls as a late enrollee or special enrollee, any period before their enrollment is not considered a waiting period

For further analysis and information on the proposed rules, please see the Barney & Barney Compliance Breaking News, released in March of 2013, Volume 2013, Issue 1.

Note: California has a maximum 60-Day Waiting Period Limitation

Final Regulations on the Maximum 90-Day Waiting Period Limitation

Many of the proposed rules were adopted in the final regulations. However, some additions to the rules were made, including:

- The period of time that occurs prior to the beginning of the initial measurement period for a new employee, plus the administrative period, may not exceed 90 days (California has a maximum 60-day waiting period)
- A former employee who is rehired could be required to once again satisfy his/her substantive eligibility requirements and a 90-day waiting period

- An employee who became ineligible for coverage due to a change in his/her employment could be required to once again satisfy his/her substantive eligibility requirements and a 90-day waiting period
- Multi-employer plans subject to collective bargaining agreements which require employees to work hours across multiple contributing employers before they become eligible for coverage would not be considered in violation of the Maximum 90-Day Waiting Period Limitation
- Carriers may rely on the eligibility information reported by an employer and would not be considered to have violated the Maximum 90-Day Waiting Period Limitation if:
    - the carrier requires the plan sponsor to make a representation of the applicable eligibility terms and waiting periods under the plan; and
    - the carrier has no specific knowledge of the imposition of a waiting period that would exceed the Maximum 90-Day Waiting Period Limitation

Proposed Rule on Orientation Period

The final regulations allow for an employer to institute an employment-based orientation period prior to an employee's eligibility to a plan, only if:

- the employment-based orientation period is for a "reasonable and bona fide" business reason; and
- the employment-based orientation period is no greater than one month
    - One calendar month would be calculated by adding one calendar month to the date of hire and subtracting one calendar day

      Example: If Employee A starts in an eligible position on May 3, the last permitted day of the orientation period is June 2.

Note: Employers should consult with legal counsel regarding the 90-day waiting period and the use of an orientation period to ensure that the orientation period is indeed for a "reasonable and bona fide" business reason.

Action Required

Employers should ensure that they begin implementing a maximum 90-day waiting period for eligible employees by the beginning of their 2014 plan renewal date. Employers should also be aware of the ability to use an orientation period prior to the beginning of the 90-day waiting period, so long as the orientation period is implemented for a "reasonable and bona fide" business reason.

For more information regarding the final regulations on the Maximum 90-Day Waiting Period Limitation, go to:

http://www.dol.gov/ebsa/pdf/90dayfinalrules.pdf

For more information regarding the proposed regulations on the orientation period as it relates to the Maximum 90-Day Waiting Period Limitation, go to:

http://www.dol.gov/opa/media/press/ebsa/20140220-redfeg2.pdf

Final Regulations Released on Information Reporting for Employers and Insurers under the Affordable Care Act

Recently, the Internal Revenue Service (IRS) released final regulations on the information reporting that will be required of employers and insurers pursuant to the Affordable Care Act (ACA). On September 9, 2013, the IRS published proposed rules on these reporting requirements. Reporting requirements are effective on or after January 1, 2015, and information reporting to the IRS and covered individuals will occur in early 2016 for coverage offered during the 2015 calendar year. These requirements include:

- Code Section 6055 reporting
    - Insurance carriers, plan sponsors of self-funded plans, governmental entities, and other parties are required to report information to the IRS regarding all covered individuals who have been provided Minimum Essential Coverage (MEC), in addition to providing statements directly to those covered individuals regarding their MEC. This reporting would help the government in its enforcement of the Individual Mandate
- Code Section 6056 reporting
    - Employers subject to the Employer Mandate are required to report information on the health benefits provided to full-time employees to the IRS. In addition, employers would also be required to provide a statement to covered individuals regarding those health benefits

For further analysis and information on the proposed rules, go to the Barney & Barney Compliance Department's Breaking News piece, released in September of 2013, Volume 2013, Issue 15.

Final Regulations on the Employer and Insurer Reporting Requirements

Many of the proposed rules were adopted in the final regulations. However, some additions to the rules were made. These revisions and additions by topic are included below.

Section 6055 and 6056 Combined Reporting

One single combined form would be created to include both the Section 6055 (insurance provider) and the Section 6056 (employer) reporting requirement. **Note: Draft forms provided by the IRS will be released in the future for comment.**

- Employers who are plan sponsors of self-funded plans would report in both Section 6055 and Section 6056
- Employers who have fully-insured plans would only be required to complete Section 6056, and the carrier would complete its Section 6055 reporting on a separate form

Section 6056 Simplified Reporting for Employers

Employers who qualify may submit simplified forms to the IRS. These two methods for filing alternative forms are outlined below:

- Reporting based upon qualifying offers
    - If an employer certifies that a "qualifying offer[1]" of coverage was made to an employee (and spouse and dependents) for all months that the employee was full-time, the employer may report simplified Section 6056 information to the IRS and provide a simplified statement to individual employees. An employer may also indicate with a distinct code that it made a "qualifying offer" of coverage for 12 months to the full-time employee, spouse, and dependent(s)

[1] A qualifying offer of coverage is defined as an offer of health coverage that provides Minimum Value (60% actuarial value) and the self-only contribution towards self-only coverage of the employee is no more than 9.5% of the Federal Poverty Line for a single person. In addition, Minimum Essential Coverage (MEC) must be offered to an employee's spouse and dependent children to allow an employer to use the simplified reporting method.

- For the 2015 year only, a transition rule provides that an employer only needs to make a qualifying offer to at least 95% of its full-time employees and their spouses and dependent(s) in order for the employer to certify an offer of coverage and provide a simplified statement to employees

- Reporting based upon an offer of coverage to "substantially all" employees
  - If an employer offers "substantially all[2]" of its employees Affordable[3] and Minimum Value[4] coverage, an employer may report to the IRS without identifying or specifying the number of full-time employees it may have. For this alternate method, an employer would need to certify that it did indeed offer "substantially all" of its employees Affordable and Minimum Value coverage.

Section 6055 Reporting Requirements

The final regulations state that providers of Minimum Essential Coverage (MEC) (insurance carriers, plan sponsors of self-funded plans, governmental entities, and other parties) must report the tax identification numbers (TINs) of **all** covered individuals. A birth date of the covered individual may be reported instead, but only if a TIN is not available after reasonable efforts are made to obtain it.

Action Required

Employers should ensure they begin obtaining TINs for covered individuals on their plans. Second, employers should ensure that they begin developing systems and protocol for tracking full-time employees and monitoring those benefits offered to those employees.

For more information regarding the final regulations on the Section 6056 reporting requirement, go to:

http://www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05050.pdf

For more information regarding the final regulations on the Section 6055 reporting requirement, go to:

https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-05051.pdf

Transition Relief Now Allows Certain Non-compliant Policies and Hardship Exemptions for Two Years

On March 5, 2014, the Centers for Medicare and Medicaid Services (CMS) announced that individuals and small groups may renew their insurance coverage that would normally have been cancelled due to non-compliance with the Affordable Care Act (ACA). At the option of States, individual policies and small group plans beginning January 1, 2014 through October 1, 2016 that are not compliant with the current ACA rules will be considered to be in compliance with the ACA. Insurers must notify the right to continued coverage to individuals and small groups.

The transition relief applies to the following non-compliant provisions within plans (in addition to others):

- Guaranteed availability and renewability
- The requirement to provide Essential Health Benefits
- Premium rating rules
- Prohibitions on pre-existing conditions and discrimination based upon a health factor (only applies to individual policies)

[2] Substantially all is defined here as 98% of employees whom the employer is required to report to the IRS in relation to Section 6056.
[3] Affordable means that an employee would not pay more than 9.5% of his/her household income for self-only coverage.
[4] Minimum Value describes coverage that provides 60% actuarial value to the insured.

Hardship exemptions from the Individual Mandate continue to be available, so long as an individual's policy was cancelled because of non-compliance and other options are more expensive for that individual.

No Action Required

Employers should be aware of the availability for employees to renew non-compliant policies. Small group employers should be especially aware of the ability to renew their non-compliant plans.

For more information regarding the CMS Notice, go to:

http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf

NEW YORK CITY ADOPTS MANDATORY SICK LEAVE LAW

Recently, New York City Council has expanded the obligations of employers subject to the New York City Earned Sick Time Act. The expansion is expected to be signed by New York City Mayor Bill de Blasio soon.

Passed into law on May 8, 2013, the ordinance requires most of the City's private employers to provide **paid** or **unpaid** sick leave to employees beginning April 1, 2014. Originally, the law required:

- Employers with 20 or more employees to begin offering **paid** leave to employees by April 1, 2014
- Employers with 15-19 employees to begin offering **paid** sick leave by October 1, 2015
- Employers with 14 or fewer employees to begin offering **unpaid** sick leave by April 1, 2014
- Employees eligible to use sick leave after 120 days of employment or the effective date of this law (now July 31, 2014)
- Sick leave to accumulate at one hour for every 30 hours worked up to 40 hours of **paid** or **unpaid** sick leave per year

For further analysis and information on the New York City Mandated Sick Leave Law, go to the Barney & Barney Compliance Department's Legislative Compliance Newsletter, released in May of 2013, Volume 2013, Issue 5.

Expansion of New York City' Earned Sick Time Act

With the latest legislation, employers with **five** or more employees and all employers of at least one domestic worker must provide **unpaid** sick time by April 1, 2014. Employers subject to this expansion of the law are provided a grace period for violations until October 1, 2014.

Sick time may be used to care for an employee's own health needs or to care for a family member (an employee's child, spouse, domestic partner, parent, sibling, grandchild or grandparent, or the child or parent of an employee's spouse or domestic partner).

Action Required

Employers with employees in New York City should ensure employees are provide sick leave, whether paid or unpaid (depending on employer size), by April 1, 2014. An employer need not create a new leave policy if their existing leave or Paid Time Off accrues at the same rate as the New York City ordinance requires.

For more information regarding this ordinance, please go to:

http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=655220&GUID=8FEF6526-0C00-45D5-BD0B-617353F90F06&Options=ID%7cText%7c&Search =97-a

QUESTION OF THE MONTH

Question: We sponsor a grandfathered, non-calendar-year self-insured health plan that imposes a three-month eligibility waiting period (our next plan year begins on August 1, 2014). As a grandfathered plan, are we required to comply with health care reform's prohibition on excessive waiting periods? And, if so, would we be in compliance with the existing three-month waiting period?

Answer: Yes, your plan must comply, and no, a three-month waiting period does not meet the requirement. For plan years beginning on or after January 1, 2014, health care reform establishes a maximum eligibility waiting period of 90 days, which is not the same as three months. Even grandfathered plans (those in existence on March 23, 2010 that have not undergone certain changes) must comply with the requirement prohibiting "excessive" waiting periods—i.e., periods exceeding 90 days. As discussed below, in certain situations, application of a reasonable and bona fide employment-based orientation period may delay when the 90-day waiting period begins to run.

A waiting period is defined as the period that must pass before coverage becomes effective for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan. (Individuals are "otherwise eligible" if they have satisfied the plan's substantive eligibility conditions, such as being in an eligible job classification or obtaining a job-related license.) To comply with the waiting period requirement, your plan cannot require an otherwise eligible employee or dependent to wait more than 90 days before coverage becomes effective. For this purpose, three months is not equivalent to 90 days, and all calendar days (including weekends and holidays) are counted toward the 90 days, beginning with the first day of the waiting period. Because three months can be longer than 90 days and there is no de minimis exception for the difference between 90 days and three months, a three-month waiting period would not comply with the 90-day limit.

However, ACA final regulations issued in February 2014 introduce a reasonable and bona fide employment-based orientation period as another example of a permissible substantive eligibility condition that delays commencement of the 90-day waiting period. This orientation period is described as a period in which the employer and employee evaluate whether the employment situation is satisfactory, and standard orientation and training processes begin. Under proposed regulations issued concurrently with the final regulations, the maximum length of such an orientation period would be one month, and the plan's waiting period may begin on the first day after the orientation period. (See our article.)

We recommend you consult with your benefits counsel about amending your plan to comply with the maximum 90-day waiting period starting with the plan year beginning August 1, 2014. In addition to using a waiting period of no more than 90 days (rather than three months), you could add an orientation period, if desired and appropriate. You should also note that if your plan is amended to impose the maximum 90-day waiting period and the 91st day is a weekend or holiday, your plan may choose to permit coverage to be effective earlier than the 91st day, for administrative convenience. However, the plan may not make the effective date of coverage later than the 91st day, even if the 91st day is a weekend or holiday. (NOTE: California law has a more restrictive 60-day waiting period limitation).

Finally, if you are an applicable large employer, you should review the final regulations regarding employer shared responsibility (play or pay) penalties. The final regulations explain the conditions under which employers will avoid potential penalties by offering coverage to new full-time employees. These rules are similar to—but different from—the rules for waiting periods, and applicable large employers should familiarize themselves with both sets of rules.

Source: EBIA Thomson Reuters