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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

T.D. 9656

RIN 1545-BL50

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB56

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 146, and 147

[CMS-9952-F]

RIN 0938-AR77

Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under the Affordable Care Act

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: These final regulations implement the 90-day waiting period limitation under section 2708 of the Public Health Service Act, as added by the Patient Protection and Affordable

Care Act (Affordable Care Act), as amended, and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code. These regulations also finalize amendments to existing regulations to conform to Affordable Care Act provisions. Specifically, these rules amend regulations implementing existing provisions such as some of the portability provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because those provisions of the HIPAA regulations have become superseded or require amendment as a result of the market reform protections added by the Affordable Care Act.

DATES: Effective date. These final regulations are effective on [insert date 60 days after publication in the **Federal Register**].

Applicability date. The 90-day waiting period limitation provisions of these final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015. The amendments made by these final regulations to the evidence of creditable coverage provisions of 26 CFR 54.9801-5, 29 CFR 2590.701-5, and 45 CFR 146.115 apply beginning December 31, 2014. All other amendments made by these final regulations apply to group health plans and health insurance issuers for plan years beginning on or after [insert date 60 days after publication in the **Federal Register**]. Until the amendments to the existing HIPAA final regulations become applicable, plans and issuers must continue to comply with the existing regulations, as applicable.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Elizabeth Schumacher, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317-6846; or Cam Moultrie Clemmons, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (410) 786-1565.

*Customer service information***:** Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's website (www.dol.gov/ebsa). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cciio.cms.gov/) and information on health reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Pub. L. 111-152, was enacted on March 30, 2010. (They are collectively known as the "Affordable Care Act".) The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.[1] The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

PHS Act section 2708, as added by the Affordable Care Act and incorporated into ERISA and the Code, provides that a group health plan or health insurance issuer offering group health

[1] The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan," as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

insurance coverage shall not apply any waiting period (as defined in PHS Act section 2704(b)(4)) that exceeds 90 days. PHS Act section 2704(b)(4), ERISA section 701(b)(4), and Code section 9801(b)(4) define a waiting period to be the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the plan. In 2004 regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) portability provisions (2004 HIPAA regulations), the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments[2]) defined a waiting period to mean the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.[3] PHS Act section 2708 does not require an employer to offer coverage to any particular individual or class of individuals, including part-time employees. PHS Act section 2708 merely prevents an otherwise eligible employee (or dependent) from being required to wait more than 90 days before coverage becomes effective. PHS Act section 2708 applies to both grandfathered and non-grandfathered group health plans and group health insurance coverage for plan years beginning on or after January 1, 2014.

On February 9, 2012, the Departments issued guidance[4] outlining various approaches under consideration with respect to both the 90-day waiting period limitation and the employer shared responsibility provisions under Code section 4980H (February 2012 guidance) and requested public comment. On August 31, 2012, following their review of the comments on the February 2012 guidance, the Departments provided temporary guidance,[5] to remain in effect at

[2] Note, however, that in the Economic Analysis and Paperwork Burden section of this preamble, in sections under headings listing only two of the three Departments, the term "Departments" generally refers only to the two Departments listed in the heading.
[3] 26 CFR 54.9801-3(a)(3)(iii), 29 CFR 2590.701-3(a)(3)(iii), and 45 CFR 146.111(a)(3)(iii).
[4] Department of Labor Technical Release 2012-01, IRS Notice 2012-17, and HHS FAQs issued February 9, 2012.
[5] Department of Labor Technical Release 2012-02, IRS Notice 2012-59, and HHS FAQs issued August 31, 2012.

least through the end of 2014, regarding the 90-day waiting period limitation, and described the approach they intended to propose in future rulemaking (August 2012 guidance). After consideration of all of the comments received in response to the February 2012 guidance and August 2012 guidance, the Departments issued proposed regulations on March 21, 2013 (78 FR 17313).

Under the proposed regulations, a group health plan and a health insurance issuer offering group health insurance coverage may not apply any waiting period that exceeds 90 days. The regulations proposed to define "waiting period" as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. Being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms). Eligibility conditions that are based solely on the lapse of a time period would be permissible for no more than 90 days. Other conditions for eligibility under the terms of a group health plan (that is, those that are not based solely on the lapse of a time period) are generally permissible under PHS Act section 2708 and the proposed regulations unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

Among other things, the proposed regulations addressed application of waiting periods to certain plan eligibility conditions. The proposed regulations provided 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 to determine whether the employee meets the plan's

eligibility condition, which may include a measurement period[6] of no more than 12 months that begins on any date between the employee's start date and the first day of the first calendar month following the employee's start date 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, and no waiting period that exceeds 90 days is imposed in addition to the measurement period.

The proposed regulations also addressed cumulative hours-of-service requirements, which use more than solely the passage of a time period in determining whether employees are eligible for coverage. Under the proposed regulations, if a group health plan or group health insurance issuer conditions eligibility on the completion by an employee (part-time or full-time) of a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.[7] Under the proposed regulations, the plan's waiting period must begin once the new employee satisfies the plan's cumulative hours-of-service requirement and may not exceed 90 days. The preamble to the proposed regulations stated that this provision is designed to be a one-time eligibility requirement only and that the proposed regulations do not permit, for example, re-application of such a requirement to the same individual each year.[8] The preamble to the proposed regulations also provided that the

[6] See 26 CFR 54.4980H-3(d)(3)(i), at 79 FR 8544 (February 12, 2014).
[7] See section 4980H of the Code and its implementing regulations for an applicable large employer's shared responsibility to provide health coverage to full-time employees.
[8] 78 FR 17313, 17316 (March 21, 2013). See also Code section 36B and its implementing regulations, and www.healthcare.gov for information on an individual's eligibility for premium tax credits in the Affordable Insurance Exchange or "Exchange (also referred to as Health Insurance Marketplace or "Marketplace) generally, as well as during a waiting period for coverage under a group health plan.

Departments would consider compliance with these proposed regulations to constitute compliance with PHS Act section 2708 at least through the end of 2014.[9]

The proposed regulations also included proposed amendments to conform to Affordable Care Act provisions already in effect as well as those that would become effective in 2014. The regulations proposed amending the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA), to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704, added by the Affordable Care Act.[10] Additionally, the regulations proposed to amend examples and provisions in 26 CFR Part 54, 29 CFR Part 2590, and 45 CFR Parts 144 and 146 to conform to other changes made by the Affordable Care Act, such as the elimination of lifetime and annual limits under PHS Act section 2711 and its implementing regulations,[11] as well as the provisions governing dependent coverage of children to age 26 under PHS Act section 2714 and its implementing regulations.[12]

After consideration of the comments and feedback received from stakeholders, the Departments are publishing these final regulations.

II. Overview of the Final Regulations

A. Prohibition on Waiting Periods That Exceed 90 Days

These final regulations provide that a group health plan, and a health insurance issuer offering group health insurance coverage, may not apply a waiting period that exceeds 90 days.

[9] The preamble to the proposed regulations stated that the proposed regulations are consistent with, and no more restrictive on employers than, the August 2012 guidance. See 78 FR 17313, 17317 (March 21, 2013). The August 2012 guidance similarly provided that group health plans and group health insurance issuers may rely on the compliance guidance through at least the end of 2014. See Department of Labor Technical Release 2012-02, IRS Notice 2012-59, and HHS FAQs issued August 31, 2012.

[10] Affordable Care Act section 1201 also moved those provisions from PHS Act section 2701 to PHS Act section 2704. See also 75 FR 37188 (June 28, 2010).

[11] 75 FR 37188 (June 28, 2010).

[12] 75 FR 27122 (May 13, 2010).

(Nothing in these final regulations requires a plan or issuer to have any waiting period, or prevents a plan or issuer from having a waiting period that is shorter than 90 days.) If, under the terms of the plan, an individual[13] can 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.

These final regulations continue to 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. These final regulations also continue to include the clarification 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. The effective date of coverage for special enrollees continues to be that set forth in the Departments' 2004 HIPAA regulations governing special enrollment[14] (and, if applicable, in HHS regulations addressing guaranteed availability[15]).

The final regulations set forth rules governing the relationship between a plan's eligibility criteria and the 90-day waiting period limitation. Specifically, these final regulations provide that being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as, 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). The 90-day waiting period limitation generally does

[13] The proposed regulations used several different terms when referencing individuals, such as employees and dependents, and participants and beneficiaries. Where it is appropriate, the final regulations replace these references with the term "individual" for consistency purposes. This is merely a change to eliminate any confusion that may occur as a result of using multiple terms interchangeably and does not change the substance of the rules as PHS Act section 2708 limits applying a waiting period that exceeds 90 days to any individual who is otherwise eligible to enroll under the terms of the plan.

[14] 26 CFR 54.9801-6, 29 CFR 2590.701-6, and 45 CFR 146.117.

[15] 45 CFR 147.104(b)(5).

not require the plan sponsor to offer coverage to any particular individual or class of individuals (including, for example, part-time employees). Instead, these final regulations prohibit requiring otherwise eligible individuals to wait more than 90 days before coverage becomes effective.[16]

Under these final regulations, eligibility conditions that are 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 (that is, those that are not based solely on the lapse of a time period) are generally permissible under PHS Act section 2708 and these final regulations, unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

The proposed regulations included an approach when applying waiting periods to variable-hour employees in cases in which a specified number of hours of service per period is a plan eligibility condition. In general, the proposed regulations provided that, except for cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether a variable-hour employee meets the plan's hours of service per period 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.

Some commenters requested a rule permitting plans to impose a 90-day waiting period in addition to the 12-month measurement period, arguing that restricting the period to 13 months plus the time remaining until the first day of the next calendar month would in effect be a one month waiting period and impose administrative hardship. Other commenters requested that the final regulations eliminate the allowance of a measurement period and require coverage to begin

[16] See also section 4980H of the Code and its implementing regulations for an applicable large employer's shared responsibility to provide health coverage to full-time employees (and their dependents).

no later than 90 days from the employee's start date. These final regulations retain the approach in the proposed regulations and 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, which may include a measurement period of no more than 12 months that begins on any date between the employee's start date and the first day of the first calendar month following the employee's start date. (This is consistent with the timeframe permitted for such determinations under Code section 4980H and its implementing regulations.) Except in cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether a variable-hour employee meets the plan's hours of service per period 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.

The proposed regulations also addressed cumulative hours-of-service requirements, which use more than solely the passage of a time period in determining whether employees are eligible for coverage. These final regulations retain the provisions of the proposed regulations, described earlier in this preamble, without change. Therefore, under these final regulations, if a group health plan or group health insurance issuer conditions eligibility on the completion by an

employee (part-time or full-time) of a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours. Under the final regulations, the plan's waiting period must begin on the first day after the employee satisfies the plan's cumulative hours-of-service requirement and may not exceed 90 days. Furthermore, this provision continues to be designed to be a one-time eligibility requirement only; these final regulations do not permit, for example, re-application of such a requirement to the same individual each year.

In response to the proposed regulations, commenters requested additional clarifications to allow plans and issuers to better coordinate the 90-day waiting period requirements with the rules under Code section 4980H, which, in the case of full-time employees of applicable large employers, generally requires as a condition for avoiding a penalty that health benefits begin by the first day of the fourth calendar month following the month in which the full-time employee begins employment. Commenters argued that, without coordination, the PHS Act section 2708 waiting period limitation could effectively require coverage to begin sooner than required under the rules implementing section 4980H of the Code and undermine the entire Code section 4980H framework, which Congress could not have intended. Other commenters argued that some employers might offer coverage to employees only because of their obligations under Code section 4980H, so that an eligibility provision that makes an offer of coverage consistent with section 4980H should be permissible without requiring coverage to begin sooner than the regulations implementing section 4980H require.

Some commenters stated that their systems are not capable of beginning coverage other than at the beginning of a month, and it is thus common practice to have a 90-day waiting period

with coverage effective the first day of the first month following a 90-day waiting period. These commenters requested the flexibility to continue this approach. Similarly, several commenters specifically requested that plans be permitted to impose a waiting period of three calendar months instead of 90 days, as it would be less confusing to participants and easier for plans and issuers to administer.

Under these final regulations, 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.[17] However, as noted above, 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. Specifically, the final regulations add an example of permissible substantive eligibility conditions under a group health plan. The proposed regulations had included being in an eligible job classification and achieving job-related licensure requirements specified in the plan's terms. The final regulations add a third example regarding the satisfaction of a reasonable and bona fide employment-based orientation period. The final regulations do not specify the circumstances under which the duration of an orientation period would not be considered "reasonable or bona fide." However, proposed regulations published elsewhere in this issue of the Federal Register propose one month as the maximum length of any orientation period meaning generally a period that begins on any day of a calendar month and is determined by adding one calendar month and then subtracting one

[17] These final regulations also note that a plan or issuer that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

calendar day).[18] Comments are invited on those proposed regulations and may be submitted as described in the proposed regulations. The Departments will consider compliance with those proposed regulations to constitute a reasonable and bona fide employment-based orientation period under PHS Act section 2708 at least through the end of 2014. To the extent final regulations or other guidance with respect to the application of the 90-day waiting period limitation to orientation periods is 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 a reasonable time period to comply.

In response to the proposed regulations, several commenters requested clarification regarding application of the rules to employees that are terminated from employment and then rehired by the same employer. Similarly, commenters requested clarification regarding application of the rules when an employee moves between a job classification that is or is not an eligible job classification for coverage under the plan.

After consideration of the comments, these final regulations provide that a former employee who is rehired may be treated as newly eligible for coverage upon rehire and, therefore, a plan or issuer may require that individual to meet the plan's eligibility criteria and to satisfy the plan's waiting period anew, if reasonable under the circumstances (for example, the termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period limitation). The same analysis would apply to an individual who moves to a job

[18] The proposed regulations provide that if there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

classification that is ineligible for coverage under the plan but then later moves back to an eligible job classification.

Many commenters raised administrative concerns relating to the application of the rules to multiemployer plans. In the preamble to the proposed regulations, the Departments recognized that multiemployer 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. Some commenters on the proposed regulations pointed out that collectively bargained plans, owing to the nature of the bargaining process, often have detailed and coordinated eligibility provisions (some requiring aggregation of data from multiple contributing employers). Others stated that the unique operating structure of multiemployer plans often allows for continued coverage after an employee's employment terminates (or after an employee's hours are reduced) until the end of the quarter.

On September 4, 2013, the Departments issued a set of frequently asked questions (FAQs) stating that, "under the proposed rules, to the extent plans and issuers impose substantive eligibility requirements not based solely on the lapse of time, these eligibility provisions are permitted if they are not designed to avoid compliance with the 90-day waiting period limitation."[19] The FAQs further provide that, "[t]herefore, for example, if a multiemployer plan operating pursuant to an arms-length collective bargaining agreement has an eligibility provision

[19] See FAQs about Affordable Care Act Implementation (Part XVI), Q2, available at http://www.dol.gov/ebsa/faqs/faq-aca16.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs16.html.

that allows employees to become eligible for coverage by working hours of covered employment across multiple contributing employers (which often aggregates hours by calendar quarter and then permits coverage to extend for the next full calendar quarter, regardless of whether an employee has terminated employment), the Departments would consider that provision designed to accommodate a unique operating structure, (and, therefore, not designed to avoid compliance with the 90-day waiting period limitation)." These final regulations include an example consistent with this FAQ.

While the requirements of PHS Act section 2708 and these final regulations apply to both the plan and issuer offering coverage in connection with such plan, to the extent coverage under a group health plan is insured by a health insurance issuer, paragraph (f) of these regulations provides that the issuer can rely on the eligibility information reported to it by an employer (or other plan sponsor) and will not be considered to violate the requirements of these final regulations in administering the 90-day waiting period limitation 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 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 applicable changes); and (2) the issuer has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.

Consistent with the statutory effective date of PHS Act section 2708, the Departments proposed that the 90-day waiting period limitation would become applicable for plan years beginning on or after January 1, 2014, for both grandfathered and non-grandfathered group health plans and health insurance issuers offering group health insurance coverage. As with the applicability of the 2004 HIPAA regulations, the proposed regulations stated that, with respect to

individuals who are in a waiting period for coverage before the applicability date of the regulations, beginning on the first day these rules apply to the plan, any waiting period can no longer apply in a manner that exceeds 90 days from the beginning of the waiting period, even if the waiting period began before the first day the rules apply to the plan.

The August 2012 guidance provided that group health plans and health insurance issuers may rely on the compliance guidance through at least the end of 2014. The preamble to the proposed regulations stated that, in the Departments' view, the proposed regulations are consistent with, and no more restrictive on employers than, the August 2012 guidance, and that therefore, the Departments will consider compliance with the proposed regulations to constitute compliance with PHS Act section 2708 at least through the end of 2014. The 90-day waiting period provisions of these final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015. For plan years beginning in 2014, the Departments will consider compliance with either the proposed regulations or these final regulations to constitute compliance with PHS Act section 2708.[20]

B. Conforming Changes to Existing Regulations

The proposed regulations included proposed conforming amendments to the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA), to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704 (as added by the Affordable Care Act) and the implementing regulations, including elimination of the requirement to issue certificates of creditable coverage. The regulations proposed that these amendments would become applicable

[20] The Departments note that, with respect to individuals who are in a waiting period for coverage before the statutory effective date of PHS Act section 2708, beginning on the first day the statute applies to the plan, any waiting period can no longer apply in a manner that exceeds 90 days. This clarification was included in the proposed regulations, but has not been retained in the final regulations, because individuals will not be in a waiting period that exceeds 90 days by the applicability date of the final regulations.

after issuance of the final regulations; however, the proposal to eliminate the requirement to issue certificates of creditable coverage was proposed to apply beginning December 31, 2014, so that individuals needing to offset a preexisting condition exclusion under a plan that will become subject to the prohibition on preexisting conditions starting with a plan year beginning on December 31, 2014 would still have access to the certificate for proof of coverage until that time. Commenters requested that the requirement to provide certificates of creditable coverage be eliminated beginning in 2014 because the certificates are no longer necessary. Commenters explained that the need for certificates after 2013 would be relatively rare and requested that plans and issuers be required to provide certificates in 2014 only upon request.

These final regulations adopt without substantive change the proposed conforming amendments. A minor clarification was added to the Example 7 of the rules regarding limitations on preexisting condition exclusion periods,[21] and Example 4 of the rules prohibiting discrimination against participants and beneficiaries based on a health factor,[22] to clarify that any reference to essential health benefit for purposes of the individual and small group markets is dependent upon the State essential health benefits benchmark plan as defined in HHS regulations at 45 CFR 156.20. Additionally, HHS is not finalizing the proposed amendments to 45 CFR 146.145(b) because the provision was stricken in previous rulemaking (78 FR at 65092, October 30, 2013).

The prohibition with respect to adults on preexisting condition exclusions applies for plan years (or, in the individual market, policy years) beginning on or after January 1, 2014. If a plan had a plan year beginning December 31, 2013, the plan could impose a preexisting condition

[21] 26 CFR 54.9801-3(a)(2) Example 8; 29 CFR 2590.701-3(a)(2) Example 8, and 45 CFR 146.111(a)(2) Example 8.
[22] 26 CFR 54.9802-1(b)(2)(i)(D) Example 4, 29 CFR 2590.702(b)(2)(i)(D) Example 4, and 45 CFR 146.121(b)(2)(i)(D) Example 4.

exclusion, and an individual could need a certificate of creditable coverage, through December 30, 2014.

All other amendments made by these final regulations to the 2004 HIPAA regulations apply to group health plans and health insurance issuers for plan years beginning on or after [insert date 60 days after publication in the **Federal Register**]. Until the amendments to the existing HIPAA final regulations become applicable, plans and issuers must continue to comply with the existing regulations, to the extent consistent with amendments to the statute.

III. Economic Impact and Paperwork Burden

A. Executive Order 12866 and 13563 – Department of Labor and Department of Health and Human Services

Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing and streamlining rules, and of promoting flexibility. It also requires federal agencies to develop a plan under which the agencies will periodically review their existing significant regulations to make the agencies' regulatory programs more effective or less burdensome in achieving their regulatory objectives.

Under Executive Order 12866, a regulatory action deemed "significant" is subject to the requirements of the Executive Order and review by the Office of Management and Budget (OMB). Section 3(f) of the Executive 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 or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the

rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

These final regulations are not economically significant within the meaning of section 3(f)(1) of the Executive Order. However, OMB has determined that the actions are significant within the meaning of section 3(f)(4) of the Executive Order. Therefore, OMB has reviewed these final regulations, and the Departments[23] have provided the following assessment of their impact.

1. Summary

As stated earlier in this preamble, these final regulations implement PHS Act section 2708, which provides that a group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days. A waiting period is defined to mean 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 generally apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

The Departments have crafted these final regulations to secure the protections intended by Congress in an economically efficient manner. The Departments lack sufficient data to quantify the regulations' economic cost or benefits; therefore, the proposed regulations provided a qualitative discussion of their economic impacts and requested detailed comment and data that would allow for quantification of the costs, benefits, and transfers. While comments were received expressing concern about the cost to employers that currently have waiting periods longer than 90 days of having to change their practices and provide coverage sooner to comply

[23] In section III of this preamble, some subsections have a heading listing one or two of the three Departments. In those subsections, the term "Departments" generally refers only to the Departments listed in the heading.

with the 90-day waiting period limitation, no comments provided additional data that would help in estimating the economic impacts of the final regulations.

2. Estimated Number of Affected Entities

The Departments estimate that 4.1 million new employees receive group health insurance coverage through private sector employers and 1.0 million new employees receive group health insurance coverage through public sector employers annually.[24] The 2013 Kaiser Family Foundation and Health Research and Education Trust Employer Health Benefits Annual Survey (the "2013 Kaiser Survey") finds that only nine percent of covered workers were subject to waiting periods of four months or more.[25] If nine percent of new employees receiving health care coverage from their employers are subject to a waiting period of four months or more, then 459,000 new employees (5.1 million x 0.09) would potentially be affected by these regulations.[26] However, it is unlikely that the survey defines the term "waiting period" in the same manner as these final regulations. For example, waiting period may have been defined by reference to an employee's start date, and it seems unlikely that the 2013 Kaiser Survey would have included the clarifications included in these final regulations regarding the measurement period for variable-hour employees or the clarification regarding cumulative hours-of-service requirements.

3. Benefits

Before Congress enacted PHS Act section 2708, Federal law did not prescribe any limits on waiting periods for group health coverage.

If employees delay health care treatment until the expiration of a lengthy waiting period, detrimental health effects could result, especially for employees and their dependents requiring

[24] This estimate is based upon internal Department of Labor calculations derived from the 2009 Medical Expenditure Panel Survey.
[25] *See e.g.,* Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits 2013 Annual Survey* (2013) available at http://ehbs.kff.org/pdf/2013/8345.pdf
[26] Approximately 373,000 private sector employees and 87,000 State and local public sector employees.

higher levels of health care, such as older Americans, pregnant women, young children, and those with chronic conditions. This could lead to lower work productivity and missed school days. Low-wage workers also are vulnerable, because they have less income to spend out-of-pocket to cover medical expenses. The Departments anticipate that these final regulations can help reduce these effects.

As discussed earlier in this preamble, these final regulations amend the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA) to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704, added by the Affordable Care Act. These amendments would provide a benefit to plans by reducing the burden associated with complying with the several Paperwork Reduction Act (PRA) information collections that are associated with the superseded regulations. For a discussion of the affected information collections and the estimated cost and burden hour reduction, please see the PRA section, later in this preamble.

4. Transfers

The possible transfers associated with these final regulations would arise if employers begin to pay their portion of premiums or contributions sooner than they otherwise would in the absence of PHS Act section 2708 and these final regulations. Recipients of the transfers would be covered employees and their dependents who would, after these final regulations become applicable, not be subject to excessive waiting periods during which they must forgo health coverage, purchase COBRA continuation coverage, or obtain an individual health insurance policy – all of which are options that could lead to higher out-of-pocket costs for employees to cover their healthcare expenditures. As discussed above, Federal law did not limit the duration of waiting periods in the group market before the enactment of PHS Act section 2708.

The Departments do not believe that these final regulations, on their own, will cause more than a marginal number of employers to offer coverage earlier to their employees. That is because a relatively small fraction of workers have waiting periods that exceed four months and these final regulations afford employers flexibility to maintain or revise their current group health plan eligibility conditions. For example, as described earlier, if a group health plan or group health insurance issuer conditions eligibility on the completion by an employee (part-time or full-time) of a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours. Additionally, the final regulations allow for a reasonable and bona fide employment-based orientation period to be imposed as a condition for eligibility for coverage under a plan. These provisions are intended to provide plan sponsors with flexibility to continue the common practice of utilizing a probationary or trial period to determine whether a new employee will be able to handle the duties and challenges of the job, while providing protections against excessive waiting periods for such employees. Under these final regulations, the plan's waiting period must begin once the new employee satisfies the plan's cumulative hours-of-service requirement or orientation period and may not exceed 90 days.

Because the 2013 Kaiser Survey reports that only nine percent of covered workers are in plans with waiting periods of four months or more and the overall average waiting period is only 1.8 months, the Departments are confident that such long waiting periods are rare.

B. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury

As described earlier in this preamble, these final regulations amend the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA) to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704, added by the Affordable Care Act.

The Departments are discontinuing the following Information Collection Requests (ICRs) that are associated with the superseded regulations: The Notice of Preexisting Condition Exclusion under Group Health Plans, which is approved under OMB Control Number 1210-0102 through January 31, 2016, and Establishing Creditable Coverage under Group Health Plans, which is approved under OMB Control Number 1210-0103 through January 31, 2016. Additionally, the Departments are revising Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers under HIPAA Titles I & IV, which is approved under OMB Control Number 1545-1537 through February 28, 2014, to remove the Health Plans Imposing Pre-existing Condition Notification Requirements, Certification Requirements, and Exclusion Period Notification Information Collections within this ICR because they are associated with the superseded regulation.

Discontinuing and revising these ICRs would result in a total burden reduction of approximately 341,000 hours (5,000 hours attributable to OMB Control Number 1210-0102, 74,000 hours attributable to OMB Control Number 1210-0103, and 262,000 hours attributable to OMB Control Number 1545-1537) and a total cost burden reduction of approximately $32.7 million ($1.1 million attributable to OMB Control Number 1210-0102, $12.4 million attributable to OMB Control Number 1210-0103, and $19.2 million attributable to OMB Control Number 1545-1537).

2. Department of Health and Human Services

These final regulations amend the 2004 HIPAA regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA) to remove provisions superseded by the prohibition on preexisting conditions under PHS Act section 2704, added by the Affordable Care Act.

HHS will discontinue the following ICRs that are associated with the superseded regulations, beginning January 1, 2015: The Notice of Preexisting Condition Exclusion and Certifications of Creditable Coverage under group health plans, which are approved under OMB Control Number 0938-0702.

Discontinuing these ICRs will result in a total annual burden reduction of approximately 2,908,569 hours and a total cost burden reduction of approximately $89.2 million.

C. Regulatory Flexibility Act – Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) applies to most Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.). Unless an agency certifies that such a rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires the agency to present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations and governmental jurisdictions. In accordance with the RFA, the Departments prepared an initial regulatory flexibility analysis at the proposed rule stage and requested comments on the analysis. No comments were received. Below is the Department's final regulatory flexibility analysis and its certification that these final regulations do not have a significant economic impact on a substantial number of small entities.

The Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. The Departments lack data to focus only on the impacts on small business. However, the Departments believe that the final regulations include flexibility that would allow small employers to minimize the transfers in health insurance premiums that they would have to pay to employees. Based on the foregoing, the Departments hereby certify that these final regulations will not have a significant economic impact on a substantial number of small entities.

D. Special Analyses—Department of the Treasury

For purposes of the Department of the Treasury, it has been determined that this final rule is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these final regulations, and, because these final regulations do not impose a collection of information requirement on small entities, a regulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to Code section 7805(f), this final rule has been submitted to the Small Business Administration for comment on its impact on small business.

E. Congressional Review Act

These final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and will be transmitted to the Congress and the Comptroller General for review.

F. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), as well as Executive Order 12875, these final regulations do not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or by the private sector, of $100 million or more adjusted for inflation ($141 million in 2013).

G. Federalism Statement--Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have "substantial direct effects" on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, these final regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or

requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of a federal standard. The conference report accompanying HIPAA indicates that this is intended to be the "narrowest" preemption of State laws. (See House Conf. Rep. No. 104-736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.)

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more consumer protective than the Federal requirements are unlikely to "prevent the application of" the Affordable Care Act, and therefore are unlikely to be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

Guidance conveying this interpretation was published in the **Federal Register** on April 8, 1997 (62 FR 16904), and December 30, 2004 (69 FR 78720), and these final regulations clarify and implement the statute's minimum standards and do not significantly reduce the discretion given the States by the statute.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy-making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending conferences of the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis.

Throughout the process of developing these final regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the

Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

IV. Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Public Law 111–148, 124 Stat. 119, as amended by Public Law 111–152, 124 Stat. 1029; Secretary of Labor’s Order 3–2010, 75 FR 55354 (September 10, 2010).

The Department of Health and Human Services regulations are adopted, with respect to 45 CFR Parts 144 and 146, pursuant to the authority contained in sections 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92), and, with respect to 45 CFR Part 147, pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 144

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Parts 146 and 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

John Dalrymple
Deputy Commissioner for Services and Enforcement,
Internal Revenue Service.

Approved: February 18, 2014

Mark J. Mazur
Assistant Secretary of the Treasury (Tax Policy).

Signed this _____12th_____ day of _____February_____, 2014.

Phyllis C. Borzi
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Dated: _February 11, 2014_____

_____

Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: _February 13, 2014_____

_____

Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54 – PENSION EXCISE TAXES

Paragraph 1. The authority citation for Part 54 is amended by adding an entry for § 54.9815–2708 in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805. * * *

Section 54.9815–2708 is also issued under 26 U.S.C. 9833.

*** * * * ***

Par. 2. Section 54.9801-1 is amended by revising paragraph (b) to read as follows:

§ 54.9801-1 Basis and scope.

*** * * * ***

(b) Scope. A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in the portability and market reform sections of this part 54. This part 54 sets forth minimum requirements for group health plans and group health insurance issuers offering group health insurance coverage concerning certain consumer protections of the Health Insurance Portability and Accountability Act (HIPAA), including special enrollment periods and the prohibition against discrimination based on a health factor, as amended by the Patient Protection and Affordable Care Act (Affordable Care Act). Other consumer protection provisions, including other protections provided by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, are set forth in this part 54.

*** * * * ***

Par. 3. Section 54.9801-2 is amended by revising the definitions of "enrollment date", "late enrollment", and "waiting period", and by adding definitions of "first day of coverage" and "late enrollee" in alphabetical order, to read as follows:

§ 54.9801-2 Definitions.

* * * * *

Enrollment date means 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.

* * * * *

First day of coverage means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

* * * * *

Late enrollee means an individual whose enrollment in a plan is a late enrollment.

Late enrollment means enrollment of an individual under a group health plan other than on the earliest date on which coverage can become effective for the individual under the terms of the plan; or through special enrollment. (For rules relating to special enrollment, see § 54.9801-6.) If an individual ceases to be eligible for coverage under a plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual

again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

* * * * *

Waiting period means waiting period within the meaning of § 54.9815-2708(b).

* * * * *

Par. 4. Section 54.9801-3 is amended by:

A. Revising the section heading.

B. Removing paragraphs (a)(2), (a)(3), (c), (d), (e), and (f).

C. Revising the heading to paragraph (a).

D. Removing the heading to paragraph (a)(1), and redesignating paragraphs (a)(1)(i) and (a)(1)(ii) as paragraphs (a)(1) and (a)(2).

E. Amending newly designated paragraph (a)(2) by revising paragraph (ii) of Examples 1 and 2, by revising Example 3 and Example 4, and by revising paragraph (ii) of Examples 5, 6, 7 and 8.

F. Revising paragraph (b).

The revisions read as follows:

§ 54.9801-3 Preexisting condition exclusions.

(a) Preexisting condition exclusion defined—

* * * * *

(2) * * *

Example 1. * * *

(ii) Conclusion. In this Example 1, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it

operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. The exclusion of benefits, therefore, is prohibited.

Example 2. * * *

(ii) Conclusion. In this Example 2, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 3. (i) Facts. A group health plan provides coverage for the treatment of diabetes, generally not subject to any requirement to obtain an approval for a treatment plan. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a requirement to obtain approval of a treatment plan in advance.

(ii) Conclusion. In this Example 3, the requirement to obtain advance approval of a treatment plan is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 4. (i) Facts. A group health plan provides coverage for three infertility treatments. The plan counts against the three-treatment limit benefits provided under prior health coverage.

(ii) Conclusion. In this Example 4, counting benefits for a specific condition provided under prior health coverage against a treatment limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 5. * * *

(ii) Conclusion. In this Example 5, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 6. * * *

(ii) Conclusion. In this Example 6, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 7. * * *

(ii) Conclusion. In this Example 7, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not prohibited. (But see 45 CFR 147.150, which may require coverage of cleft palate as an essential health benefit for health insurance coverage in the individual or small group market, depending on the essential health benefits benchmark plan as defined in 45 CFR 156.20).

Example 8. * * *

(ii) Conclusion. In this Example 8, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

(b) General rules. See section 2704 of the Public Health Service Act, incorporated into section 9815 of the Code, and its implementing regulations for rules prohibiting the imposition of a preexisting condition exclusion.

Par. 5. Section 54.9801-4 is amended by removing paragraphs (a)(3) and (c), and revising paragraph (b) to read as follows:

§ 54.9801-4 Rules relating to creditable coverage.

* * * * *

(b) Counting creditable coverage rules superseded by prohibition on preexisting condition exclusion. See section 2704 of the Public Health Service Act, incorporated into section 9815 of the Code, and its implementing regulations for rules prohibiting the imposition of a preexisting condition exclusion.

Par. 6. Section 54.9801-5 is revised to read as follows:

§ 54.9801-5 Evidence of creditable coverage.

(a) In general. The rules for providing certificates of creditable coverage and demonstrating creditable coverage have been superseded by the prohibition on preexisting condition exclusions. See section 2704 of the Public Health Service Act, incorporated into

section 9815 of the Code, and its implementing regulations for rules prohibiting the imposition of a preexisting condition exclusion.

(b) Applicability. The provisions of this section apply beginning December 31, 2014.

Par. 7. Section 54.9801-6 is amended by removing paragraph (a)(3)(i)(E) and revising paragraphs (a)(3)(i)(C), (a)(3)(i)(D), (a)(4)(i), and (d)(2) to read as follows:

§ 54.9801-6 Special enrollment periods.

(a) * * *

(3) * * *

(i) * * *

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(D) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in §54.9802-1(d)) that includes the individual.

* * * * *

(4) * * *

(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section to request enrollment (for the employee or the employee's dependent).

* * * * *

(d) * * *

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

* * * * *

Par. 8. Section 54.9802-1 is amended by:

A. Revising paragraphs (b)(1)(i) and (b)(2)(i)(B).

B. Revising Example 1, paragraph (i) of Example 2, paragraph (ii) of Example 4, paragraph (ii) of Example 5, and removing Example 8, in paragraph (b)(2)(i)(D).

C. Removing paragraph (b)(3).

D. Revising Example 2 and paragraph (i) of Example 5 in paragraph (d)(4).

E. Revising paragraph (ii) of Example 2 in paragraph (e)(2)(i)(B).

F. Revising Example 1 in paragraph (g)(1)(ii).

The revisions read as follows:

§ 54.9802-1 Prohibiting discrimination against participants and beneficiaries based on a health factor.

* * * * *

(b) * * *

(1) * * *

(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 (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).

* * * * *

(2) * * *

(i) * * *

(B) However, benefits provided under a plan 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 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 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 ERISA, the Affordable Care Act (including the requirements related to essential health benefits), the Americans with Disabilities Act, or any other law, whether State or Federal.)

* * * * *

(D) * * *

Example 1. (i) Facts. A group health plan applies a $10,000 annual limit on a specific covered benefit that is not an essential health benefit 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 coverage of the specific, non-essential health benefit up to $10,000 is 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 $500 deductible on all benefits 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 $2,000 deductible on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

* * * * *

Example 4. * * *

(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. (However, applying a lifetime limit on TMJ may violate PHS Act section 2711 and its implementing regulations, if TMJ coverage is an essential health

benefit, depending on the essential health benefits benchmark plan as defined in 45 CFR 156.20. This example does not address whether the plan provision is permissible under any other applicable law, including PHS Act section 2711 or the Americans with Disabilities Act.)

Example 5. * * *

(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. Additionally, this plan provision is prohibited under PHS Act section 2711 and its implementing regulations because it imposes a lifetime limit on essential health benefits.

* * * * *

(d) * * *

(4) * * *

Example 2. (i) Facts. Under a group health plan, coverage is made available to employees, their spouses, and their children. However, coverage is made available to a child only if the child is under age 26 (or under age 29 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 children differently by imposing an age limitation on children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and 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 children who are under age 26 (or full-time students under age 29) as a group of similarly situated individuals separate from those who are age 26 or older (or age 29 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 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 higher deductible than in the benefit package made available to the other six employees.

* * * * *

(e) * * *

(2) * * *

(i) * * *

(B) * * *

Example 2. * * *

(ii) Conclusion. In this Example 2, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service. (In addition, any eligibility provision that is time-based must comply with the requirements of PHS Act section 2708 and its implementing regulations.)

* * * * *

(g) * * *

(1) * * *

(ii) * * *

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 26. However, dependent children who are disabled are eligible for coverage beyond age 26.

(ii) Conclusion. In this Example 1, the plan provision allowing coverage for disabled dependent children beyond age 26 satisfies this paragraph (g)(1) (and thus does not violate this section).

* * * * *

Par. 9. Section 54.9815-2708 is added to read as follows:

§ 54.9815-2708 Prohibition on waiting periods that exceed 90 days.

(a) General rule. A group health plan, and a health insurance issuer offering group health insurance coverage, must not apply any waiting period that exceeds 90 days, in accordance with the rules of this section. If, under the terms of a plan, an individual can elect coverage that

would begin on a date that is not later than the end of the 90-day waiting period, this paragraph (a) is considered satisfied. Accordingly, in that case, a plan or issuer will not be considered to have violated this paragraph (a) solely because individuals take, or are permitted to take, additional time (beyond the end of the 90-day waiting period) to elect coverage.

(b) Waiting period defined. For purposes of this part, a waiting period is 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. If an individual enrolls as a late enrollee (as defined under §54.9801-2) or special enrollee (as described in §54.9801-6), any period before such late or special enrollment is not a waiting period.

(c) Relation to a plan's eligibility criteria – (1) In general. Except as provided in paragraphs (c)(2) and (c)(3) of this section, being otherwise eligible to enroll under the terms of a group health plan means having met the plan's substantive eligibility conditions (such as, 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). Moreover, except as provided in paragraphs (c)(2) and (c)(3) of this section, nothing in this section requires a plan sponsor to offer coverage to any particular individual or class of individuals (including, for example, part-time employees). Instead, this section prohibits requiring otherwise eligible individuals to wait more than 90 days before coverage is effective. See also section 4980H of the Code and its implementing regulations for an applicable large employer's shared responsibility to provide health coverage to full-time employees.

(2) Eligibility conditions based solely on the lapse of time. Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days.

(3) Other conditions for eligibility. Other conditions for eligibility under the terms of a group health plan are generally permissible under PHS Act section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation, determined in accordance with the rules of this paragraph (c)(3).

(i) Application to variable-hour employees in cases in which a specified number of hours of service per period is a plan eligibility condition. 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. Except in cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether such 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.

(ii) Cumulative service requirements. If a group health plan or health insurance issuer conditions eligibility on an employee's having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.

(d) Application to rehires. A plan or issuer may treat an employee whose employment has terminated and who then is rehired as newly eligible upon rehire and, therefore, required to meet the plan's eligibility criteria and waiting period anew, if reasonable under the circumstances (for example, the termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period limitation).

(e) Counting days. Under this section, all calendar days are counted beginning on the enrollment date (as defined in § 54.9801-2), including weekends and holidays. A plan or issuer that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

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

Example 1. (i) Facts. A group health plan provides that full-time employees are eligible for coverage under the plan. Employee A begins employment as a full-time employee on January 19.

(ii) Conclusion. In this Example 1, any waiting period for A would begin on January 19 and may not exceed 90 days. Coverage under the plan must become effective no later than April 19 (assuming February lasts 28 days).

Example 2. (i) Facts. A group health plan provides that only employees with job title M are eligible for coverage under the plan. Employee B begins employment with job title L on January 30.

(ii) Conclusion. In this Example 2, B is not eligible for coverage under the plan, and the period while B is working with job title L and therefore not in an eligible class of employees, is not part of a waiting period under this section.

Example 3. (i) Facts. Same facts as in Example 2, except that B transfers to a new position with job title M on April 11.

(ii) Conclusion. In this Example 3, B becomes eligible for coverage on April 11, but for the waiting period. Any waiting period for B begins on April 11 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than July 10.

Example 4. (i) Facts. A group health plan provides that only employees who have completed specified training and achieved specified certifications are eligible for coverage under

the plan. Employee C is hired on May 3 and meets the plan's eligibility criteria on September 22.

(ii) Conclusion. In this Example 4, C becomes eligible for coverage on September 22, but for the waiting period. Any waiting period for C would begin on September 22 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than December 21.

Example 5. (i) Facts. A group health plan provides that employees are eligible for coverage after one year of service.

(ii) Conclusion. In this Example 5, the plan's eligibility condition is based solely on the lapse of time and, therefore, is impermissible under paragraph (c)(2) of this section because it exceeds 90 days.

Example 6. (i) Facts. Employer V's group health plan provides for coverage to begin on the first day of the first payroll period on or after the date an employee is hired and completes the applicable enrollment forms. Enrollment forms are distributed on an employee's start date and may be completed within 90 days. Employee D is hired and starts on October 31, which is the first day of a pay period. D completes the enrollment forms and submits them on the 90th day after D's start date, which is January 28. Coverage is made effective 7 days later, February 4, which is the first day of the next pay period.

(ii) Conclusion. In this Example 6, under the terms of V's plan, coverage may become effective as early as October 31, depending on when D completes the applicable enrollment forms. Under the terms of the plan, when coverage becomes effective depends solely on the length of time taken by D to complete the enrollment materials. Therefore, under the terms of the plan, D may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, and the plan complies with this section.

Example 7. (i) Facts. Under Employer W's group health plan, only employees who are full-time (defined under the plan as regularly averaging 30 hours of service per week) are eligible for coverage. Employee E begins employment for Employer W on November 26 of Year 1. E's hours are reasonably expected to vary, with an opportunity to work between 20 and 45 hours per week, depending on shift availability and E's availability. Therefore, it cannot be determined at E's start date that E is reasonably expected to work full-time. Under the terms of the plan, variable-hour employees, such as E, are eligible to enroll in the plan if they are determined to be a full-time employee after a measurement period of 12 months that begins on the employee's start date. Coverage is made effective no later than the first day of the first calendar month after the applicable enrollment forms are received. E's 12-month measurement period ends November 25 of Year 2. E is determined to be a full-time employee and is notified of E's plan eligibility. If E then elects coverage, E's first day of coverage will be January 1 of Year 3.

(ii) Conclusion. In this Example 7, the measurement period is permissible because it is not considered to be designed to avoid compliance with the 90-day waiting period limitation.

The plan may use a reasonable period of time to determine whether a variable-hour employee is a full-time employee, provided that (a) the period of time is no longer than 12 months; (b) the period of time begins on a date between the employee's start date and the first day of the next calendar month (inclusive); (c) coverage is made effective no later than 13 months from E'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; and (d) in addition to the measurement period, no more than 90 days elapse prior to the employee's eligibility for coverage.

Example 8. (i) Facts. Employee F begins working 25 hours per week for Employer X on January 6 and is considered a part-time employee for purposes of X's group health plan. X sponsors a group health plan that provides coverage to part-time employees after they have completed a cumulative 1,200 hours of service. F satisfies the plan's cumulative hours of service condition on December 15.

(ii) Conclusion. In this Example 8, the cumulative hours of service condition with respect to part-time employees is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, coverage for F under the plan must begin no later than the 91st day after F completes 1,200 hours. (If the plan's cumulative hours-of-service requirement was more than 1,200 hours, the requirement would be considered to be designed to avoid compliance with the 90-day waiting period limitation.)

Example 9. (i) Facts. 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.

(ii) Conclusion. In this Example 9, 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.

Example 10. (i) Facts. Employee G retires at age 55 after 30 years of employment with Employer Y with no expectation of providing further services to Employer Y. Three months later, Y recruits G to return to work as an employee providing advice and transition assistance for G's replacement under a one-year employment contract. Y's plan imposes a 90-day waiting period from an employee's start date before coverage becomes effective.

(ii) Conclusion. In this Example 10, Y's plan may treat G as newly eligible for coverage under the plan upon rehire and therefore may impose the 90-day waiting period with respect to G for coverage offered in connection with G's rehire.

(g) Special rule for health insurance issuers. To the extent coverage under a group health plan is insured by a health insurance issuer, the issuer is 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 requirements of this section with respect to its administration of any waiting period, if both of the following conditions are satisfied:

(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 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

(2) The issuer has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.

(h) No effect on other laws. Compliance with this section is not determinative of compliance with any other provision of State or Federal law (including ERISA, the Code, or other provisions of the Patient Protection and Affordable Care Act). See e.g., § 54.9802-1, which prohibits discrimination in eligibility for coverage based on a health factor and section 4980H, which generally requires applicable large employers to offer coverage to full-time employees and their dependents or make an assessable payment.

(i) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2015. See section 1251 of the Affordable Care Act, as amended by section 10103 of the Affordable Care Act and section 2301 of the Health Care and Education Reconciliation Act, and its implementing regulations providing that the prohibition on waiting periods exceeding 90 days applies to all group health plans and group health insurance issuers, including grandfathered health plans.

§ 54.9831-1 [Amended]

Par. 10. Section 54.9831-1 is amended by removing paragraph (b)(2)(i), and redesignating paragraphs (b)(2)(ii) through (b)(2)(viii) as (b)(2)(i) through (b)(2)(vii).

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons stated in the preamble, the Department of Labor amends 29 CFR part 2590 as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

11. The authority citation for Part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1185c, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104-191, 110 Stat. 1936; sec. 401(b), Pub. L. 105-200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110-343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111-148, 124 Stat. 119, as amended by Pub. L. 111-152, 124 Stat. 1029; Secretary of Labor's Order 3-2010, 75 FR 55354 (September 10, 2010).

12. Section 2590.701-1 is amended by revising paragraph (b) to read as follows:

§ 2590.701-1 Basis and scope.

*** * * * ***

(b) Scope. A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this Subpart B. This Subpart B sets forth minimum requirements for group health plans and group health insurance issuers offering group health insurance coverage concerning certain consumer

protections of the Health Insurance Portability and Accountability Act (HIPAA), including special enrollment periods and the prohibition against discrimination based on a health factor, as amended by the Patient Protection and Affordable Care Act (Affordable Care Act). Other consumer protection provisions, including other protections provided by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, are set forth in Subpart C of this part.

13. Section 2590.701-2 is amended by revising the definitions of "enrollment date", "late enrollment", and "waiting period", and by adding definitions of "first day of coverage" and "late enrollee" in alphabetical order, to read as follows:

§ 2590.701-2 Definitions.

* * * * *

Enrollment date means 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.

* * * * *

First day of coverage means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

* * * * *

Late enrollee means an individual whose enrollment in a plan is a late enrollment.

Late enrollment means enrollment of an individual under a group health plan other than on the earliest date on which coverage can become effective for the individual under the terms of

the plan; or through special enrollment. (For rules relating to special enrollment, see § 2590.701-6.) If an individual ceases to be eligible for coverage under a plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

* * * * *

Waiting period means waiting period within the meaning of § 2590.715-2708(b).

14. Section 2590.701-3 is amended by:

A. Revising the section heading.

B. Removing paragraphs (a)(2), (a)(3), (c), (d), (e), and (f).

C. Revising the heading to paragraph (a).

D. Removing the heading to paragraph (a)(1), and redesignating paragraphs (a)(1)(i) and (a)(1)(ii) as paragraphs (a)(1) and (a)(2).

E. Amending newly designated paragraph (a)(2) by revising paragraph (ii) of Examples 1 and 2, by revising Example 3 and Example 4, and by revising paragraph (ii) of Examples 5, 6, 7 and 8.

F. Revising paragraph (b).

The revisions read as follows:

§ 2590.701-3 Preexisting condition exclusions.

(a) Preexisting condition exclusion defined—

* * * * *

(2) * * *

Example 1. * * *

(ii) Conclusion. In this Example 1, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. The exclusion of benefits, therefore, is prohibited.

Example 2. * * *

(ii) Conclusion. In this Example 2, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 3. (i) Facts. A group health plan provides coverage for the treatment of diabetes, generally not subject to any requirement to obtain an approval for a treatment plan. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a requirement to obtain approval of a treatment plan in advance.

(ii) Conclusion. In this Example 3, the requirement to obtain advance approval of a treatment plan is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 4. (i) Facts. A group health plan provides coverage for three infertility treatments. The plan counts against the three-treatment limit benefits provided under prior health coverage.

(ii) Conclusion. In this Example 4, counting benefits for a specific condition provided under prior health coverage against a treatment limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 5. * * *

(ii) Conclusion. In this Example 5, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 6. * * *

(ii) Conclusion. In this Example 6, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 7. * * *

(ii) Conclusion. In this Example 7, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not prohibited. (But see 45 CFR 147.150, which may require coverage of cleft palate as an essential health benefit for health insurance coverage in the individual or small group market, depending on the essential health benefits benchmark plan as defined in 45 CFR 156.20).

Example 8. * * *

(ii) Conclusion. In this Example 8, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

(b) General rules. See § 2590.715-2704 for rules prohibiting the imposition of a preexisting condition exclusion.

15. Section 2590.701-4 is amended by removing paragraphs (a)(3) and (c), and revising paragraph (b) to read as follows:

§ 2590.701-4 Rules relating to creditable coverage.

* * * * *

(b) Counting creditable coverage rules superseded by prohibition on preexisting condition exclusion. See § 2590.715-2704 for rules prohibiting the imposition of a preexisting condition exclusion.

16. Section 2590.701-5 is revised to read as follows:

§ 2590.701-5 Evidence of creditable coverage.

(a) In general. The rules for providing certificates of creditable coverage and demonstrating creditable coverage have been superseded by the prohibition on preexisting condition exclusions. See § 2590.715-2704 for rules prohibiting the imposition of a preexisting condition exclusion.

(b) Applicability. The provisions of this section apply beginning December 31, 2014.

17. Section 2590.701-6 is amended by removing paragraph (a)(3)(i)(E) and revising paragraphs (a)(3)(i)(C), (a)(3)(i)(D), (a)(4)(i), and (d)(2) to read as follows:

§ 2590.701-6 Special enrollment periods.

* * * * *

(a) * * *

(3) * * *

(i) * * *

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(D) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in §2590.702(d)) that includes the individual.

* * * * *

(4) * * *

(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section to request enrollment (for the employee or the employee's dependent).

* * * * *

(d) * * *

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

* * * * *

18. Section 2590.701-7 is revised to read as follows:

§ 2590.701-7 HMO affiliation period as an alternative to a preexisting condition exclusion.

The rules for HMO affiliation periods have been superseded by the prohibition on preexisting condition exclusions. See § 2590.715-2704 for rules prohibiting the imposition of a preexisting condition exclusion.

19. Section 2590.702 is amended by:

A. Revising paragraphs (b)(1)(i) and (b)(2)(i)(B).

B. Revising Example 1, paragraph (i) of Example 2, paragraph (ii) of Example 4, paragraph (ii) of Example 5, and removing Example 8, in paragraph (b)(2)(i)(D).

C. Removing paragraph (b)(3).

D. Revising Example 2 and paragraph (i) of Example 5 in paragraph (d)(4).

E. Revising paragraph (ii) of Example 2 in paragraph (e)(2)(i)(B).

F. Revising Example 1 in paragraph (g)(1)(ii).

The revisions read as follows:

§ 2590.702 Prohibiting discrimination against participants and beneficiaries based on a health factor.

* * * * *

(b) * * *

(1) * * *

(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 (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).

* * * * *

(2) * * *

(i) * * *

(B) However, benefits provided under a plan 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 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 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 ERISA, the Affordable Care Act (including the requirements related to essential health benefits), the Americans with Disabilities Act, or any other law, whether State or Federal.)

* * * * *

(D) * * *

Example 1. (i) Facts. A group health plan applies a $10,000 annual limit on a specific covered benefit that is not an essential health benefit 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 coverage of the specific, non-essential health benefit up to $10,000 is 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 $500 deductible on all benefits 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 $2,000 deductible on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

* * * * *

Example 4. * * *

(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. (However, applying a lifetime limit on TMJ may violate § 2590.715-2711, if TMJ coverage is an essential health benefit, depending on the essential health benefits benchmark plan as defined in 45 CFR 156.20. This example does not address whether the plan provision is permissible under any other applicable law, including PHS Act section 2711 or the Americans with Disabilities Act.)

Example 5. * * *

(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. Additionally, this plan provision is prohibited under § 2590.715-2711 because it imposes a lifetime limit on essential health benefits.

* * * * *

(d) * * *

(4) * * *

Example 2. (i) Facts. Under a group health plan, coverage is made available to employees, their spouses, and their children. However, coverage is made available to a child only if the child is under age 26 (or under age 29 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 children differently by imposing an age limitation on children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and 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 children who are under age 26 (or full-time students under age 29) as a group of similarly situated individuals separate from those who are age 26 or older (or age 29 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 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 higher deductible than in the benefit package made available to the other six employees.

* * * * *

(e) * * *

(2) * * *

(i) * * *

(B) * * *

Example 2. * * *

(ii) Conclusion. In this Example 2, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service. (In addition, any eligibility provision that is time-based must comply with the requirements of PHS Act section 2708 and its implementing regulations.)

* * * * *

(g) * * *

(1) * * *

(ii) * * *

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 26. However, dependent children who are disabled are eligible for coverage beyond age 26.

(ii) Conclusion. In this Example 1, the plan provision allowing coverage for disabled dependent children beyond age 26 satisfies this paragraph (g)(1) (and thus does not violate this section).

* * * * *

20. Section 2590.715-2708 is added to read as follows:

§ 2590.715-2708 Prohibition on waiting periods that exceed 90 days.

(a) General rule. A group health plan, and a health insurance issuer offering group health insurance coverage, must not apply any waiting period that exceeds 90 days, in accordance with the rules of this section. If, under the terms of a plan, an individual can elect coverage that would begin on a date that is not later than the end of the 90-day waiting period, this paragraph (a) is considered satisfied. Accordingly, in that case, a plan or issuer will not be considered to have violated this paragraph (a) solely because individuals take, or are permitted to take, additional time (beyond the end of the 90-day waiting period) to elect coverage.

(b) Waiting period defined. For purposes of this part, a waiting period is 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. If an individual enrolls as a late enrollee (as defined under §2590.701-2) or special enrollee (as described in §2590.701-6), any period before such late or special enrollment is not a waiting period.

(c) Relation to a plan's eligibility criteria – (1) In general. Except as provided in paragraphs (c)(2) and (c)(3) of this section, being otherwise eligible to enroll under the terms of a group health plan means having met the plan's substantive eligibility conditions (such as, 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). Moreover, except as provided in paragraphs (c)(2) and (c)(3) of this section, nothing in this section requires a plan sponsor to offer coverage to any particular individual or class of individuals (including, for example, part-time employees). Instead, this section prohibits requiring otherwise eligible individuals to wait more than 90 days before coverage is effective. See also section 4980H of the Code and its implementing regulations for an applicable large employer's shared responsibility to provide health coverage to full-time employees.

(2) Eligibility conditions based solely on the lapse of time. Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days.

(3) Other conditions for eligibility. Other conditions for eligibility under the terms of a group health plan are generally permissible under PHS Act section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation, determined in accordance with the rules of this paragraph (c)(3).

(i) Application to variable-hour employees in cases in which a specified number of hours of service per period is a plan eligibility condition. 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. Except in cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the

time period for determining whether such 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.

(ii) Cumulative service requirements. If a group health plan or health insurance issuer conditions eligibility on an employee's having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.

(d) Application to rehires. A plan or issuer may treat an employee whose employment has terminated and who then is rehired as newly eligible upon rehire and, therefore, required to meet the plan's eligibility criteria and waiting period anew, if reasonable under the circumstances (for example, the termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period limitation).

(e) Counting days. Under this section, all calendar days are counted beginning on the enrollment date (as defined in § 2590.701-2), including weekends and holidays. A plan or issuer that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

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

Example 1. (i) Facts. A group health plan provides that full-time employees are eligible for coverage under the plan. Employee A begins employment as a full-time employee on January 19.

(ii) Conclusion. In this Example 1, any waiting period for A would begin on January 19 and may not exceed 90 days. Coverage under the plan must become effective no later than April 19 (assuming February lasts 28 days).

Example 2. (i) Facts. A group health plan provides that only employees with job title M are eligible for coverage under the plan. Employee B begins employment with job title L on January 30.

(ii) Conclusion. In this Example 2, B is not eligible for coverage under the plan, and the period while B is working with job title L and therefore not in an eligible class of employees, is not part of a waiting period under this section.

Example 3. (i) Facts. Same facts as in Example 2, except that B transfers to a new position with job title M on April 11.

(ii) Conclusion. In this Example 3, B becomes eligible for coverage on April 11, but for the waiting period. Any waiting period for B begins on April 11 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than July 10.

Example 4. (i) Facts. A group health plan provides that only employees who have completed specified training and achieved specified certifications are eligible for coverage under the plan. Employee C is hired on May 3 and meets the plan's eligibility criteria on September 22.

(ii) Conclusion. In this Example 4, C becomes eligible for coverage on September 22, but for the waiting period. Any waiting period for C would begin on September 22 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than December 21.

Example 5. (i) Facts. A group health plan provides that employees are eligible for coverage after one year of service.

(ii) Conclusion. In this Example 5, the plan's eligibility condition is based solely on the lapse of time and, therefore, is impermissible under paragraph (c)(2) of this section because it exceeds 90 days.

Example 6. (i) Facts. Employer V's group health plan provides for coverage to begin on the first day of the first payroll period on or after the date an employee is hired and completes the applicable enrollment forms. Enrollment forms are distributed on an employee's start date and may be completed within 90 days. Employee D is hired and starts on October 31, which is the first day of a pay period. D completes the enrollment forms and submits them on the 90th day after D's start date, which is January 28. Coverage is made effective 7 days later, February 4, which is the first day of the next pay period.

(ii) Conclusion. In this Example 6, under the terms of V's plan, coverage may become effective as early as October 31, depending on when D completes the applicable enrollment

forms. Under the terms of the plan, when coverage becomes effective depends solely on the length of time taken by D to complete the enrollment materials. Therefore, under the terms of the plan, D may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, and the plan complies with this section.

Example 7. (i) Facts. Under Employer W's group health plan, only employees who are full-time (defined under the plan as regularly averaging 30 hours of service per week) are eligible for coverage. Employee E begins employment for Employer W on November 26 of Year 1. E's hours are reasonably expected to vary, with an opportunity to work between 20 and 45 hours per week, depending on shift availability and E's availability. Therefore, it cannot be determined at E's start date that E is reasonably expected to work full-time. Under the terms of the plan, variable-hour employees, such as E, are eligible to enroll in the plan if they are determined to be a full-time employee after a measurement period of 12 months that begins on the employee's start date. Coverage is made effective no later than the first day of the first calendar month after the applicable enrollment forms are received. E's 12-month measurement period ends November 25 of Year 2. E is determined to be a full-time employee and is notified of E's plan eligibility. If E then elects coverage, E's first day of coverage will be January 1 of Year 3.

(ii) Conclusion. In this Example 7, the measurement period is permissible because it is not considered to be designed to avoid compliance with the 90-day waiting period limitation. The plan may use a reasonable period of time to determine whether a variable-hour employee is a full-time employee, provided that (a) the period of time is no longer than 12 months; (b) the period of time begins on a date between the employee's start date and the first day of the next calendar month (inclusive); (c) coverage is made effective no later than 13 months from E'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; and (d) in addition to the measurement period, no more than 90 days elapse prior to the employee's eligibility for coverage.

Example 8. (i) Facts. Employee F begins working 25 hours per week for Employer X on January 6 and is considered a part-time employee for purposes of X's group health plan. X sponsors a group health plan that provides coverage to part-time employees after they have completed a cumulative 1,200 hours of service. F satisfies the plan's cumulative hours of service condition on December 15.

(ii) Conclusion. In this Example 8, the cumulative hours of service condition with respect to part-time employees is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, coverage for F under the plan must begin no later than the 91st day after F completes 1,200 hours. (If the plan's cumulative hours-of-service requirement was more than 1,200 hours, the requirement would be considered to be designed to avoid compliance with the 90-day waiting period limitation.)

Example 9. (i) Facts. 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.

(ii) Conclusion. In this Example 9, 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.

Example 10. (i) Facts. Employee G retires at age 55 after 30 years of employment with Employer Y with no expectation of providing further services to Employer Y. Three months later, Y recruits G to return to work as an employee providing advice and transition assistance for G's replacement under a one-year employment contract. Y's plan imposes a 90-day waiting period from an employee's start date before coverage becomes effective.

(ii) Conclusion. In this Example 10, Y's plan may treat G as newly eligible for coverage under the plan upon rehire and therefore may impose the 90-day waiting period with respect to G for coverage offered in connection with G's rehire.

(g) Special rule for health insurance issuers. To the extent coverage under a group health plan is insured by a health insurance issuer, the issuer is 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 requirements of this section with respect to its administration of any waiting period, if both of the following conditions are satisfied:

(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 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

(2) The issuer has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.

(h) No effect on other laws. Compliance with this section is not determinative of compliance with any other provision of State or Federal law (including ERISA, the Code, or other provisions of the Patient Protection and Affordable Care Act). See e.g., § 2590.702, which

prohibits discrimination in eligibility for coverage based on a health factor and Code section 4980H, which generally requires applicable large employers to offer coverage to full-time employees and their dependents or make an assessable payment.

(i) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2015. See § 2590.715-1251 providing that the prohibition on waiting periods exceeding 90 days applies to all group health plans and group health insurance issuers, including grandfathered health plans.

21. Section 2590.731 by revising paragraph (c)(2) to read as follows:

§ 2590.731 Preemption; State flexibility; construction.

*** * * * ***

(c) *** * ***

(2) Exceptions. Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision requires special enrollment periods in addition to those required under section 701(f) of the Act.

*** * * * ***

§ 2590.732 [Amended]

22. Section 2590.732 is amended by removing paragraph (b)(2)(i), and redesignating paragraphs (b)(2)(ii) through (b)(2)(ix) as (b)(2)(i) through (b)(2)(viii).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Subtitle A

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR parts 144, 146, and 147 as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

23. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92).

24. Section 144.103 is amended by revising the definitions of "enrollment date", "late enrollment", and "waiting period", and by adding definitions of "first day of coverage" and "late enrollee" in alphabetical order, to read as follows:

§ 144.103 Definitions.

* * * * *

Enrollment date means 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.

* * * * *

First day of coverage means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

* * * * *

Late enrollee means an individual whose enrollment in a plan is a late enrollment.

Late enrollment means enrollment of an individual under a group health plan other than on the earliest date on which coverage can become effective for the individual under the terms of the plan; or through special enrollment. (For rules relating to special enrollment and limited open enrollment, see §146.117 and §147.104 of this subchapter.) If an individual ceases to be eligible for coverage under a plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

* * * * *

Waiting period has the meaning given the term in 45 CFR 147.116 (b).

PART 146 – REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

25. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg-1 through 300gg-5, 300gg-11 through 300gg-23, 300gg-91, and 300gg-92).

26. Section 146.101 is amended by revising paragraph (b)(1) to read as follows:

§146.101 Basis and scope.

*** * * * ***

(b) *** * ***

(1) Subpart B. Subpart B of this part sets forth minimum requirements for group health plans and group health insurance issuers offering group health insurance coverage concerning

certain consumer protections of the Health Insurance Portability and Accountability Act (HIPAA), as amended, including special enrollment periods, prohibiting discrimination against participants and beneficiaries based on a health factor, and additional requirements prohibiting discrimination against participants and beneficiaries based on genetic information.

* * * * *

27. Section 146.111 is amended by:

A. Revising the section heading.

B. Removing paragraphs (a)(2), (a)(3), (c), (d), (e), and (f).

C. Revising the heading to paragraph (a).

D. Removing the heading to paragraph (a)(1), and redesignating paragraphs (a)(1)(i) and (a)(1)(ii) as paragraphs (a)(1) and (a)(2).

E. Amending newly designated paragraph (a)(2) by revising paragraph (ii) of Examples 1 and 2, by revising Example 3 and Example 4, and by revising paragraph (ii) of Examples 5, 6, 7 and 8.

F. Revising paragraph (b).

The revisions read as follows:

§ 146.111 Preexisting condition exclusions.

(a) Preexisting condition exclusion defined—

* * * * *

(2) * * *

Example 1. * * *

(ii) Conclusion. In this Example 1, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it

operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. The exclusion of benefits, therefore, is prohibited.

Example 2. * * *

(ii) Conclusion. In this Example 2, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 3. (i) Facts. A group health plan provides coverage for the treatment of diabetes, generally not subject to any requirement to obtain an approval for a treatment plan. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a requirement to obtain approval of a treatment plan in advance.

(ii) Conclusion. In this Example 3, the requirement to obtain advance approval of a treatment plan is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 4. (i) Facts. A group health plan provides coverage for three infertility treatments. The plan counts against the three-treatment limit benefits provided under prior health coverage.

(ii) Conclusion. In this Example 4, counting benefits for a specific condition provided under prior health coverage against a treatment limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 5. * * *

(ii) Conclusion. In this Example 5, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 6. * * *

(ii) Conclusion. In this Example 6, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 7. * * *

(ii) Conclusion. In this Example 7, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not prohibited. (But see 45 CFR 147.150, which may require coverage of cleft palate as an essential health benefit for health insurance coverage in the individual or small group market, depending on the essential health benefits benchmark plan as defined in §156.20 of this subchapter).

Example 8. * * *

(ii) Conclusion. In this Example 8, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

* * * * *

(b) General rules. See § 147.108 of this subchapter for rules prohibiting the imposition of a preexisting condition exclusion.

28. Section 146.113 is amended by removing paragraphs (a)(3) and (c), and revising paragraph (b) to read as follows:

§ 146.113 Rules relating to creditable coverage.

* * * * *

(b) Counting creditable coverage rules superseded by prohibition on preexisting condition exclusion. See § 147.108 of this subchapter for rules prohibiting the imposition of a preexisting condition exclusion.

29. Section 146.115 is revised to read as follows:

§146.115 Certification and disclosure of previous coverage.

(a) In general. The rules for providing certificates of creditable coverage and demonstrating creditable coverage have been superseded by the prohibition on preexisting condition exclusions. See § 147.108 of this subchapter for rules prohibiting the imposition of a preexisting condition exclusion.

(b) Applicability. The provisions of this section apply beginning December 31, 2014.

30. Section 146.117 is amended by removing paragraph (a)(3)(i)(E) and revising paragraphs (a)(3)(i)(C), (a)(3)(i)(D), (a)(4)(i), and (d)(2) to read as follows:

§146.117 Special enrollment periods.

* * * * *

(a) * * *

(3) * * *

(i) * * *

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(D) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in §146.121(d)) that includes the individual.

* * * * *

(4) * * *

(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section to request enrollment (for the employee or the employee's dependent).

* * * * *

(d) * * *

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

* * * * *

31. Section 146.119 is revised to read as follows:

§146.119 HMO affiliation period as an alternative to a preexisting condition exclusion.

The rules for HMO affiliation periods have been superseded by the prohibition on preexisting condition exclusions. See §147.108 of this subchapter for rules prohibiting the imposition of a preexisting condition exclusion.

32. Section 146.121 is amended by:

A. Revising paragraphs (b)(1)(i) and (b)(2)(i)(B).

B. Revising Example 1, paragraph (i) of Example 2, paragraph (ii) of Example 4, paragraph (ii) of Example 5, and removing Example 8, in paragraph (b)(2)(i)(D).

C. Removing paragraph (b)(3).

D. Revising Example 2 and paragraph (i) of Example 5 in paragraph (d)(4).

E. Revising paragraph (ii) of Example 2 in paragraph (e)(2)(i)(B).

F. Revising Example 1 in paragraph (g)(1)(ii).

The revisions read as follows:

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

* * * * *

(b) * * *

(1) * * *

(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 (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).

* * * * *

(2) * * *

(i) * * *

(B) However, benefits provided under a plan 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 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 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 ERISA, the Affordable Care Act (including the requirements related to essential health benefits), the Americans with Disabilities Act, or any other law, whether State or Federal.)

* * * * *

(D) * * *

Example 1. (i) Facts. A group health plan applies a $10,000 annual limit on a specific covered benefit that is not an essential health benefit 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 coverage of the specific, non-essential health benefit up to $10,000 is 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 $500 deductible on all benefits 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 $2,000 deductible on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

* * * * *

Example 4. * * *

(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. (However, applying a lifetime limit on TMJ may violate §147.126 of this subchapter, if TMJ coverage is an essential health benefit, depending on the essential health benefits benchmark plan as defined in § 156.20 of this subchapter. This example does not address whether the plan provision is permissible under any other applicable law, including PHS Act section 2711 or the Americans with Disabilities Act.)

Example 5. * * *

(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. Additionally, this plan provision is prohibited under §147.126 of this subchapter because it imposes a lifetime limit on essential health benefits.

* * * * *

(d) * * *

(4) * * *

Example 2. (i) Facts. Under a group health plan, coverage is made available to employees, their spouses, and their children. However, coverage is made available to a child only if the child is under age 26 (or under age 29 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 children differently by imposing an age limitation on children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and 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 children who are under age 26 (or full-time students under age 29) as a group of similarly situated individuals separate from those who are age 26 or older (or age 29 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 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 higher deductible than in the benefit package made available to the other six employees.

* * * * *

(e) * * *

(2) * * *

(i) * * *

(B) * * *

Example 2. * * *

(ii) Conclusion. In this Example 2, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service. (In addition, any eligibility provision that is time-based must comply with the requirements of PHS Act section 2708 and its implementing regulations.)

* * * * *

(g) * * *

(1) * * *

(ii) * * *

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 26. However, dependent children who are disabled are eligible for coverage beyond age 26.

(ii) Conclusion. In this Example 1, the plan provision allowing coverage for disabled dependent children beyond age 26 satisfies this paragraph (g)(1) (and thus does not violate this section).

* * * * *

33. Section 146.143 is amended by revising paragraph (c)(2) to read as follows:

§146.143 Preemption; State flexibility; construction.

*** * * * ***

(c) *** * ***

(2) Exceptions. Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision requires special enrollment periods in addition to those required under section 2702 of the Act.

*** * * * ***

PART 147 – HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

34. The authority citation for part 147 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

35. Section 147.116 is added to read as follows:

§147.116 Prohibition on waiting periods that exceed 90 days.

(a) General rule. A group health plan, and a health insurance issuer offering group health insurance coverage, must not apply any waiting period that exceeds 90 days, in accordance with the rules of this section. If, under the terms of a plan, an individual can elect coverage that would begin on a date that is not later than the end of the 90-day waiting period, this paragraph (a) is considered satisfied. Accordingly, in that case, a plan or issuer will not be considered to have violated this paragraph (a) solely because individuals take, or are permitted to take, additional time (beyond the end of the 90-day waiting period) to elect coverage.

(b) Waiting period defined. For purposes of this part, a waiting period is 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. If an individual enrolls as a late enrollee (as defined under §144.103 of this subchapter) or special enrollee (as described in §146.117 of this subchapter), any period before such late or special enrollment is not a waiting period.

(c) Relation to a plan's eligibility criteria – (1) In general. Except as provided in paragraphs (c)(2) and (c)(3) of this section, being otherwise eligible to enroll under the terms of a group health plan means having met the plan's substantive eligibility conditions (such as, 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). Moreover, except as provided in paragraphs (c)(2) and (c)(3) of this section, nothing in this section requires a plan sponsor to offer coverage to any particular individual or class of individuals (including, for example, part-time employees). Instead, this section prohibits requiring otherwise eligible individuals to wait more than 90 days before coverage is effective. See also section 4980H of the Code and its implementing regulations for an applicable large employer's shared responsibility to provide health coverage to full-time employees.

(2) Eligibility conditions based solely on the lapse of time. Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days.

(3) Other conditions for eligibility. Other conditions for eligibility under the terms of a group health plan are generally permissible under PHS Act section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation, determined in accordance with the rules of this paragraph (c)(3).

(i) Application to variable-hour employees in cases in which a specified number of hours of service per period is a plan eligibility condition. 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. Except in cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether such 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.

(ii) Cumulative service requirements. If a group health plan or health insurance issuer conditions eligibility on an employee's having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.

(d) Application to rehires. A plan or issuer may treat an employee whose employment has terminated and who then is rehired as newly eligible upon rehire and, therefore, required to meet the plan's eligibility criteria and waiting period anew, if reasonable under the circumstances

(for example, the termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period limitation).

(e) Counting days. Under this section, all calendar days are counted beginning on the enrollment date (as defined in § 144.103), including weekends and holidays. A plan or issuer that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

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

Example 1. (i) Facts. A group health plan provides that full-time employees are eligible for coverage under the plan. Employee A begins employment as a full-time employee on January 19.

(ii) Conclusion. In this Example 1, any waiting period for A would begin on January 19 and may not exceed 90 days. Coverage under the plan must become effective no later than April 19 (assuming February lasts 28 days).

Example 2. (i) Facts. A group health plan provides that only employees with job title M are eligible for coverage under the plan. Employee B begins employment with job title L on January 30.

(ii) Conclusion. In this Example 2, B is not eligible for coverage under the plan, and the period while B is working with job title L and therefore not in an eligible class of employees, is not part of a waiting period under this section.

Example 3. (i) Facts. Same facts as in Example 2, except that B transfers to a new position with job title M on April 11.

(ii) Conclusion. In this Example 3, B becomes eligible for coverage on April 11, but for the waiting period. Any waiting period for B begins on April 11 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than July 10.

Example 4. (i) Facts. A group health plan provides that only employees who have completed specified training and achieved specified certifications are eligible for coverage under the plan. Employee C is hired on May 3 and meets the plan's eligibility criteria on September 22.

(ii) Conclusion. In this Example 4, C becomes eligible for coverage on September 22, but for the waiting period. Any waiting period for C would begin on September 22 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than December 21.

Example 5. (i) Facts. A group health plan provides that employees are eligible for coverage after one year of service.

(ii) Conclusion. In this Example 5, the plan's eligibility condition is based solely on the lapse of time and, therefore, is impermissible under paragraph (c)(2) of this section because it exceeds 90 days.

Example 6. (i) Facts. Employer V's group health plan provides for coverage to begin on the first day of the first payroll period on or after the date an employee is hired and completes the applicable enrollment forms. Enrollment forms are distributed on an employee's start date and may be completed within 90 days. Employee D is hired and starts on October 31, which is the first day of a pay period. D completes the enrollment forms and submits them on the 90th day after D's start date, which is January 28. Coverage is made effective 7 days later, February 4, which is the first day of the next pay period.

(ii) Conclusion. In this Example 6, under the terms of V's plan, coverage may become effective as early as October 31, depending on when D completes the applicable enrollment forms. Under the terms of the plan, when coverage becomes effective depends solely on the length of time taken by D to complete the enrollment materials. Therefore, under the terms of the plan, D may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, and the plan complies with this section.

Example 7. (i) Facts. Under Employer W's group health plan, only employees who are full-time (defined under the plan as regularly averaging 30 hours of service per week) are eligible for coverage. Employee E begins employment for Employer W on November 26 of Year 1. E's hours are reasonably expected to vary, with an opportunity to work between 20 and 45 hours per week, depending on shift availability and E's availability. Therefore, it cannot be determined at E's start date that E is reasonably expected to work full-time. Under the terms of the plan, variable-hour employees, such as E, are eligible to enroll in the plan if they are determined to be a full-time employee after a measurement period of 12 months that begins on the employee's start date. Coverage is made effective no later than the first day of the first calendar month after the applicable enrollment forms are received. E's 12-month measurement period ends November 25 of Year 2. E is determined to be a full-time employee and is notified of E's plan eligibility. If E then elects coverage, E's first day of coverage will be January 1 of Year 3.

(ii) Conclusion. In this Example 7, the measurement period is permissible because it is not considered to be designed to avoid compliance with the 90-day waiting period limitation. The plan may use a reasonable period of time to determine whether a variable-hour employee is a full-time employee, provided that (a) the period of time is no longer than 12 months; (b) the period of time begins on a date between the employee's start date and the first day of the next calendar month (inclusive); (c) coverage is made effective no later than 13 months from E'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; and (d) in addition to the measurement period, no more than 90 days elapse prior to the employee's eligibility for coverage.

Example 8. (i) Facts. Employee F begins working 25 hours per week for Employer X on January 6 and is considered a part-time employee for purposes of X's group health plan. X sponsors a group health plan that provides coverage to part-time employees after they have completed a cumulative 1,200 hours of service. F satisfies the plan's cumulative hours of service condition on December 15.

(ii) Conclusion. In this Example 8, the cumulative hours of service condition with respect to part-time employees is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, coverage for F under the plan must begin no later than the 91st day after F completes 1,200 hours. (If the plan's cumulative hours-of-service requirement was more than 1,200 hours, the requirement would be considered to be designed to avoid compliance with the 90-day waiting period limitation.)

Example 9. (i) Facts. 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.

(ii) Conclusion. In this Example 9, 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.

Example 10. (i) Facts. Employee G retires at age 55 after 30 years of employment with Employer Y with no expectation of providing further services to Employer Y. Three months later, Y recruits G to return to work as an employee providing advice and transition assistance for G's replacement under a one-year employment contract. Y's plan imposes a 90-day waiting period from an employee's start date before coverage becomes effective.

(ii) Conclusion. In this Example 10, Y's plan may treat G as newly eligible for coverage under the plan upon rehire and therefore may impose the 90-day waiting period with respect to G for coverage offered in connection with G's rehire.

(g) Special rule for health insurance issuers. To the extent coverage under a group health plan is insured by a health insurance issuer, the issuer is 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 requirements of this section with respect to its administration of any waiting period, if both of the following conditions are satisfied:

(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 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

(2) The issuer has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.

(h) No effect on other laws. Compliance with this section is not determinative of compliance with any other provision of State or Federal law (including ERISA, the Code, or other provisions of the Patient Protection and Affordable Care Act). See e.g., § 146.121 of this subchapter and § 147.110, which prohibits discrimination in eligibility for coverage based on a health factor and Code section 4980H, which generally requires applicable large employers to offer coverage to full-time employees and their dependents or make an assessable payment.

(i) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2015. See § 147.140 providing that the prohibition on waiting periods exceeding 90 days applies to all group health plans and group health insurance issuers, including grandfathered health plans.

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