



VCU Medical Center

Office of Health Innovation

Proposed Rule: Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements under the Affordable Care Act

Description: These proposed rules implement the 90-day waiting period limitation under section 2708 of the Public Health Service Act. They also propose amendments to regulations to conform to Affordable Care Act provisions already in effect as well as those that will become effective beginning 2014. The proposed conforming amendments make changes to existing requirements such as preexisting condition limitations and other portability provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations because they have become moot or need amendment due to new market reform protections under the Affordable Care Act.

Major Provisions

These proposed regulations generally would apply for plan years beginning on or after January 1, 2014, consistent with the statutory effective date of PHS Act section 2708.

Prohibition on Waiting Periods That Exceed 90 Days

A group health plan, and a health insurance issuer offering group health insurance coverage, shall not apply any waiting period that exceeds 90 days.

- The waiting period may not extend beyond 90 days and all calendar days are counted beginning on the enrollment date, including weekends and holidays.
- If the 91st day is a weekend or holiday, the plan or issuer may choose to permit coverage to be effective earlier than the 91st day, for administrative convenience.
- However, a plan or issuer may not make the effective date of coverage later than the 91st day.
- Neither a plan nor an issuer offering coverage is required to have any waiting period.

Other conditions for eligibility under the terms of a group health plan (i.e., those that are not based solely on the lapse of a time period) are generally permissible under PHS Act section 2708 and these proposed regulations unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

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 (no more than 12 months) to determine whether the employee meets the plan's eligibility condition.

If a group health plan or health insurance issuer conditions eligibility on any employee's (part-time or full-time) 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.

Conforming Changes to Existing Regulations

These proposed regulations would amend the 2004 HIPAA regulations implementing Code sections 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 and the implementing regulations.

Additionally, these regulations propose to amend examples 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, as well as the provisions governing dependent coverage of children to age 26 under PHS Act section 2714 and its implementing regulations.

Technical Amendment Relating to OPM Multi-State Plan Program and External Review

PHS Act section 2719 and its implementing regulations provide that group health plans and health insurance issuers must comply with either a State external review process or the Federal external review process. Generally, if a State has an external review process that meets, at a minimum, the consumer protections set forth in the interim final regulations, then the issuer (or a plan) subject to the State process must comply with the State process.

In this rule, the Departments propose to clarify that Multi-State Plans (MSPs) will be subject to the Federal external review process under PHS section 2719(b)(2) and paragraph (d) of the internal claims and appeals and external review regulations. In doing so, the Departments interpret section 2719(b)(2) to apply to *all plans not subject to a State's external review process*.