Subject: **Ninety-Day Waiting Period Limitation, Certificates of Creditable Coverage, HHS Draft Application for Exchange Participation, and Internal Claims and Appeals Process and External Review**

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NINETY-DAY WAITING PERIOD LIMITATION

One of the Affordable Care Act's (ACA) provisions that take effect in 2014 is a restriction on the maximum waiting period that can be imposed before coverage takes effect. This is known as the "waiting period." For plan years beginning on or after January 1, 2014 (January 1 for a calendar year plan), the maximum waiting period that can be imposed is 90 days. This provision applies to virtually all types of plans, including insured and self-funded plans, whether grandfathered or not, and without regard to plan size.

The Agencies (Department of Labor's Employee Benefits Security Administration, the Internal Revenue Service and the Department of Health and Human Services) have issued a set of proposed regulations defining this ninety-day wait. These regulations in large part follow some temporary guidance issued in September, 2012 (see CBIZ Health Reform Bulletin, *Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee*, 9/4/12). If final regulations are more restrictive, they will take effect no earlier than January 1, 2015.

Of particular note, the regulations propose that the 90 day period be construed strictly. The 90 days is 90 calendar days, including weekends and holidays. Health coverage must be made available no later than the 91st day. If the 91st day happens to fall on a weekend, coverage, of course, could be effective on the previous work day, but could not be made effective on the next following work day. In other words, a plan can round back but not up.

The regulations proposed define "waiting period" in the same way as the Health Insurance Portability and Accountability Act (HIPAA), meaning the time that must pass before coverage takes effect. A plan can base condition for eligibility of coverage on completion of a goal, such as attainment of a license.

However, for employers subject to the Shared Responsibility requirement (see CBIZ Health Reform Bulletin, *Shared Responsibility Guidance*, 1/9/13), caution should be exercised, in that the individual working on achieving the goal may still be considered a full-time employee and an excise tax penalty could be triggered, if adequate coverage at an affordable rate is not offered within 13 calendar months following hire date. In other words, the ninety-day waiting period and the shared responsibility provision are not identical. Special planning may be required to ensure not running afoul of either provision.

It should also be noted that the regulations propose that any eligibility condition, such as an hours worked requirement, that is determined to be intended as a way to avoid the ninety-day wait, will be deemed to violate the law.

CERTIFICATES OF CREDITABLE COVERAGE

Another health plan provision that takes effect on the first day of the first plan year occurring on or after January 1, 2014, is a requirement that no preexisting condition be imposed on anyone. Again, this applies to plans of all sizes, insured or self-funded, and grandfathered or not.

Ever since the enactment of HIPAA, health plans have been required to provide a Certificate of Creditable Coverage to anyone whose coverage ends under a health plan. The purpose of the Certificate of Creditable Coverage is to provide proof of continuous coverage. Since no preexisting condition exclusion can be imposed, these regulations suggest that the Certificate of Creditable Coverage is no longer necessary.

The regulations propose that effective January 1, 2015 plans will no longer be required to provide these certificates. Certificates will continue to be required during 2014, in that plans with plan anniversaries late in the year, will continue to be subject to the preexisting condition limitation for much of 2014.

HHS DRAFT APPLICATION FOR EXCHANGE PARTICIPATION

The ACA provides several avenues for obtaining health coverage, among these are purchasing health insurance through the marketplace, sometimes referred to as the exchange. Also, available to some individuals is government provided financial assistance, and to others, coverage may be available through Medicaid or CHIP.

The marketplace is charged with the responsibility of determining what entitlements may be available to an individual and his/her family. To this end, HHS has issued a draft application. The purpose of which is to serve as a single point of entry for the purchase of health coverage through the marketplace. This application would be used to access eligibility for programs such as Medicaid or CHIP, as well as determining eligibility for government assistance in the form of premium assistance or cost-sharing.

While this application is only in draft form, employers may be interested in the section requiring information on the employer plan, such as date employee is eligible for coverage, name of the lowest cost self-only health plan that meets the "minimum value standard," and how much and how often premiums are paid. This, in part, will be used to determine whether the individual seeking coverage has access to adequate coverage at an affordable rate from the employer. Employers subject to the Shared Responsibility requirement (those employing 50 or more full-time and full time equivalent employees) may wish to familiarize themselves with this information (see, CBIZ Health Reform Bulletin, *Shared Responsibility Guidance*, 1/9/13).

INTERNAL CLAIMS AND APPEALS PROCESS AND EXTERNAL REVIEW

The ACA requires non-grandfathered plans, both those subject to ERISA and those exempt from ERISA, to comply with an Internal Claims and Appeals Process and External Review.

These rules are summarized in the following CBIZ Health Reform Bulletins:

- *Modifications to Claims and Appeals, and External Review*, 7/11/11
- *Delay in Claims and Appeals Enforcement*, 3/22/11
- *Agencies Issue PPACA Clarifications*, 10/12/10
- *Limited PPACA Exemption for Self-Funded, Non-Federal*, 10/12/10
- *Federal External Claims Review: Interim Procedures and Model Notices*, 8/30/10
- *Internal Claims and Appeals, and External Review Process*, 7/26/10

Recently issued, Technical Release 2013-01, by DOL's Employee Benefits Security Administration, extends previously issued guidance until January 1, 2016. Issuers and self-funded nonfederal government plans will be in compliance, if they comply with an applicable state external review process that meets the temporary NAIC-similar process standards.

Beginning January 1, 2016, a state external review process will need to satisfy the standards of conformity with the 16 consumer protection standards listed in the NAIC's Uniform Health Carrier External Review Model Act or issuers (and, if applicable, self-funded nonfederal government plans) in that state will need to comply with a federally-administered external review process.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.