

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XVI)

September 4, 2013

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of various provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/> and <http://www.cms.gov/ccio/resources/fact-sheets-and-faqs/index.html>), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

Notice of Coverage Options Available Through the Exchanges

Section 18B of the Fair Labor Standards Act (FLSA), as added by section 1512 of the Affordable Care Act, generally provides that, in accordance with regulations promulgated by the Secretary of Labor, employers must provide each employee notice of coverage options available through a Health Insurance Marketplace (also referred to as an Exchange). On May 8, 2013, the Department of Labor issued Technical Release 2013-02 provided temporary guidance on FLSA section 18B, as well as model notices.¹

Q1: Is it permissible for another entity (such as an issuer, multiemployer plan, or third-party administrator) to send the Notice of Coverage Options on behalf of an employer to satisfy the employer's obligations under FLSA section 18B?

Yes, an employer will have satisfied its obligation to provide the notice with respect to an individual if another party provides a timely and complete notice. The Department of Labor notes that, as explained in Technical Release 2013-02, FLSA section 18B requires employers to provide notice to all employees, regardless of whether an employee is enrolled in, or eligible for, coverage under a group health plan. Accordingly, an employer is not relieved of its statutory obligation to provide notice under FLSA section 18B if another entity sends the notice to only participants enrolled in the plan, if some employees are not enrolled in the plan. When providing notices on behalf of employers, multiemployer plans, issuers, and third party administrators should take proper steps to ensure that a notice is provided to all employees regardless of plan enrollment, or communicate clearly to employers that the plan, issuer, or third party administrator will provide notice only to a subset of employees (*e.g.*, employees enrolled in the plan) and advise of the residual obligations of employers with respect to other employees (*e.g.*, employees who are not enrolled in the plan).

¹ See Technical Release 2013-02, model notice for employers who offer a health plan to some or all employees, and model notice for employers who do not offer a health plan, available at <http://www.dol.gov/ebsa/healthreform/>.

90-day Waiting Period Limitation

PHS Act section 2708 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. Section 2704(b)(4) of the PHS Act, section 701(b)(4) of ERISA, and section 9801(b)(4) of the Code define a waiting period to be the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

On February 9, 2012, the Departments issued guidance outlining various approaches under consideration with respect to PHS Act section 2708 and solicited comments. After reviewing those comments, the Departments provided temporary guidance on August 31, 2012, to remain in effect at least through the end of 2014, regarding the 90-day waiting period limitation. This guidance also solicited comments. After consideration of all of the comments received in response to the February 2012 and August 2012 guidance, the Departments published proposed regulations on March 21, 2013.

The proposed regulations generally provide that a group health plan or health insurance issuer offering group health insurance coverage may not impose a waiting period that exceeds 90 days. The proposed rules also provide that a waiting period is the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. For this purpose, being otherwise eligible to enroll in a plan generally 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). However, eligibility conditions based solely on the lapse of time are permissible for no more than 90 days. Other conditions for eligibility under a plan are generally permissible unless the condition is designed to avoid compliance with the 90-day waiting period limitation. The proposed regulations provide several illustrations of how to apply this rule.²

The preamble to the proposed regulations stated that, in the Departments' view, the proposed rules were consistent with, and no more restrictive on employers than, the August 2012 guidance.³ Therefore, the Departments stated they will consider compliance with the proposed rules as compliance with PHS Act section 2708 at least through 2014.⁴

Q2: Will the Departments be issuing final regulations under PHS Act section 2708 that give plans and issuers sufficient time to comply with the waiting period limitation?

Yes. As stated in the proposed rules, plans and issuers can rely on guidance provided in the March 2013 proposed rules at least through 2014. To the extent final regulations are more restrictive on plans or issuers than the proposed regulations, they will not be effective prior to January 1, 2015 and the Departments expect they will give plans and issuers sufficient time to comply.⁵

² See paragraph (c)(3)(i) and (ii) of the proposed regulations, addressing the application of plan provisions requiring certain hours-of-service per period to variable hour employees and cumulative service requirements.

³ 78 FR 17317, March 21, 2013.

⁴ *Id.*

⁵ 78 FR 71313, 17317 (March 21, 2013).

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. Therefore, for example, if 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 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).