• OAR 340–200 General Air Pollution Procedures and Definitions
• OAR 340–204 Designation of Air Quality Areas
• OAR 340–216 Air Contaminant Discharge Permits

EPA analysis: The regulations cited by the State were previously approved on December 27, 2011 (76 FR 80747), and provide for consultation and participation in SIP development by local political subdivisions affected by the SIP. Therefore the EPA proposes to find that the State's SIP meets the requirements of CAA section 110(a)(2)(M) for the 1997 $PM_{2.5,}$ 2006 $PM_{2.5}$, and 2008 ozone NAAQS.

VI. Scope of Proposed Action

Oregon has not demonstrated authority to implement and enforce the Oregon Administrative rules within ''Indian Country'' as defined in 18 U.S.C. 1151. ''Indian country'' is defined under 18 U.S.C. 1151 as: (1) All land within the limits of any Indian reservation under the jurisdiction of the United States Government, notwithstanding the issuance of any patent, and including rights-of-way running through the reservation, (2) all dependent Indian communities within the borders of the United States, whether within the original or subsequently acquired territory thereof, and whether within or without the limits of a State, and (3) all Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through the same. Under this definition, the EPA treats as reservations trust lands validly set aside for the use of a Tribe even if the trust lands have not been formally designated as a reservation. Therefore, this SIP approval does not extend to ''Indian Country'' in Oregon. See CAA sections 110(a)(2)(A) (SIP shall include enforceable emission limits), 110(a)(2)(E)(i) (State must have adequate authority under State law to carry out SIP), and 172(c)(6) (nonattainment SIPs shall include enforceable emission limits).

VII. Proposed Action

The EPA is proposing to find that the Federally-approved provisions currently in the Oregon SIP meet the following CAA section 110(a)(2) infrastructure elements for the 1997 $PM_{2.5}$, 2006 $PM_{2.5}$, and the 2008 ozone NAAQS: (A), (B), (C), (D)(ii), (E), (F), (G), (H), (J), (K), (L), and (M). The EPA is also proposing to find that the Federally-approved provisions currently in the Oregon SIP meet the requirements of CAA section 110(a)(2)(D)(i)(II) as it applies to prevention of significant deterioration for the 2008 ozone NAAQS, and CAA section 110(a)(2)(D)(i)(II) as it applies to visibility for the 2006 $PM_{2.5}$ and 2008 ozone NAAQS. This action does not propose to approve any additional provisions into the Oregon SIP but is a proposed finding that the current provisions of the Oregon SIP are adequate to satisfy the above-mentioned infrastructure elements required by the CAA. This action is being taken under section 110 of the CAA.

VIII. Statutory and Executive Order Reviews

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, the EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this proposed action merely approves the state's law as meeting Federal requirements and does not impose additional requirements beyond those imposed by the state's law. For that reason, this proposed action:

• Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
• does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
• is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
• does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
• does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
• is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
• is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
• is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and
• does not provide the EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in Oregon, and the EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Ozone, Particulate Matter, and Reporting and recordkeeping requirements.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: March 6, 2013.

Dennis J. McLerran,

Regional Administrator, Region 10.

[FR Doc. 2013–06309 Filed 3–20–13; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[REG–122706–12]

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–P]

RIN 0938–AR77

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

AGENCY: 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: Proposed rules.

SUMMARY: These proposed rules 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. 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.

DATES: Comments are due on or before May 20, 2013.

ADDRESSES: Written comments may be submitted to the Department of Labor as specified below. Any comment that is submitted will be shared with the other Departments and will also be made available to the public. Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments may be posted on the Internet and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Comments, identified by ''Waiting Periods'', may be submitted by one of the following methods:

Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

Mail or Hand Delivery: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N–5653, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, *Attention:* Waiting Periods.

Comments received will be posted without change to *www.regulations.gov* and available for public inspection at the Public Disclosure Room, N–1513, Employee Benefits Security Administration, 200 Constitution Avenue NW., Washington, DC 20210, including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Elizabeth Schumacher, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Karen Levin or Kathryn Johnson, Internal Revenue Service, Department of the Treasury, at (202) 927–9639; 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 Web site (*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) Web site (*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, Public Law 111–148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 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 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, and the Treasury (the Departments) 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.[2] 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.

PHS Act section 2708 does not require an employer to offer coverage to any particular employee or class of employees, 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. Furthermore, nothing in the Affordable Care Act penalizes small employers for choosing not to offer coverage, or applicable large employers, as defined in the employer shared responsibility provisions under Code section 4980H, for choosing to limit their offer of coverage to full-time employees (and their dependents), as defined in the employer shared responsibility provisions under Code section 4980H.

On February 9, 2012, the Departments issued guidance [3] 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). Public comments were invited generally, as well as specifically, regarding how rules relating to the potential look-back/stability period safe harbor method for determining the number of full-time employees under Code section 4980H should be coordinated with the 90-day waiting period limitation.

[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.

[2] 26 CFR 54.9801–3(a)(3)(iii), 29 CFR 2590.701–3(a)(3)(iii), and 45 CFR 146.111(a)(3)(iii).

[3] Department of Labor Technical Release 2012–01, IRS Notice 2012–17, and HHS FAQs issued February 9, 2012.

On August 31, 2012, following their review of the comments on the February 2012 guidance, the Departments provided temporary guidance,[4] to remain in effect at least through the end of 2014, regarding the 90-day waiting period limitation, and described the approach they intended to propose in rulemaking in the future (August 2012 guidance). The August 2012 guidance provides that employers, plans, and issuers may rely on the compliance guidance at least through the end of 2014 and that, for purposes of enforcement by the Departments, compliance with the approach set forth in the August 2012 guidance will be considered compliance with the provisions of PHS Act section 2708 at least through the end of 2014.

In general, the August 2012 guidance provides, among other things, that eligibility conditions 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 are generally permissible under PHS Act section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation. The August 2012 guidance further clarifies that if, under the terms of a plan, an employee may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, the 90-day waiting period limitation is considered satisfied and, accordingly, a plan or issuer will not be considered to have violated PHS Act section 2708 solely because employees may take additional time to elect coverage.

The August 2012 guidance also addresses the application of PHS Act section 2708 to variable-hour employees in cases in which a specified number of hours of service per period is a plan eligibility condition. Specifically, the guidance provides that if a group health plan conditions eligibility on an employee regularly working a specified number of hours 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 that is consistent with the timeframe permitted for such determinations under Code section 4980H.[5] 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.

The August 2012 guidance also addresses application of the rules to plans with cumulative hours-of-service requirements. The August 2012 guidance includes an example stating that, if a plan's cumulative hours-of-service requirement is more than 1,200 hours, the Departments would consider the requirement to be designed to avoid compliance with the 90-day waiting period limitation.

After consideration of all of the comments received in response to the February 2012 guidance and in response to the August 2012 guidance, the Departments are proposing these regulations. Public comments on these proposed regulations are invited.

II. Overview of the Proposed Regulations

A. Prohibition on Waiting Periods That Exceed 90 Days

These regulations propose that a group health plan, and a health insurance issuer offering group health insurance coverage, not apply any waiting period that exceeds 90 days. (Neither a plan nor an issuer offering coverage is required to have any waiting period.) If, under the terms of the plan, an employee can elect coverage that becomes effective on a date that does not exceed the 90-day waiting period limitation, the coverage complies with the waiting period rules, and the plan or issuer will not be considered to violate the waiting period rules merely because individuals choose to elect coverage beyond the end of the 90-day waiting period.

In these proposed regulations, the definition of waiting period is the same as that used in the 2004 HIPAA regulations. (However, the definition is proposed to be moved from the section on preexisting condition exclusions to this section. See below for an explanation of other technical and conforming changes proposed to be made to the 2004 HIPAA regulations.) Accordingly, under these proposed regulations, waiting period would continue to be defined 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. These proposed regulations would also continue to include the clarification that, if an employee or dependent enrolls as a late enrollee or special enrollee, any period before such 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.[6]

Paragraph (c) of the proposed regulations sets forth rules governing the relationship between a plan's eligibility criteria and the 90-day waiting period limitation. Specifically, this paragraph provides that 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). However, the 90-day waiting period limitation generally does not require the plan sponsor to offer coverage to any particular employee or class of employees (including, for example, part-time employees). Instead, these proposed regulations would prohibit requiring otherwise eligible participants and beneficiaries to wait more than 90 days before coverage is effective.[7]

Under these proposed regulations, 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 (*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.

These regulations propose an approach when applying waiting periods to variable-hour employees in

[4] Department of Labor Technical Release 2012–02, IRS Notice 2012–59, and HHS FAQs issued August 31, 2012.

[5] The August 2012 guidance provides that an employer may use a measurement period that is consistent with Code section 4980H, whether or not it is an applicable large employer subject to Code section 4980H.

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

[7] While a substantive eligibility condition that denies coverage for employees may be permissible under PHS Act section 2708, an applicable large employer's denial of coverage to a full-time employee may, nonetheless, give rise to an assessable payment under section 4980H of the Code and its implementing regulations.

cases in which a specified number of hours of service per period (such as 30 hours per week or 250 hours per quarter) is a plan eligibility condition. Under these proposed regulations, 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 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 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 clarification regarding employees with specific or unique work schedules, and whether they would be treated as variable-hour employees. In this regard, unlike the rules under Code section 4980H, whether an employee has been appropriately classified as part-time, full-time, or variable-hour is of limited application under PHS Act section 2708. That is, conditions for eligibility under the terms of a group health plan are generally permissible under PHS Act section 2708, unless based solely on the lapse of time or designed to avoid compliance with the 90-day waiting period limitation. Accordingly, plan provisions that base eligibility on whether an employee is, for example, meeting certain sales goals or earning a certain level of commission, are generally substantive eligibility provisions that do not trigger the 90-day waiting period limitation. Some plan eligibility provisions, such as whether an employee has a specified number of hours of service per period (such as 30 hours per week or 250 hours per quarter) necessarily require the passage of time in order to determine whether the plan's substantive eligibility provision has been met. These proposed regulations set forth an approach under which such plan provisions will not be considered to be designed to avoid compliance with the 90-day waiting period limitation. However, whether a particular employee is classified appropriately as part-time, full-time, or variable-hour is generally not an issue under PHS Act section 2708, although other provisions of law (such as Code section 4980H, the HIPAA nondiscrimination provisions, and other provisions of ERISA) may be applicable.

Another type of plan eligibility provision addressed in the August 2012 guidance was cumulative hours-of-service requirements, which use more than solely the passage of a time period in determining whether employees are eligible for coverage. Specifically, the August 2012 guidance included an example stating that if a plan's cumulative hours-of-service requirement were more than 1,200 hours, the Departments would consider the requirement to be designed to avoid compliance with the 90-day waiting period limitation. Under these proposed regulations, 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.[8] Under the proposed rules, 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. Furthermore, this provision is designed to be a one-time eligibility requirement only; these proposed regulations do not permit, for example, re-application of such a requirement to the same individual each year.

In response to the August 2012 guidance, some commenters requested clarification regarding application of the rule to plan provisions that require employees to work sufficient number of hours per measurement period but permit employees, if they do not have a sufficient number of hours, to make a self-payment (or buy-in) equal to the amount which would allow them to have a sufficient number of hours within the measurement period. PHS Act section 2708 and these proposed regulations do not prohibit plan procedures permitting self-payment (or buy-in) to satisfy any otherwise permissible hours-of-service requirement.

Some commenters raised concerns about communication between a plan and issuer regarding the 90-day limitation on waiting periods. Commenters stated that many issuers rely on the plan sponsor for information about an individual's eligibility for coverage and that issuers may not have knowledge of certain plan terms, such as eligibility conditions and waiting periods. These commenters expressed concern that health insurance issuers are required to comply with the requirements of PHS Act section 2708, but must rely on the information plan sponsors and employers report to them regarding eligibility information such as an employee's start date. At the same time, small employers purchasing insurance coverage often rely on their issuers for compliance assistance. Therefore, while the requirements of PHS Act section 2708 and these proposed regulations would be applicable to both the plan and issuer, to the extent coverage under a group health plan is insured by a health insurance issuer, paragraph (f) of the proposed regulations would provide 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 proposed regulations in administering the 90-day waiting period limitation if 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 employer's plan (and requires the plan sponsor to update this representation with any changes), and the issuer has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.

Paragraph (d) of the proposed regulations clarifies the method for counting days when applying a 90-day waiting period. Some commenters stated that it is common practice to have a 90-day waiting period with coverage effective the first day of the month after the 90-day waiting period and requested flexibility for administrative ease. Others requested the Departments to create a *de minimis* exception for the

[8] While a cumulative hours-of-service eligibility condition up to 1,200 hours may be permissible under PHS Act section 2708, an applicable large employer's denial of coverage to a full-time employee may, nonetheless, give rise to an assessable payment under section 4980H of the Code and its implementing regulations.

difference between 90 days and 3 months. Under these proposed regulations, due to the clear text of the statute, the waiting period may not extend beyond 90 days and all calendar days are counted beginning on the enrollment date, including weekends and holidays. For a plan with a waiting period, ''enrollment date'' is defined as the first day of the waiting period.[9] If, with respect to a plan or issuer imposing a 90-day waiting period, 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.

The Departments recognize 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 comments received on the August 2012 guidance gave examples of plan eligibility provisions based on complex formulas for earnings and residuals. As discussed earlier, the Departments view eligibility provisions that are based on compensation as substantive eligibility provisions that are not designed to avoid compliance with the 90-day waiting period limitation. In addition, hours banks, which are common multiemployer plan provisions that allow workers to bank excess hours from one measurement period and then draw down on them to compensate for any shortage in a succeeding measurement period and prevent lapses in coverage, function as buy-in provisions, which were discussed earlier as permissible. It is the Departments' view that the proposed rules provide flexibility to both multiemployer and single-employer health plans to meet their needs in defining eligibility criteria, while also ensuring that employees are protected from excessive waiting periods. Comments are invited on these proposed rules and on whether any additional examples or provisions are needed to address multiemployer plans.

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. The rules would apply to 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, with respect to individuals who are in a waiting period for coverage before the applicability date, 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. However, as discussed below, the proposed amendment to eliminate the requirement to issue a certificate of creditable coverage is proposed to apply December 31, 2014, so that individuals needing to offset a preexisting condition exclusion under a plan that operates with a plan year beginning later than January 1 would still have access to the certificate for proof of coverage. Comments are invited on these proposed applicability dates.

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. In the Departments' view, these proposed regulations are consistent with, and no more restrictive on employers than, the August 2012 guidance. Therefore, the Departments will consider compliance with these proposed regulations as compliance with PHS Act section 2708 at least through the end of 2014. (However, for changes outside of PHS Act section 2708 made to existing HIPAA regulations, such as the elimination of the requirement to provide a certificate of creditable coverage, the existing HIPAA regulations continue to apply until amended in new final regulations.) To the extent final regulations or other guidance with respect to the 90-day waiting period limitation is more restrictive on plans and issuers than these proposed regulations, the final regulations or other guidance will not be effective prior to January 1, 2015.

B. Conforming Changes to Existing Regulations

Sections 9801 of the Code and 701 of ERISA, and section 2701 of the PHS Act as originally added by HIPAA included requirements pertaining to the application of preexisting condition exclusions and waiting periods, as well as methods of crediting coverage. Final regulations implementing Code section 9801, ERISA section 701, and PHS Act section 2701 (as originally added by HIPAA) were adopted in 2004. The 2004 HIPAA regulations permit limited exclusions of coverage based on a preexisting condition under certain circumstances. PHS Act section 2704, added by the Affordable Care Act and incorporated into ERISA and the Code, amends the HIPAA requirements relating to preexisting conditions to provide that a group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion.[10] PHS Act section 2704 and the interim final regulations implementing that section are generally effective with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition became effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010.[11] Therefore, 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,[12] as well as the provisions governing dependent coverage of children to age 26 under PHS Act section 2714 and its implementing regulations.[13]

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

Section 1334 of the Affordable Care Act creates the Multi-State Plan Program (MSPP) to foster competition in the Affordable Insurance Exchanges (Exchanges) and directs the U.S. Office of Personnel Management (OPM) to contract with private health insurance issuers to offer at least two multi-state plans (MSPs) on each of the Exchanges in the 50 states and the District of Columbia. Under Affordable Care Act section 1334(a)(4), OPM is to administer this program ''in a manner similar to the manner in which'' it implements the contracting provisions of the Federal Employee Health Benefits Program (FEHBP). OPM has interpreted Affordable Care Act section 1334(a)(4) to require implementation of a uniform, nationally applicable external review

[9] *See* 26 CFR 54.9801–3(a)(3)(i); 29 CFR 2590.701–3(a)(3)(i); and 45 CFR 146(a)(3)(i), which would be moved under these proposed rules to 26 CFR 54.9801–2; 29 CFR 2590.701–2; and 45 CFR 144.103.

[10] Affordable Care Act section 1201 also moved those provisions from PHS Act section 2701 to PHS Act section 2704.

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

[12] 75 FR 37188 (June 28, 2010).

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

process consistent with the requirements of PHS Act section 2719 for MSPs similar to that administered by OPM under FEHBP,[14] to ensure that the MSPP contract is administered consistently throughout all 51 jurisdictions that would be served by an MSP (as FEHBP currently does).

The ''level playing field'' requirement in section 1324 of the Affordable Care Act provides that ''[n]otwithstanding any other provision of law,'' requirements under State or Federal law in 13 categories (including appeals) ''shall not'' apply to ''health insurance offered by a private health insurance issuer'' if the requirement does not apply to MSPs established under the Affordable Care Act. Non-grandfathered health insurance coverage is generally required to comply with PHS Act section 2719 and its implementing regulations regarding internal claims and appeals and external review processes.[15] As a result, MSPP plans must also so comply, or other non-grandfathered insurance coverage would have to be similarly exempted.[16]

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.[17] For plans and issuers not subject to an existing State external review process (including self-insured plans), a Federal external review process applies.[18] The statute requires the Departments to establish standards, ''through guidance,'' governing a Federal external review process. Among such guidance that has been issued by the Departments, HHS has established a Federal external review process for self-insured nonfederal governmental health plans, as well as for plans and issuers in States that do not meet the minimum consumer protections in the regulations.

In this rule, the Departments propose to clarify that 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* (emphasis added).[19] OPM's final rule on the establishment of the multi-State plan program[20] requires the MSPP external review process to meet the requirements of PHS Act section 2719 and its implementing regulations.

Additionally, the Departments propose to clarify that the scope of the Federal external review process, as described in paragraph (d)(1)(ii) of the regulations, is the minimum required scope of claims eligible for external review for plans using a Federal external review process, and that Federal external review processes developed in accordance with paragraph (d) may have a scope that exceeds the minimum requirements. For example, OPM stated that the scope of the MSP external review process would allow for appeals of all disputed claims.[21] This clarification would reiterate that the proposed external review process would meet the minimum requirement for the scope of a Federal external review process under the regulations.

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 proposed 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 proposed regulations, and the Departments have provided the following assessment of their impact.

1. Summary

As stated earlier in this preamble, these proposed regulations would implement PHS Act section 2708, which provides that 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 proposed regulations define ''waiting period'' as the period that must pass before coverage for an

[14] OPM published a final rule on establishment of the MSPP on March 11, 2013 at 78 FR 15559.

[15] The interim final regulations relating to internal claims and appeals and external review processes are codified at 26 CFR 54.9815–2719T, 29 CFR 2590.715–2719, and 45 CFR 147.136. These requirements do not apply to grandfathered health plans. The interim final regulations relating to status as a grandfathered health plan are codified at 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140.

[16] The amendments in these proposed regulations only seek to address the differences that exist between the proposed MSPP external review process and the external review requirements for group health plans and health insurance issuers. While MSPP is also required to comply with the requirements related to internal claims and appeals, OPM's proposed process does not differ from the internal claims and appeals requirements for group health plans and health insurance issuers.

[17] More information on the regulatory requirements for State external review processes, including the regulations, Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners, technical releases, and other guidance, is available at *http://www.dol.gov/ebsa* and *http://cciio.cms.gov.*

[18] More information on the regulatory requirements for the Federal external review process, including the regulations, technical releases, and other guidance, is available at *http://www.dol.gov/ebsa* and *http://cciio.cms.gov.*

[19] We note that this interpretation of section 2719(b)(2) as applicable to MSPs is supported by the fact that Congress directed that the MSPP be implemented by OPM, and OPM is not a state.

[20] *See 45 CFR 800.115(k)* and *45 CFR part 800.*

[21] 45 CFR 800.504(a). See also 78 FR 15559, 15582–15584 (March 11, 2013), the Preamble to the Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges; Final Rule.

employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective, which is the same definition used in the 2004 HIPAA regulations. The proposed regulations would generally apply to plan years beginning on or after January 1, 2014, consistent with the statutory effective date of PHS Act section 2708.[22]

The Departments have crafted these proposed regulations to secure the protections intended by Congress in an economically efficient manner. The Departments do not have sufficient data to quantify the regulations' economic cost or benefits; therefore, they have provided a qualitative discussion of their economic impacts and request detailed comment and data that would allow for quantification of the costs, benefits, and transfers that would be brought about by the proposed rule.

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.[23] The 2012 Kaiser Family Foundation and Health Research and Education Trust Employer Health Benefits Annual Survey (the ''2012 Kaiser Survey'') finds that only eight percent of covered workers were subject to waiting periods of four months or more.[24] If eight percent of new employees receiving health care from their employers are subject to a waiting period of four months or more, then 408,000 new employees (5.1 million × 0.08) would be affected by this rule.[25] However, the Departments would note that it is unlikely that the survey defines the term ''waiting period'' in the same manner as these proposed regulations. For example, waiting period may have been defined by reference to an employee's start date, and it seems unlikely that the 2012 Kaiser Survey would have included the clarifications included in these proposed 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 insurance coverage.

If employees delay health care treatment until the expiration of a prolonged waiting period, detrimental health effects can result, especially for employees and their dependents requiring 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 proposed regulations can help reduce these effects, although the overall benefit may be limited because—as discussed in greater detail below—a small fraction of employers are expected to offer earlier health insurance coverage as a result of these proposed regulations.

As discussed earlier in this preamble, 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. These amendments would provide a benefit to plans by reducing the burden associated with complying with the several Paperwork Reduction Act 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 Paperwork Reduction Act section, below.

4. Transfers Associated with the Rule

The possible transfers associated with this proposed rule would arise if employers begin to pay their portion of health insurance premiums or contributions sooner than they did before the enactment of PHS Act section 2708 and issuance of these proposed regulations. Recipients of the transfers would be covered employees and their dependents who would, if these proposed regulations are finalized, 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 health plans market before the enactment of PHS Act section 2708.

The Departments do not believe that this rule, on its own, will cause more than a marginal number of employers to offer coverage earlier to their employees because this provision on its own does not require employers to offer coverage and there is significant flexibility afforded to employers in these proposed regulations to maintain or revise their current group health plan eligibility conditions. For example, paragraph (c)(3)(ii) of the proposed regulations provides that 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. This is 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 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.

Therefore, an employee who must meet a cumulative hours-of-service requirement of 1,200 hours could be employed for ten months [26] before their health coverage becomes effective and only employers that had a waiting period longer than ten months before the enactment of PHS Act section 2708 and these proposed regulations would necessarily incur a transfer for additional coverage. Because the 2012 Kaiser Survey reports that just eight percent of covered workers are in plans with waiting periods of four months or more and the overall average waiting period is just 2.3 months, the

[22] As stated earlier, the Departments' 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. In the Departments' view, these proposed regulations are consistent with, and no more restrictive on employers than, the August 2012 guidance. Therefore, the Departments will consider compliance with these proposed regulations as compliance with PHS Act section 2708 at least through the end of 2014.

[23] This estimate is based upon internal Department of Labor calculations derived from the 2009 Medical Expenditure Panel Survey.

[24] *See e.g.,* Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits 2012 Annual Survey* (2012) available at *http://ehbs.kff.org/pdf/2012/8345.pdf.*

[25] Approximately 331,000 private sector employees and 77,000 state and local public sector employees.

[26] 1,200 hours/40 hours per week = 30 weeks; 30 weeks *7 days/week = 210 days; 210 days eligibility requirement + 90 day wait period = 300 days.

Departments are confident that such long waiting periods are rare.

B. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury

As stated above, Sections 9801 of the Code and 701 of ERISA, and 2701 of the PHS Act as originally added by Health Insurance Portability and Accountability Act of 1996, included requirements pertaining to the application of preexisting conditions exclusions and waiting periods as well as methods of crediting coverage. The 2004 HIPAA regulations (in effect prior to the effective date of these amendments) permit limited exclusions of coverage based on a preexisting condition under certain circumstances.

PHS Act section 2704, added by the Affordable Care Act and incorporated into ERISA and the Code, amends the 2004 HIPAA regulations relating to preexisting conditions to provide that a group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion. PHS Act section 2704 and the interim final regulations implementing that section are generally effective with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition became effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010. Therefore, these regulations propose to 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.

The Departments are proposing to discontinue the following Information Collection Requests (ICRs) that are associated with the superseded regulation: 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 proposing to revise 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 January 31, 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).

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.

For purposes of analysis under the RFA, the Departments propose to continue to consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis of this definition is found in section 104(a)(3) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for welfare benefit plans that cover fewer than 100 participants.[27]

Further, while some large employers may have small plans, in general, small employers maintain most small plans. Thus, the Departments believe that assessing the impact of these proposed regulations on small plans is an appropriate substitute for evaluating the effect on small entities.

The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). The Departments therefore request comments on the appropriateness of the size standard used in evaluating the impact of these proposed regulations on 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 proposed rule includes flexibility that would allow small employers to minimize the transfers in health insurance premiums that they would have to pay to employees.

The Departments hereby certify that these proposed regulations will not have a significant economic impact on a substantial number of small entities. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that would allow the Departments to assess the impacts specifically on small plans or suggest alternative rules that accomplish the stated purpose of PHS Act section 2708 and minimize the impact on small entities.

D. Special Analyses—Department of the Treasury

For purposes of the Department of the Treasury, it has been determined that this notice of proposed rulemaking 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 proposed regulations, and, because these proposed 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 notice of proposed rulemaking has been

[27] Under ERISA section 104(a)(2), the Secretary may also provide exemptions or simplified reporting and disclosure requirements for pension plans. Pursuant to the authority of ERISA section 104(a)(3), the Department of Labor has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46, and 2520.104b–10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans, that cover fewer than 100 participants and satisfy certain other requirements.

submitted to the Small Business Administration for comment on its impact on small business.

E. Congressional Review Act

These proposed 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, if finalized, 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 proposed rules do not include any proposed 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 proposed 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 stringent than the Federal requirements are unlikely to ''prevent the application of'' the Affordable Care Act, and 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 proposed rules would clarify and implement the statute's minimum standards and would 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 proposed 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 proposed to be adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are proposed to be 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 Law 104–191, 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 proposed to be adopted, with respect to 45 CFR Part 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.

Steven T. Miller,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Signed this 14th day of March, 2013.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: March 13, 2013.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: March 14, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Accordingly, 26 CFR part 54 is proposed to be 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 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. Removing paragraphs (a)(2), (a)(3), (c), (d), (e) and (f).

■ B. Revising the heading to paragraph (a).

■ C. Removing paragraph (a)(1) introductory text, and redesignating paragraphs (a)(1)(i) and (a)(1)(ii) as paragraphs (a)(1) and (a)(2).

■ D. Amending 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.

■ E. Revising paragraph (b).

The revisions read as follows:

§ 54.9801–3 Limitations on preexisting condition exclusion period.

(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).

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* § 54.9815–2704T 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* § 54.9815–2704T 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* § 54.9815–2704T for rules prohibiting the imposition of a preexisting condition exclusion.

(b) *Applicability.* The amendments made under 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. Removing paragraph (b)(3) and 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. Revising Example 2, and paragraph (i) of Example 5, in paragraph (d)(4).

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

■ E. 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 may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan 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 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 § 54.9815–2711, if TMJ coverage is an essential health benefit. 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 § 54.9815–2711 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).

* * * * *

■ **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 employee 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, a plan or issuer in that case will not be considered to have violated this paragraph (a) solely because employees (or other classes of participants) may 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 employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent 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) 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 or achieving job-related licensure requirements specified in the plan's terms). 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 employee or class of employees (including, for example, part-time employees). Instead, this section prohibits requiring otherwise eligible participants and beneficiaries to wait more than 90 days before coverage is effective. (While a substantive eligibility condition that denies coverage to employees may be permissible under this section, a failure by an applicable large employer (as defined in section 4980H) to offer coverage to a full-time employee might, for example, nonetheless give rise to an assessable payment under section 4980H and its implementing regulations.)

(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 day 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) *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. If, in the case of a plan or issuer imposing a 90-day waiting period, the 91st day is a weekend or holiday, the plan or issuer may choose to permit coverage to become effective earlier than the 91st day, for administrative convenience. Similarly, plans and issuers that do not want to start coverage in the middle of a month (or pay period) may choose to permit coverage to become effective earlier than the 91st day, for administrative convenience. For example, a plan may impose a waiting period of 60 days plus a fraction of a month (or pay period) until the first day of the next month (or pay period). However, a plan or issuer that extends the effective date of coverage beyond the 91st day fails to comply with the 90-day waiting period limitation.

(e) *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 in 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 in 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 *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. 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. 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 *W*'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. Coverage is made effective 7 days later, which is the first day of the next pay period.

(ii) *Conclusion.* In this *Example 6,* under the terms of *W*'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 is dependent 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 *Y*'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 *Y* 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 the period of time is no longer than 12 months and begins on a date between the employee's start date and the first day of the next calendar month, provided 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 provided that, 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 *Z* on January 6 and is considered a part-time employee for purposes of *Z*'s group health plan. *Z* 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.)

(f) *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 employer's 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.

(g) *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.

(h) *Applicability date*—(1) *In general.* The provisions of this section apply for plan years beginning on or after January 1, 2014. *See* § 54.9815–1251T providing that the prohibition on waiting periods exceeding 90 days applies to all group health plans and health insurance issuers, including grandfathered health plans.

(2) *Application to individuals in a waiting period prior to the applicability date*—(i) With respect to individuals who are in a waiting period for coverage before the applicability date of this section, beginning on the first day the section applies, the waiting period can no longer apply to the individual if it would exceed 90 days with respect to the individual.

(ii) This paragraph (h)(2) is illustrated by the following example:

Example. (i) *Facts.* A group health plan is a calendar year plan. Prior to January 1, 2014, the plan provides that full-time employees are eligible for coverage after a 6-month waiting period. Employee *A* begins work as a full-time employee on October 1, 2013.

(ii) *Conclusion.* In this *Example 1,* the first day of A's waiting period is October 1, 2013 because that is the first day *A* is otherwise eligible to enroll under the plan's substantive eligibility provisions, but for the waiting period. Beginning January 1, 2014, the plan may not apply a waiting period that exceeds 90 days. Accordingly, *A* must be given the opportunity to elect coverage that begins no later than January 1, 2014 (which is 93 days after *A*'s start date) because otherwise, on January 1, 2014, the plan would be applying a waiting period that exceeds 90 days. The plan is not required to make coverage effective before January 1, 2014 under the rules of this section.

Par. 10. Section 54.9815–2719T is amended by adding a sentence to the end of the introductory text of paragraph (d) and revising paragraph (d)(1)(i) to read as follows:

§ 54.9815–2719T Internal claims and appeals and external review processes.

* * * * *

(d) * * * A Multi State Plan or MSP, as defined by 45 CFR 800.20, must provide an effective Federal external review process in accordance with this paragraph (d).

(1) * * *

(i) *In general.* Subject to the suspension provision in paragraph (d)(1)(ii) of this section and except to the extent provided otherwise by the Secretary in guidance, the Federal external review process established pursuant to this paragraph (d) applies, at a minimum, to any adverse benefit determination or final adverse benefit determination (as defined in paragraphs (a)(2)(i) and (a)(2)(v) of this section), except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for the Federal external review process under this paragraph (d).

* * * * *

Par. 11. 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 proposes to amend 29 CFR part 2590 as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 12. 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).

■ 13. 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.

■ 14. 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).

■ 15. Section 2590.701–3 is amended by:

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

■ B. Revising the heading to paragraph (a).

■ C. Removing paragraph (a)(1) introductory text, and redesignating paragraphs (a)(1)(i) and (a)(1)(ii) as paragraphs (a)(1) and (a)(2).

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

■ E. Revising paragraph (b).

The revisions read as follows:

§ 2590.701–3 Limitations on preexisting condition exclusion period.

(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).

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.

■ 16. 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.

■ 17. 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 amendments made under this section apply beginning December 31, 2014.

■ 18. 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.

* * * * *

■ 19. 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.

■ 20. Section 2590.702 is amended by:

■ A. Removing paragraph (b)(3) and 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. Revising Example 2, and paragraph (i) of Example 5, in paragraph (d)(4).

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

■ E. 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. 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).

* * * * *

21. 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 employee 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, a plan or issuer in that case will not be considered to have violated this paragraph (a) solely because employees (or other classes of participants) may 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 employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent 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) 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 or achieving job-related licensure requirements specified in the plan's terms). 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 employee or class of employees (including, for example, part-time employees). Instead, this section prohibits requiring otherwise eligible participants and beneficiaries to wait more than 90 days before coverage is effective. (While a substantive eligibility condition that denies coverage to employees may be permissible under this section, a failure by an applicable large employer (as defined in section 4980H of the Code) to offer coverage to a full-time employee might, for example, nonetheless give rise to an assessable payment under Code section 4980H and its implementing regulations.)

(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 day 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) *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. If, in the case of a plan or issuer imposing a 90-day waiting period, the 91st day is a weekend or holiday, the plan or issuer may choose to permit coverage to become effective earlier than the 91st day, for

administrative convenience. Similarly, plans and issuers that do not want to start coverage in the middle of a month (or pay period) may choose to permit coverage to become effective earlier than the 91st day, for administrative convenience. For example, a plan may impose a waiting period of 60 days plus a fraction of a month (or pay period) until the first day of the next month (or pay period). However, a plan or issuer that extends the effective date of coverage beyond the 91st day fails to comply with the 90-day waiting period limitation.

(e) *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 in 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 in 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 *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. 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. 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 *W*'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. Coverage is made effective 7 days later, which is the first day of the next pay period.

(ii) *Conclusion.* In this *Example 6,* under the terms of *W*'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 is dependent 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 *Y*'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 *Y* 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 the period of time is no longer than 12 months and begins on a date between the employee's start date and the first day of the next calendar month, provided 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 provided that, 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 *Z* on January 6 and is considered a part-time employee for purposes of *Z*'s group health plan. *Z* 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.)

(f) *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 employer's 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.

(g) *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.

(h) *Applicability date*—(1) *In general.* The provisions of this section apply for plan years beginning on or after January 1, 2014. *See* § 2590.715–1251 providing that the prohibition on waiting periods exceeding 90 days applies to all group health plans and health insurance issuers, including grandfathered health plans.

(2) *Application to individuals in a waiting period prior to the applicability date*—(i) With respect to individuals

who are in a waiting period for coverage before the applicability date of this section, beginning on the first day the section applies, the waiting period can no longer apply to the individual if it would exceed 90 days with respect to the individual.

(ii) This paragraph (h)(2) is illustrated by the following example:

Example. (i) *Facts.* A group health plan is a calendar year plan. Prior to January 1, 2014, the plan provides that full-time employees are eligible for coverage after a 6-month waiting period. Employee *A* begins work as a full-time employee on October 1, 2013.

(ii) *Conclusion.* In this *Example 1,* the first day of A's waiting period is October 1, 2013 because that is the first day *A* is otherwise eligible to enroll under the plan's substantive eligibility provisions, but for the waiting period. Beginning January 1, 2014, the plan may not apply a waiting period that exceeds 90 days. Accordingly, *A* must be given the opportunity to elect coverage that begins no later than January 1, 2014 (which is 93 days after *A*'s start date) because otherwise, on January 1, 2014, the plan would be applying a waiting period that exceeds 90 days. The plan is not required to make coverage effective before January 1, 2014 under the rules of this section.

■ 22. Section 2590.715–2719 is amended by adding a sentence to the end of the introductory text of paragraph (d) and revising paragraph (d)(1)(i) to read as follows:

§ 2590.715–2719 Internal claims and appeals and external review processes.

* * * * *

(d) * * * A Multi State Plan or MSP, as defined by 45 CFR 800.20, must provide an effective Federal external review process in accordance with this paragraph (d).

(1) * * *

(i) *In general.* Subject to the suspension provision in paragraph (d)(1)(ii) of this section and except to the extent provided otherwise by the Secretary in guidance, the Federal external review process established pursuant to this paragraph (d) applies, at a minimum, to any adverse benefit determination or final adverse benefit determination (as defined in paragraphs (a)(2)(i) and (a)(2)(v) of this section), except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for the Federal external review process under this paragraph (d).

* * * * *

■ 23. Section 2590.731 is amended 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.

* * * * *

■ 24. 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 proposes to amend 45 CFR parts 144, 146, and 147 as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 25. 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).

■ 26. 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 other than through special or limited open enrollment. (For rules relating to special enrollment and limited open enrollment, *see* § 146.117 and § 147.104.) 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

■ 27. 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).

■ 28. 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 health insurance issuers offering group health insurance coverage under the Health Insurance Portability and Accountability Act (HIPAA), as amended by the Patient Protection and Affordable Care Act (Affordable Care Act), 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.

* * * * *

■ 29. Section 146.111 is amended by:

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

■ B. Revising the heading to paragraph (a).

■ C. Removing paragraph (a)(1) introductory text, and redesignating paragraphs (a)(1)(i) and (a)(1)(ii) as paragraphs (a)(1) and (a)(2).
■ D. Amending 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.
■ E. Revising paragraph (b).

The revisions read as follows:

§ 146.111 Prohibition of preexisting condition exclusion period.

(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).

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 for rules prohibiting the imposition of a preexisting condition exclusion.

■ 30. 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.

■ 31. 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 amendments made under this section apply beginning December 31, 2014.

■ 32. Section 146.117 is amended by removing paragraph (a)(3)(i)(E) and revising paragraph (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.

* * * * *

■ 33. 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.

■ 34. Section 146.121 is amended by:
■ A. Removing paragraph (b)(3) and revising paragraphs (b)(1)(i) and (b)(2)(i)(B).
■ B. Revising Example 1, paragraph (i) of Example 2, paragraph (ii) of Example 4, and paragraph (ii) of Example 5, and removing Example 8 in paragraph (b)(2)(i)(D).

■ C. Revising Example 2, and paragraph (i) of Example 5, in paragraph (d)(4).
■ D. Revising paragraph (ii) of Example 2 in paragraph (e)(2)(i)(B).
■ E. 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, if TMJ coverage is an essential health benefit. 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 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).

* * * * *

■ 35. 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.

* * * * *

■ 36. Amend § 146.145 by revising paragraph (b) to read as follows:

§ 146.145 Special rules relating to group health plans.

* * * * *

(b) *General exception for certain small group health plans.* The requirements of this part, other than § 146.130 and the provisions with respect to genetic nondiscrimination (found in § 146.121(b), § 146.121(c), § 146.121(e), § 146.122(b), § 146.122(c), § 146.122(d), and § 146.122(e)) do not apply to any group health plan (and group health insurance coverage) for any plan year, if on the first day of the plan year, the plan has fewer than two participants who are current employees.

* * * * *

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

■ 37. 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.

■ 38. 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 employee 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, a plan or issuer in that case will not be considered to have violated this paragraph (a) solely because employees (or other classes of participants) may 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 employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent 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) 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 or achieving job-related licensure requirements specified in the plan's terms). 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 employee or class of employees (including, for example, part-time employees). Instead, this section prohibits requiring otherwise eligible participants and beneficiaries to wait more than 90 days before coverage is effective. (While a substantive eligibility condition that denies coverage to employees may be permissible under this section, a failure by an applicable large employer (as defined in section 4980H of the Code) to offer coverage to a full-time employee might, for example, nonetheless give rise to an assessable payment under section 4980H and its implementing regulations.)

(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 day 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) *Counting days.* Under this section, all calendar days are counted beginning on the enrollment date (as defined in § 144.103 of this subchapter), including weekends and holidays. If, in the case of a plan or issuer imposing a 90-day waiting period, the 91st day is a weekend or holiday, the plan or issuer may choose to permit coverage to become effective earlier than the 91st

day, for administrative convenience. Similarly, plans and issuers that do not want to start coverage in the middle of a month (or pay period) may choose to permit coverage to become effective earlier than the 91st day, for administrative convenience. For example, a plan may impose a waiting period of 60 days plus a fraction of a month (or pay period) until the first day of the next month (or pay period). However, a plan or issuer that extends the effective date of coverage beyond the 91st day fails to comply with the 90-day waiting period limitation.

(e) *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 in 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 in 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 *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. 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. 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 *W*'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. Coverage is made effective 7 days later, which is the first day of the next pay period.

(ii) *Conclusion.* In this *Example 6,* under the terms of *W*'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 is dependent 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 *Y*'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 *Y* 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 the period of time is no longer than 12 months and begins on a date between the employee's start date and the first day of the next calendar month, provided 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 provided that, 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 *Z* on January 6 and is considered a part-time employee for purposes of *Z*'s group health plan. *Z* 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.)

(f) *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 employer's 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.

(g) *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 Affordable Care Act). *See e.g.,* § 146.121 of this subchapter, 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.

(h) *Applicability date*—(1) *In general.* The provisions of this section apply for plan years beginning on or after January 1, 2014. *See* § 147.140 providing that the prohibition on waiting periods exceeding 90 days applies to all group health plans and health insurance issuers, including grandfathered health plans.

(2) *Application to individuals in a waiting period prior to the applicability date*—(i) With respect to individuals who are in a waiting period for coverage

before the applicability date of this section, beginning on the first day the section applies, the waiting period can no longer apply to the individual if it would exceed 90 days with respect to the individual.

(ii) This paragraph (h)(2) is illustrated by the following example:

Example. (i) *Facts.* A group health plan is a calendar year plan. Prior to January 1, 2014, the plan provides that full-time employees are eligible for coverage after a 6-month waiting period. Employee *A* begins work as a full-time employee on October 1, 2013.

(ii) *Conclusion.* In this *Example 1,* the first day of A's waiting period is October 1, 2013 because that is the first day *A* is otherwise eligible to enroll under the plan's substantive eligibility provisions, but for the waiting period. Beginning January 1, 2014, the plan may not apply a waiting period that exceeds 90 days. Accordingly, *A* must be given the opportunity to elect coverage that begins no later than January 1, 2014 (which is 93 days after *A's* start date) because otherwise, on January 1, 2014, the plan would be applying a waiting period that exceeds 90 days. The plan is not required to make coverage effective before January 1, 2014 under the rules of this section.

■ 39. Section 147.136 is amended by adding a sentence to the end of the introductory text of paragraph (d) and revising paragraph (d)(1)(i) to read as follows:

§ 147.136 Internal claims and appeals and external review processes.

* * * * *

(d) * * * A Multi State Plan or MSP, as defined by 45 CFR 800.20, must provide an effective Federal external review process in accordance with this paragraph (d).

(1) * * *

(i) *In general.* Subject to the suspension provision in paragraph (d)(1)(ii) of this section and except to the extent provided otherwise by the Secretary in guidance, the Federal external review process established pursuant to this paragraph (d) applies, at a minimum, to any adverse benefit determination or final adverse benefit determination (as defined in paragraphs (a)(2)(i) and (a)(2)(v) of this section), except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for the Federal external review process under this paragraph (d).

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[Docket No. 120815345–3223–01]

RIN 0648–BC41

Snapper-Grouper Fishery off the Southern Atlantic States; Snapper-Grouper Management Measures

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS proposes regulations to implement a regulatory amendment (Regulatory Amendment 13) to the Fishery Management Plan for the Snapper-Grouper Fishery of the South Atlantic Region (FMP), as prepared by the South Atlantic Fishery Management Council (Council). If implemented, this rule would revise the annual catch limits (ACLs) (including sector ACLs) for 37 species in the snapper-grouper fishery management unit (FMU). The intent of this rule is to ensure that the ACLs are based on the best scientific information available, and to prevent unnecessary negative socio-economic impacts to participants in the snapper-grouper fishery and fishing community that could occur if the ACLs are not revised, in accordance with the provisions set forth in the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act).

DATES: Written comments must be received on or before April 22, 2013.

ADDRESSES: You may submit comments on this document, identified by ''NOAA–NMFS–2012–0245'', by any of the following methods:

- *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2012-0245,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.
- *Mail:* Submit written comments to Nikhil Mehta, Southeast Regional Office, NMFS, 263 13th Avenue South, St. Petersburg, FL 33701.

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, or Adobe PDF file formats only.

Electronic copies of documents supporting this proposed rule including an environmental assessment, initial regulatory flexibility analysis (IRFA), regulatory impact review, and fishery impact statement may be obtained from the Southeast Regional Office Web site at *http://sero.nmfs.noaa.gov/sf/SASnapperGrouperHomepage.htm.*

FOR FURTHER INFORMATION CONTACT: Nikhil Mehta, telephone: 727–824–5305, or email: *Nikhil.Mehta@noaa.gov.*

SUPPLEMENTARY INFORMATION: The snapper-grouper fishery of the South Atlantic is managed under the FMP and includes the 37 snapper-grouper species addressed in Regulatory Amendment 13 and this proposed rule. These 37 snapper-grouper species do not have stock assessments; their acceptable biological catch estimates (ABCs) are greater than zero; and their ABCs were specified using a formula established in the Comprehensive ACL Amendment. Species in the FMU with stock assessments and species with an ABC equal to zero are not addressed in Regulatory Amendment 13. However, they will be considered in future amendments. The FMP was prepared by the Council and implemented through regulations at 50 CFR parts 622 under the authority of the Magnuson-Stevens Act.

Background

The Magnuson-Stevens Act requires NMFS and regional fishery management councils to prevent overfishing of federally managed fish stocks, to the extent practicable. This mandate is intended to ensure that fishery resources are managed for the greatest overall benefit to the nation, particularly with respect to providing food production and recreational opportunities, and protecting marine ecosystems. National Standard 2 of the Magnuson-Stevens Act states that the conservation and management measures of fishery management plans and any regulations promulgated to implement any such plan shall be based upon the best scientific information available.