

opposed to this implementation notice. In the interim, a unit under HAP contract must be re-inspected at least biennially, through either the regular inspection process or the alternative inspection method.

### C. Extremely Low-Income

Section 238 of the 2014 Appropriations Act amends section 3 of the 1937 Act (42 U.S.C. 1437a) to add a definition of extremely low-income (ELI) families. ELI families are defined as very low-income families whose incomes do not exceed the higher of the Federal poverty level or 30 percent of Area Median Income. This provision affects the ELI targeting requirements in section 16 of the 1937 Act (42 U.S.C. 1437n) for the public housing, housing choice voucher (HCV), project-based voucher (PBV), and multifamily project-based section 8 programs. As of the effective date of this notice, compliance with the targeting requirements under each of these programs must take into account the new definition of ELI.

Beginning with the effective date of this notice, a PHA or HUD, if HUD is the contract administrator, shall meet its targeting requirements through a combination of ELI admissions prior to the effective date (using the old definition) and ELI admissions after the effective date (using the new statutory definition). Neither a PHA nor HUD may skip over a family on the waiting list if that family meets the new definition of ELI as enacted by this section.

For the public housing program, not less than 40 percent of the units that become available per PHA fiscal year must be made available for occupancy by ELI families.

For the HCV and PBV programs, compliance with targeting requirements is determined for each of the PHA's fiscal years based on new admissions to both programs (i.e., a single, combined total). Not less than 75 percent of such admissions shall be ELI families.

For the multifamily project-based section 8 programs, the contract administrator (i.e., HUD or a PHA under an Annual Contributions Contract with HUD) must make available for occupancy by ELI families not less than 40 percent of the section 8-assisted dwelling units that become available for occupancy in any fiscal year.

The following example clarifies how a PHA administering the HCV and PBV programs would comply with this provision: A PHA with a fiscal year end of December 31 shall consider admissions to the HCV and PBV programs from January 1 up until the effective date of this notice using the old

definition; from the effective date of this notice through December 31, it shall consider admissions using the new definition. To further illustrate, assume the PHA admitted 50 families into their HCV program between January 1 and the effective date of this notice. Forty families were ELI (under the old definition), 6 families did not meet the old definition of ELI but would have met the new definition of ELI had it been implemented at the time of their admission, and 4 did not meet either definition of ELI. In terms of calculating the ELI targeting requirement for the period of the PHA fiscal year prior to implementation of the change in the ELI definition, only 40 families met the ELI definition with regard to the targeting requirement (not 46). Assume the PHA admitted another 50 families before the end of the PHA fiscal year and 45 of those families met the new definition of ELI. The total number of families that met the ELI requirement for the PHA fiscal year would be 85 (40 plus 45), or 85 percent.

In some communities, the extremely low-income and very low-income levels will be identical for some or all household sizes, in which case PHAs meet their ELI targeting requirements by serving VLI households, since those families meet the new definition of ELI. To reduce the work a PHA or contract administrator must do to determine which standard it should be using, HUD's Office of Policy Development and Research has calculated the new income limits for extremely low-income families, taking the previous sentence into account, and has made the new area income limits available online at <http://www.huduser.org/portal/datasets/il/il14/index.html>.

### D. Utility Allowances

Section 242 of the 2014 Appropriations Act limits the utility allowance payment for tenant-based vouchers to the family unit size for which the voucher is issued, irrespective of the size of the unit rented by the family, with an exemption for families with a person with disabilities.

Under section 242, the utility allowance for a family shall be the lower of: (1) The utility allowance amount for the family unit size; or (2) the utility allowance amount for the unit size of the unit rented by the family. However, upon the request of a family that includes a person with disabilities, the PHA must approve a utility allowance higher than the applicable amount if such a higher utility allowance is needed as a reasonable accommodation in accordance with HUD's regulations in 24 CFR part 8 to make the program

accessible to and usable by the family member with a disability. This provision applies only to vouchers issued after the effective date of this notice and to current program participants. For current program participants, a PHA must implement the new allowance at the family's next annual reexamination, provided that the PHA is able to provide a family with at least 60 days' notice prior to the reexamination.

Dated: June 12, 2014.

**Carol J. Galante,**

*Assistant Secretary for Housing—Federal Housing Commissioner.*

**Milan Ozdinec,**

*Deputy Assistant Secretary for the Office of Public Housing and Voucher Program.*

[FR Doc. 2014-14915 Filed 6-24-14; 8:45 am]

**BILLING CODE 4210-67-P**

## DEPARTMENT OF THE TREASURY

### Internal Revenue Service

#### 26 CFR Part 54

[TD 9671]

RIN 1545-BL97

## DEPARTMENT OF LABOR

### Employee Benefits Security Administration

#### 29 CFR Part 2590

RIN 1210-AB61

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### 45 CFR Part 147

[CMS-9952-F2]

RIN 0938-AR77

### Ninety-Day Waiting Period Limitation

**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:** Final rules.

**SUMMARY:** These final regulations clarify the maximum allowed length of any reasonable and bona fide employment-based orientation period, consistent with the 90-day waiting period limitation set forth in 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.

**DATES:** *Effective date.* These final regulations are effective on August 25, 2014.

*Applicability date.* These final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

**FOR FURTHER INFORMATION CONTACT:**

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

*Customer service information:* Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's Web site ([www.dol.gov/ebsa](http://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/](http://www.cciio.cms.gov/)) and information on health reform can be found at [www.HealthCare.gov](http://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.<sup>1</sup> 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 (HHS), and the Treasury (the Departments<sup>2</sup>) 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.<sup>3</sup> PHS Act section 2708 does not require an employer to offer coverage to any particular individual or class of individuals, including part-time employees. PHS Act section 2708 prevents an otherwise eligible individual from being required to wait more than 90 days before coverage becomes effective. PHS Act section 2708 applies to both grandfathered and non-grandfathered group health plans and group health insurance coverage for plan years beginning on or after January 1, 2014.

On February 9, 2012, the Departments issued guidance<sup>4</sup> outlining various approaches under consideration with respect to both the 90-day waiting period limitation and the employer shared responsibility provisions under Code section 4980H (February 2012 guidance) and requested public comment. On August 31, 2012,

<sup>2</sup> Note, however, that in the Economic Analysis and Paperwork Burden section of this preamble, in sections under headings listing only two of the three Departments, the term "Departments" generally refers only to the two Departments listed in the heading.

<sup>3</sup> 26 CFR 54.9801-3(a)(3)(iii), 29 CFR 2590.701-3(a)(3)(iii), and 45 CFR 146.111(a)(3)(iii).

<sup>4</sup> Department of Labor Technical Release 2012-01, IRS Notice 2012-17, and HHS FAQs issued February 9, 2012.

following their review of the comments on the February 2012 guidance, the Departments provided temporary guidance,<sup>5</sup> 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 future rulemaking (August 2012 guidance). After consideration of all of the comments received in response to the February 2012 guidance and August 2012 guidance, the Departments issued proposed regulations on March 21, 2013 (78 FR 17313). After consideration of comments on the proposed regulations, the Departments published final regulations on February 24, 2014 (79 FR 10295).

Under the final regulations, a group health plan and a health insurance issuer offering group health insurance coverage may not apply any waiting period that exceeds 90 days. The regulations define "waiting period" as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. Being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period).

Contemporaneous with the publication of the final regulations, the Departments published proposed regulations (79 FR 10319) to address orientation periods under the 90-day waiting period limitation of PHS Act section 2708 and solicit comment before promulgation of final regulations on this specific issue. The proposed regulations provided that one month would be the maximum allowed length of any reasonable and bona fide employment-based orientation period. The Departments stated that, during an orientation period, they envisioned that an employer and employee could evaluate whether the employment situation was satisfactory for each party, and standard orientation and training processes would begin. Under the proposed regulations, if a group health plan conditions eligibility on an employee's having completed a reasonable and bona fide employment-based orientation period, the eligibility condition would not be considered to be

<sup>5</sup> Department of Labor Technical Release 2012-02, IRS Notice 2012-59, and HHS FAQs issued August 31, 2012.

<sup>1</sup> 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.

designed to avoid compliance with the 90-day waiting period limitation if the orientation period did not exceed one month and the maximum 90-day waiting period would begin on the first day after the orientation period.

Many commenters were generally supportive of the proposed rule. Commenters agreed that a limitation on the length of an orientation period of one month was appropriate and also agreed with the proposal that determining whether an orientation period is “reasonable” and “bona fide” should be a facts and circumstances analysis. Some commenters urged the Departments to clarify the interplay between the 90-day waiting period provision and the employer shared responsibility provisions.

After consideration of the comments and feedback received from stakeholders, the Departments are publishing these final regulations that incorporate the proposed regulations without any substantive changes.

## II. Overview of the Final Regulations

The final regulations implementing PHS Act section 2708 set forth rules governing the relationship between a plan’s eligibility criteria and the 90-day waiting period limitation. Specifically, the final regulations provide that being otherwise eligible to enroll in a plan means having met the plan’s substantive eligibility conditions (for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan’s terms, or satisfying a reasonable and bona fide employment-based orientation period). Under the final regulations, after an individual is determined to be otherwise eligible for coverage under the terms of the plan, any waiting period may not extend beyond 90 days, and all calendar days are counted beginning on the enrollment date, including weekends and holidays.<sup>6</sup>

Orientation periods are commonplace and the Departments do not intend to call into question the reasonableness of short, bona fide orientation periods. The danger of abuse increases, however, as the length of the period expands. Accordingly, the final regulations provide that one month is the maximum allowed length of an employment-based orientation period. The creation of a clear maximum prevents abuse and facilitates compliance.

During an orientation period, the Departments envision that an employer

and employee will evaluate whether the employment situation is satisfactory for each party, and standard orientation and training processes will begin. For any period longer than one month that precedes a waiting period, the Departments refer back to the general rule, which provides that the 90-day period begins after an individual is otherwise eligible to enroll under the terms of a group health plan. While a plan may impose substantive eligibility criteria, such as requiring the worker to fit within an eligible job classification or to achieve job-related licensure requirements, it may not impose conditions that are mere subterfuges for the passage of time.

Under these final regulations, one month would be determined by adding one calendar month and subtracting one calendar day, measured from an employee’s start date in a position that is otherwise eligible for coverage. For example, if an employee’s start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee’s start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee’s start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee’s start date is August 31, the last permitted day of the orientation period is September 30. If a group health plan conditions eligibility on an employee’s having completed a reasonable and bona fide employment-based orientation period, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the orientation period does not exceed one month and the maximum 90-day waiting period begins on the first day after the orientation period.

Compliance with these final regulations is not determinative of compliance with section 4980H of the Code, under which an applicable large employer may be subject to an assessable payment if it fails to offer affordable minimum value coverage to certain newly-hired full-time employees by the first day of the fourth full calendar month of employment. For example, an applicable large employer that has a one-month orientation period may comply with both PHS Act section 2708 and Code section 4980H by

offering coverage no later than the first day of the fourth full calendar month of employment. However, an applicable large employer plan may not be able to impose the full one-month orientation period and the full 90-day waiting period without potentially becoming subject to an assessable payment under Code section 4980H. For example, if an employee is hired as a full-time employee on January 6, a plan may offer coverage May 1 and comply with both provisions. However, if the employer is an applicable large employer and starts coverage May 6, which is one month plus 90 days after date of hire, the employer may be subject to an assessable payment under Code section 4980H.

These final regulations apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2015. Until these final rules are applicable, as stated in the preamble to the proposed rules, the Departments will consider compliance with the proposed regulations to constitute compliance with PHS Act section 2708. See 79 FR 10320, 10321 (February 24, 2014).

## 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)

<sup>6</sup> The final regulations also note that a plan or issuer that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

These final regulations are not economically significant within the meaning of section 3(f)(1) of the Executive Order. However, OMB has determined that the actions are significant within the meaning of section 3(f)(4) of the Executive Order. Therefore, OMB has reviewed these final regulations, and the Departments<sup>7</sup> have provided the following assessment of their impact.

#### 1. Summary

As stated earlier in this preamble, these final regulations provide that one month is the maximum allowed length of any reasonable and bona fide employment-based orientation period. The final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

The Departments have crafted these final regulations to secure the protections intended by Congress in an economically efficient manner. The Departments lack sufficient data to quantify the regulations' economic cost or benefits. The preamble to the proposed rules implementing PHS Act section 2708, published<sup>8</sup> in the **Federal Register** on February 24, 2014 provided a qualitative discussion of economic impacts of clarifying the maximum allowed length of any reasonable and bona fide orientation period and requested detailed comment and data that would allow for quantification of the costs, benefits, and transfers associated with the term. The Departments received no comments providing additional data that would help it estimate the economic impacts of the final regulations.

#### 2. Estimated Number of Affected Entities

The Departments estimate that 4.1 million new employees receive group health insurance coverage through private sector employers and 1.0 million new employees receive group health insurance coverage through public

sector employers annually.<sup>9</sup> The 2013 Kaiser Family Foundation and Health Research and Education Trust Employer Health Benefits Annual Survey (the "2013 Kaiser Survey") finds that 30 percent of covered workers were subject to waiting periods of three months or more.<sup>10</sup> If 30 percent of new employees receiving health care coverage from their employers are subject to a waiting period of three months or more, then 1.5 million new employees (5.1 million × 0.30) would potentially be affected by these regulations.<sup>11</sup> However, it is unlikely that the survey defines the term "waiting period" in the same manner as the final regulations. For example, the term "waiting period" may have been defined by reference to an employee's start date, not matching the definition in the final regulations.

#### 3. Benefits

The final regulations implementing PHS Act section 2708<sup>12</sup> set forth rules governing the relationship between a plan's eligibility criteria and the 90-day waiting period limitation. Specifically, the final regulations provide that being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). These final regulations provide that one month is the maximum allowed length of any reasonable and bona fide employment-based orientation period. This period of no longer than one month 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 final regulations, the plan's waiting period must begin once the new employee satisfies the maximum one month orientation period requirement and the waiting period may not exceed 90 days.

<sup>9</sup> This estimate is based upon internal Department of Labor calculations derived from the 2009 Medical Expenditure Panel Survey.

<sup>10</sup> See e.g., Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits 2013 Annual Survey* (2013) available at <http://ehbs.kff.org/pdf/2013/8345.pdf>.

<sup>11</sup> Approximately 1.2 million private sector employees and 287,000 State and local public sector employees.

<sup>12</sup> 79 FR 10295 (February 24, 2014).

#### 4. Costs

These final regulations extend the maximum amount of time between an employee beginning work and obtaining health care coverage relative to the time before the issuance of the final regulations implementing PHS Act section 2708 and these final regulations. If employees delay health care treatment until the expiration of the orientation period and waiting period, detrimental health effects could result, especially for low-wage employees and their dependents and those requiring higher levels of health care, such as those with chronic conditions. This could lead to lower work productivity and missed school days. However, the Departments anticipate that such effects may be limited because few employees are likely to be affected and it is anticipated that the inclusion of an orientation period will not result in most employees facing a full additional month between being hired and obtaining coverage.

#### 5. Transfers

The possible transfers associated with these final regulations would arise when employers begin to pay their portion of premiums or contributions later than they did before the issuance of these final regulations. Recipients of the transfer would be employers who implement an orientation period in addition to the 90-day waiting period, thus delaying having to pay premiums. The source of the transfers would be covered employees who, after these final regulations become applicable, would have to wait longer between being employed and obtaining health coverage. During this period, affected employees might obtain an individual health insurance policy, purchase COBRA continuation coverage, or forgo health coverage—which could, depending on the policy, have higher out-of-pocket costs for their healthcare expenditures.

The Departments expect these transfers to be minimal because under these final regulations, only a small number of employers would further effectively extend start date for coverage to their employees. That is because a relatively small fraction of workers have waiting periods that exceed three months; this rule does not create an incentive that is not in the system already.

#### *B. 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

<sup>7</sup> In section III of this preamble, some subsections have a heading listing one or two of the three Departments. In those subsections, the term "Departments" generally refers only to the Departments listed in the heading.

<sup>8</sup> 79 FR 10321.

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

The Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. The Departments lack data to focus only on the impacts on small business. However, the Departments believe that by providing small businesses with flexibility to design reasonable and bona fide employment-based orientation periods, consistent with the 90-day waiting period limitation set forth in PHS Act section 2708, the final regulations reduce the burden on such businesses to comply with the provision. Based on the foregoing, the Departments hereby certify that these final regulations will not have a significant economic impact on a substantial number of small entities.

#### *C. Special Analyses—Department of the Treasury*

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

Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to Code section 7805(f), the proposed rule was submitted to the Small Business Administration for comment on its impact on small business.

#### *D. Paperwork Reduction Act*

This final rule is not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. 3501 et seq.), because it does not contain a collection of information as defined in 44 U.S.C. 3502(3).

#### *E. Congressional Review Act*

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

#### *F. Unfunded Mandates Reform Act*

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

#### *G. Federalism Statement—Department of Labor and Department of Health and Human Services*

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

In the Departments' view, these final regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. In general, through section 514, ERISA supersedes

State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be “construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the “narrowest” preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.)

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more 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 final 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 final regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

#### IV. Statutory Authority

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

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public 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 adopted 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 147

Health care, Health insurance, Reporting and recordkeeping

requirements, and State regulation of health insurance.

#### John Dalrymple,

*Deputy Commissioner for Services and Enforcement, Internal Revenue Service.*

Approved: June 18, 2014.

#### Mark J. Mazur,

*Assistant Secretary of the Treasury (Tax Policy).*

Signed this 18th day of June, 2014.

#### Phyllis C. Borzi,

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

Dated: June 19, 2014.

#### Marilyn Tavenner,

*Administrator, Centers for Medicare & Medicaid Services.*

Dated: June 19, 2014.

#### Sylvia Burwell,

*Secretary, Department of Health and Human Services.*

#### Department of the Treasury

#### Internal Revenue Service

#### 26 CFR Chapter I

Accordingly, 26 CFR part 54 is amended as follows:

#### PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for Part 54 continues 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 54.9815–2708 is amended by adding paragraph (c)(3)(iii) and a new Example 11 in paragraph (f) to read as follows:

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

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(iii) *Limitation on orientation periods.*

To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month. For this purpose, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee's start date in an otherwise eligible

position is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

\* \* \* \* \*

(f) \* \* \*

*Example 11.* (i) *Facts.* Employee *H* begins working full time for Employer *Z* on October 16. *Z* sponsors a group health plan, under which full time employees are eligible for coverage after they have successfully completed a bona fide one-month orientation period. *H* completes the orientation period on November 15.

(ii) *Conclusion.* In this *Example 11*, the orientation period is not considered a subterfuge for the passage of time and is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, plan coverage for *H* must begin no later than February 14, which is the 91st day after *H* completes the orientation period. (If the orientation period was longer than one month, it would be considered to be a subterfuge for the passage of time and designed to avoid compliance with the 90-day waiting period limitation. Accordingly it would violate the rules of this section.)

\* \* \* \* \*

#### Department of Labor

*Employee Benefits Security Administration*

#### 29 CFR Chapter XXV

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

#### PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ **3.** 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).

■ **4.** Section 2590.715–2708 is amended by adding paragraph (c)(3)(iii) and a

new Example 11 in paragraph (f) to read as follows:

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

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(iii) Limitation on orientation periods. To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month. For this purpose, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee's start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

\* \* \* \* \*

(f) \* \* \*

Example 11. (i) Facts. Employee H begins working full time for Employer Z on October 16. Z sponsors a group health plan, under which full time employees are eligible for coverage after they have successfully completed a bona fide one-month orientation period. H completes the orientation period on November 15.

(ii) Conclusion. In this Example 11, the orientation period is not considered a subterfuge for the passage of time and is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, plan coverage for H must begin no later than February 14, which is the 91st day after H completes the orientation period. (If the orientation period was longer than one month, it would be considered to be a subterfuge for the passage of time and designed to avoid compliance with the 90-day waiting period limitation. Accordingly it would violate the rules of this section.)

\* \* \* \* \*

Department of Health and Human Services

45 CFR Subtitle A

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

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

■ 5. 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).

■ 6. Section 147.116 is amended by adding paragraph (c)(3)(iii) and a new Example 11 in paragraph (f) to read as follows:

§ 147.116 Prohibition on waiting periods that exceed 90 days.

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(iii) Limitation on orientation periods. To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month. For this purpose, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee's start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

\* \* \* \* \*

(f) \* \* \*

Example 11. (i) Facts. Employee H begins working full time for Employer Z on October 16. Z sponsors a group health plan, under which full time employees are eligible for coverage after they have successfully

completed a bona fide one-month orientation period. H completes the orientation period on November 15.

(ii) Conclusion. In this Example 11, the orientation period is not considered a subterfuge for the passage of time and is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, plan coverage for H must begin no later than February 14, which is the 91st day after H completes the orientation period. (If the orientation period was longer than one month, it would be considered to be a subterfuge for the passage of time and designed to avoid compliance with the 90-day waiting period limitation. Accordingly it would violate the rules of this section.)

\* \* \* \* \*

[FR Doc. 2014-14795 Filed 6-20-14; 4:15 pm]

BILLING CODE 4830-01-P; 4510-29-P; 4120-01-P; 6325-64-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket Number USCG-2014-0073]

RIN 1625-AA08

Special Local Regulation; Annual Swim Around Key West, Atlantic Ocean and Gulf of Mexico; Key West, FL

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a special local regulation on the waters of the Atlantic Ocean and the Gulf of Mexico surrounding the island of Key West, Florida during the Annual Swim around Key West on June 28, 2014. The event entails a large number of participants who will begin at Smather's Beach and swim one full circle clockwise around the island of Key West, Florida. The special local regulation is necessary to provide for the safety of the spectators, participants, participating support vessels and kayaks, and other vessels and users of the waterway during the event. The special local regulation will consist of a moving area that will temporarily restrict vessel traffic in a portion of both the Atlantic Ocean and the Gulf of Mexico, and will prevent non-participant vessels from entering, transiting through, anchoring in, or remaining within the area unless authorized by the Captain of the Port Key West or a designated representative.

DATES: This rule is effective and will be enforced from 7:30 a.m. until 3:30 p.m. on June 28, 2014.