

Practice Tips

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Adjudicator of Last Resort. Consider amending the plan document is the adjudicator of last resort both as to recordkeeping and claims determinations. Where (a) the plan supervisor is capable of such determinations, (b) the employer is comfortable with such transfer of fiduciary duties, (c) the employer wishes to be totally *insulated* from the claims decisions, and (d) the employer and plan supervisor both wish the maximum protection of the plan decisions being not reviewed *de novo*, this amendment will likely be a wise move.

Allied Services. The plan supervisor should normally attempt to provide these services by means of one-stop shopping for the medium/small employers:

- Recordkeeping including COBRA
- Claims administration
- Consulting and risk management.
- Managed care (rental PPO, e.g.) and utilization review
- Arranging of stop-loss.

Avoiding FAS 106 Actuarial Computation. In the instance where the plan provides retiree-paid medical benefits from, say, the earlier of age 60 or 30 years of service to the earlier of age 65 or acquisition of a Medicare card, a FAS 106 actuarial computation is normally required. Such computation may be avoided by amending the plan so as to fund such benefit as an extension of the COBRA continuation benefit. The effect of the plan amendment is to make the benefit a *post-termination* benefit and not a *post-retirement* benefit. By force of COBRA statute, a COBRA continuation benefit is not subject to FAS 112 (applicable to post-termination benefits such as disability and severance).

Avoiding Plan Assets. Plan assets may be inadvertently created either by participant contributions or by the conduit computer trust account.

- **Participant Contributions**

By shifting the payment burden of participant contributions to the employer by means of the premium option plan, such participant contributions are eliminated, thereby eliminating any plan assets. Where a premium option plan is not used, participant contributions may be used to pay claims or stop-loss premiums or both. Where used to pay claims only, no plan assets are created. Where used to pay claims and stop-loss premiums, such stop-loss contract becomes a plan asset; with the stop-loss becoming a plan asset, commissions thereon must be reported to the plan supervisor. However, such plan assets are not subject to audit because they are insurance contracts with special exemption.

- **Conduit Computer Trust Account**
Where the computer trust account is subdivided into individual employer sub accounts, such account balances are not plan assets, but are merely extensions of employer funds. A computer trust account may commingle employer contributions therein without creating a plan asset only if the trust agreement contains several critical provisions; (a) employer's contributions totally and forever expunge any further employer obligation on account of such contributions; (b) fraud, errors, bank charges, etc, are the responsibility of the trustees; (c) checks uncashed escheat to the state after the 5 or 7 years so required. With any other arrangement, plan assets are created.

Booklet/Document Efficiencies. Let the plan document text be as detailed as needed; let the booklet text be as brief as possible (no definitions, e.g.); let a single Schedule of Benefits be congruent to and *drive* both documents. Further, make the plan supervisor-provided administration guide claims guide and

privacy guide (or parts thereof) part of the plan

document by exhibit. Also, use the 8-1/2" x 11" booklet. To the greatest extent practicable, use the same booklet/document text for all plans, making plan variations only in the Schedule of Benefits. Some of the advantages therefrom are these:

- Lowest possible production and maintenance costs.
- Honors the plan supervisor's administration by making the terms thereof part of the plan document; such terms must also be honored by the stop-loss carrier as well as employer.
- Administrative consistency by having a common booklet/document text.
- Standard 8-1/2 x 11" booklet size is more workable by all parties to the plan than the smaller size.
- Conforms with both the letter and spirit of ERISA and the relevant Department of Labor Regulations in that the booklet is a summary and not a *clone* of the documents.
- Maximizes safety in that while the texts are different, the Schedule of Benefits is the same for both documents.

COBRA Administration. To be as safe as possible and to keep the administrative costs as low as possible, these are the things to do:

- The initial notification is the booklet; the dependent spouse should also get a booklet. The qualifying event notification and election is done by the employer as a personnel (and not a plan) function.
- Use coupons, not monthly billings.
- Be disciplined and consistent in all administrative matters, using first class mail all of the time.

Commission Disclosure. Only where stop-loss is a plan asset and the plan is in excess of 100 lives is commission disclosure required. Stop-loss is a plan asset where any portion thereof is paid (a) by a participant contribution in

supervisors routinely disclose such commissions in *all* instances to be on the *safe side*. While perhaps laudable the fact remains that such disclosure is added work, to be done annually, which in the majority of the instances is needless. The safest way for the general asset plan to be sure that the stop-loss is not a plan asset is to adopt a premium option plan. This technique for the majority of users, will eliminate participant contributions, thereby making the disclosure unneeded.

Complaints to the Insurance Department.

When the self-funded plan finds that a complaint has gone to the insurance department, it may either (a) respond reluctantly or not at all, citing lack of jurisdiction, or (b) respond eagerly believing that the dialogue available through the Insurance Commissioner's offices will usually be a blessing and not a bane to the plan. The wise plan supervisor will choose (b). The proper way to view the process is that a free forum to get the positions surfaced, reviewed, and understood is much preferred over having to deal from the outset with a trial lawyer.

Confirmations. Because such process is not legally plan-related, always follow up with a written confirmation or use a *black* box recorder to recall what was told the providers or participants.

Describing Self-Funding. The so-called *coffee napkin* explanation is this: a self-funded plan is an *owned* plan (as you own your home), while a fully insured plan is a *rented* plan (as you rent your apartment). You know each month what your rent is (insured plan premium) but your home ownership costs are variable. For the self-funded plan, these variable costs are paid claims. To protect the homeowner in the event of pipes breaking or the roof falling in, coverage (called stop-loss) is purchased; also, to keep the family budget on track, a line of credit (stop-loss specific and aggregate advances) is arranged.

To not burden the homeowners with

a general asset plan or (b) by a trust fund asset where the plan is trustee. Many plan to go to a home for financial reasons, but they remain in the home for personal or emotional reasons (control of the property, e.g.). Most, but not all people, favor home ownership. Except for the occasional year when the pipes break, the homeowner saves money; over the long pull the savings are significant. With changing lifestyles (managed care, e.g.), the homeowners, more than the renters, are able to keep up.

Discrimination. In dealing with discrimination in plan matters, three groups must be considered:

- Protected group (age, sex, race, etc.)
- Prohibited group (owners, highly paid, etc.)
- Non-employees.

Protected Group. The plan may discriminate in favor of the protected group without consequence. The plan may not discriminate against the protected group; if it does, the ELOC may bring legal action under federal civil rights statutes.

Prohibited Group. The plan may discriminate against the prohibited group without consequence. The plan may discriminate in favor of the protected group, but with tax consequences (IRS Form 1099 income to the highly paid person, e.g.).

Non-Employees. The Department of Labor would doubtless let a few non-employees on the plan as a matter of contract, without such action spoiling the ERISA status of the plan as one of employee benefits. If excessive, the ERISA status of the plan is threatened as an ERISA matter as determined by the Department of Labor.

Do-It-Yourself Precert/Recert. What the plan supervisor does is (a) redefine the purpose and scope of the precert-recert and then (b) carve out such function the other utilization review functions (case management, e.g.) so as to provide such precert-recert directly as a plan supervisor function.

maintenance duties, a cleaning-yard-pool service is hired (TPA). Most people leave the apartment on an adversarial basis with the providers, but rather as budgeters/schedulers. That is, the role of the precertifier is to be aggressive enough to gain from the *sentinel* effect but not so aggressive as to perform a utilization review function as contemplated by the legal definitions of utilization review.

Redefined Function. The plan supervisor's obligation in providing the precert-recert functions should be clearly set forth in the plan supervisor's agreement with the fees therefore shown in the annual costs for such services. That is, the precert-recert is merely an additional administrative function provided by the plan supervisor.

Other utilization review functions (case management, hospital audits, etc.) continue to be outsourced.

Advantages of this method are as follows:

- It is consistent with one-stop service; outsourced services to a health care plan carry potential liabilities for the plan supervisor.
- Professional precertifiers sometimes alienate the clients and participants. In addition, they may occasionally precertify non-covered slays, thereby exposing plans to potential losses.
- Risk pool management by the plan supervisor is helped by knowing in advance who is to be admitted to the hospital as well as knowing those already in a hospital.
- Precertification can be profitable even with a small fee.
- By being budgeters or schedulers only, the worry of liability is eliminated; i.e., the function is not utilization review, in the legal meaning.

Due Diligence of Stop-Loss Carrier. While stop-loss carrier should be diligent in dealing only with *qualified* plan supervisors, the reverse is also true. A plan supervisor-

Redefined Precert-Recert. This is done by going through the essential steps of precert-recert (toll-free calls, LOS/PAS books, etc.), not

statement, (b) how aggregate audits are handled, (c) recognition will plan supervisor get for being an underwriter as well as a broker, and (d) what plan amendments (waiver of waiting period, e.g.) that may be approved by the plan supervisor, are examples of issues to be settled before business is placed with such carrier.

Enrolling Made Simple. When the sale is made and the signatures are obtained, the TPA should bring back to its office either the plan's most recent billing (or members' list) or the employer's old enrollment applications. The TPA then transcribes such information onto its own enrollment forms as though such had been submitted by the applicants. Using such enrollments forms, an initial billing and members' list is prepared. This gets the plan started. The forms are reproduced and the originals sent to the employer for updating/correction/signatures by the applicants.

Executive Benefit Plans. IRC §105(h) provides that discriminatory benefits from self-funded health care plans must result in tax consequences to such *top hats*. To gain nearly the same results without the *tax consequence* burden, the plan may offer a *high* and a low benefit plan to all participants. Where most (not all) of the *top hats* take the rich plan, and where all of the rank and file may select such rich plan, there is likely no resultant discrimination.

Getting Along with Providers. Treat provider-assignees as beneficiaries of the plan equal in importance with the employer and participants. By so honoring them, the relationships are both clarified and simplified.

Harmony with Stop-Loss Carrier. These simple steps will help the relationship go smoothly:

- Avoid instances where the stop-loss carrier is remote from the risk. An

prepared questionnaire to be completed by the stop-loss carrier is recommended. Many issues such as (a) interpretation of disclosure

- Make the employer-TPA administrative rules an Exhibit to the plan document and thereby apart of the stop-loss agreement.
- Avoid stop-loss with conditions/provisions/exclusions which are, or might be, contrary to the plan document.
- Establish what the stop-loss carrier's retrocession agreements are.
- Avoid potential recordkeeping problems with the medical and the stop-loss required life insurance.
- Establish a written understanding as to (a) precise rules governing disclosure; (b) whether refunds will be pro rata or last out-first in; (c) how aggregate audits are conducted (e.g., Is an outside firm hired with bonuses for recoveries provided); (d) will specific claims be withheld if stop-loss premiums are not current; (e) is 30-day claim currency rule enforced; (f) will specific advances be routinely made; (g) is lasing required or only offered; (h) will TPA be able to do its own late applicant underwriting; and (i) are waivers of probationary periods routinely approved if supported by a plan amendment.
- Is a stop-loss carrier-provided due diligence statement on file?
- What support with managed care is available (e.g., hospital audits, large case management)?
- Be certain the TPA is clear as to what determines *disability* for covered dependents.

Improving Claims Processing Efficiency.

- Keep all files literally within arm's length of examiner.
- Slave computer for dental-only.
- Require a periodic field/client visit by the

intermediary with no assumption of risk or no financial involvement, or a stop-loss carrier acting as a frontier only, are two examples.

loss carrier demands that the group life be as a condition of the placing of stop-loss, there is no choice but to slave the stop-loss and group life. However, where such life insurance is not required by the stop-loss carrier but is to be part of the plan, the plan supervisor may be well advised to place all such life insurance with a single insurer. The primary reasons for doing so are these:

- Better terms for such life insurance. Having the eligibility conditions for the life and medical identical by special agreement is an example. Note: because of subtleties of provisions, such congruency may not be the case. The no loss-no gain provision may give a participant a longer eligibility period for medical, but such has no applicability to the life, e.g.
- Lower overall costs because of volume discounts.
- Lower administrative costs because of not having to shop and maintain numerous life carriers as vendors.

Limited Power of Attorney. At the time of the *close*, the TPA might obtain a limited power of attorney from (the employer which would empower the TPA to execute plan-related documents (primarily stop-loss and the plan document) as well as endorse stop-loss prepared claim checks from the payee (employer) to providers. This empowerment accelerates the work flow dramatically, but will work only where the employer and TPA operate as co-fiduciaries and not as master-minister; that is, there must be a *bond of faith* between them. If the homeowner (employer) has sufficient faith in the cleaning service (TPA), it is to both parties' advantage that the cleaning service has a key to the house.

The purposes of this power of attorney are

examiner.

Life Insurance As a general rule, where employers self-fund their health care plans, they wish to have the group life insurance administered as a part thereof. Where the stop- and (b) endorse stop-loss claim checks (made payable to the employer) directly over to the provider cutting down such payment delays (often important where networks are involved).

- **Psychological**

It elevates the role of the plan supervisor reflecting the *position of authority* and control *such supervisor* has over the plan. It makes the plan supervisor a co-fiduciary which is doubtless the case in most circumstances anyway.

- **Paperwork**

- Be quick, not slow, to amend. This is easier done where the plan supervisor has the power of attorney.
- Do a written and formal ERISA denial with great frequency; it never does harm and it will generally do good to be quick to formally deny. Perfecting the ERISA denial process is a smart move on the part of the plan supervisor.

Plan Supervisor as the Banker. The so-called *aggregate advance* is provided by many stop-loss carriers for a modest monthly fee. This amounts to the *outsourcing of* a banking function to the stop-loss carrier. Might such function be provided directly by the plan supervisor as part of its assumed duties? The response is yes. The advantages are primarily administrative in nature; it is easier to provide a service in-house than to provide it by outsourcing. The service also has the potential of being offered at a lower fee.

In assuming this responsibility, the plan supervisor should keep in mind that (a) the advances are generally modest, (b) the frequency of such advances are one in thirteen by Monte Carlo simulation, (c) the advances are virtually 100% secure, and (d) the arranging of a line of

these:

- Administrative

It speeds up the paperwork by permitting the plan supervisor to (a) execute plan documents and applications (not the Form 5500, however) for the employer participants. Should this frighten the plan supervisor? No, and for these reasons:

- If the plan supervisor is unable to live within the 2% margin, it will either lose the plan eventually due to poor service or otherwise fail as a plan supervisor.
- The performance agreement codifies and quantifies the fact that the plan supervisor is not perfect. Absent the agreement, the plan supervisor will be *expected* to be perfect. That is, having a 2% to go *an* is much better than having *nothing* to go *on*.
- Usually the performance agreement will come *into* play as the result of an aggregate audit. Such audit is rather rare remembering that the likelihood of an aggregate claim is in the 5-10%, range.

The following are examples of typical performance agreements:

- Municipality

- Ninety-five percent of all noninvestigated claims must be paid within 16 calendar days; if not, there is a fairly stiff financial penalty.
- Financial accuracy of 98% or better; if not, there is a penalty.

- Manufacturer

One employer demanded that a special unit of the plan supervisor handle its claims alone; regular meetings were held with the plan supervisor and the employer to discuss problems.

- One large employer paid its plan supervisor 4-6% of paid claims; the more typical cost for ASO arrangements is 7-8%.
- Some employers who are very service-sensitive put limits on the number of

credit is quite simple and usually readily available.

Performance Agreements. Consider a proposed simple performance agreement whereby the plan supervisor guarantees a 2% or better error rate for a plan of say, 200

certain percent, that the plan supervisor must increase its audits until the error rate is reduced to acceptable levels.

- The most typical turnaround time for clean claims is ten days and an accuracy rate of 98%; some are stretching for 99% accuracy.
- Some employers audit the plan supervisor on their own without the benefit of any performance agreements.

- Manufacturer

- This employer has fifty performance measures which include turnaround time, financial accuracy, clerical accuracy, and accessibility of account executives. The aim is not to acquire penalties, but to achieve quality of service. The difficulty with the penalty performance agreement is the hassle of making a settlement. Some plan supervisors do not agree to large, one-ended performance agreements.

- Model Agreement

- *Claim turnaround time.* 90% of claims not needing investigation received will be processed in 10 working days with 100% processed in 15 working days.
- *Payment accuracy.* The dollar value of overpayments and underpayments divided by total dollars audited will not exceed 2%.
- *Coding accuracy.* Claims data will be captured properly and coding errors will be limited to less than 5%.
- *Telephone response.* Service inquires will be responded to within 24 hours or one working day.

- **Relationship.**

- Honor the provider-assignee as a plan

times the plan supervisor's phone rings before it is answered – or similar service-oriented measures.

Service Firm

- One of the larger and better *letter houses* recommends that where the plan supervisor's accuracy falls below a

handled by such broker solo, and never let the broker be the agent-of-record on the stop-loss.

Role of Aggressive Broker/Rick Manager/Consultant. Presume that the plan supervisor, by agreement, has assigned duties, with discretionary powers. Further, presume that the broker/risk manager/consultant is asserting power to dominate/control. Several situations must be considered:

- Assumed Powers of Broker are Unsubstantiated

The plan supervisor may either (a) ignore and go along or (b) force the issue. To ignore and go along has the danger of setting the plan supervisor up for a miscommunication error or letting power flow to such broker so as to sour the employer-plan supervisor relationship. To force the issue is to amend the plan supervisor's agreement stating clearly the broker-plan supervisor relationship. Where the agreement is not amended, the plan supervisor should resign.

- Assumed powers are Substantial
The plan supervisor's agreement should be modified to reflect the role of the broker.

Showing Administration Fees Separately or Combined with Stop-Loss. If the plan supervisor's agreement is crafted so that the duties of the plan supervisor include the usual administrative chores (claims processing, recordkeeping, consulting, etc.) plus the providing of quality stop-loss on best terms, the plan supervisor has not only the right, but indeed the obligation, to show the fees and stop-loss premiums combined.

beneficiary along with the participant.

- Treat the State Insurance Department Consumer Complaint Department as a friend – not an adversary.
- Treat the broker with all due respect because such broker controls the business, but do not let the close be

by Department of Labor regulations.

Such slaving of fees may also be done with such items as utilization review fees, PPO access fees, etc. if the agreement is so crafted.

This *tip* only deals with how the combining is done. That the plan supervisor and the employer wish or do not wish them to be combined is another matter. There are many pros and cons to either method.

Small Claim Processing. Pick some amount (say, \$100) such that all claims under \$100 are processed instantly and without pending. That is, preexisting, questionable charges, etc. are not investigated. Obviously ineligible claims will still be denied. Keep in mind the 90-10 rule (90% of claims are due to 10% of the participants). There is a *huge* pick-up in speed and a real drop-down in work load. The errors noticeable from this practice are negligible and the response from both employer and participants should be positive, if such is ever disclosed. Note: if not disclosed and a squabble with the employer should result (rare), the plan supervisor should be prepared to pay the disputed claim out of its own funds.

There are many ways of handling the disclosure as of this claims procedure:

- No disclosure to employer; may or may not be disclosed to the stop-loss carrier.
- Disclosed to employer (a) outside the plan document, (b) in the plan document, (c) in the plan supervisor-provided administration rules (either freestanding or incorporated as part of the document by attachment).
- Disclosure to the participant is not deemed to be needed.

Subrogation. Amend the plan so as to

It is important to note that this wording in the plan supervisor's agreement must be both clear and accepted by the employer. If not, the fees and stop-loss premiums *must* be shown separately.

This slaving of the administrative fees with the stop-loss premiums so as to have a single fixed cost rather than separate fixed costs will not avoid the necessity of disclosing commissions where such is otherwise required (Agreement). Once the two documents are executed, the plan supervisor may safely release the claims knowing that the attorney, with a fiduciary obligation to the plan (its client), will tend to the plan's interests.

The attorney will not refuse the demands of the covered person which are required by the plan. If the covered person and the attorney both refuse, the plan should hold up the claims. The employer keeps its option open to relieve the covered person of this obligation; however, by so doing, the employer is free to always appoint its own attorney.

If, for any reason, the plan refuses to accept representation by the person's attorney, the chore of legally representing the plan may be assumed by any of the following:

- Employer's attorney.
- Plan supervisor (with or without an attorney)
- Subrogation recovery firm.
- Attorney independent of all the parties thereto.

Sample plan wording is as follows:

"A covered person must cooperate in every way including claims investigation, completing promptly and accurately the subrogation agreement, recovery of overpayments, furnishing information and assistance, executing and delivering necessary instruments, as may be required and not to prejudge the rights of the plan. Failure to cooperate or prejudicing a right of the plan may result in a loss of benefits. Specifically, the plan may require, as a condition to the payment of any benefits, that the covered

require that a covered, direct such person's attorney, if an, in a subrogation matter, to represent the plan and such person jointly. The attorney will not be slighted on its fees by so doing. Such attorney is paid standard fees by the plan. After the investigation and while the claims are frozen, two signatures are obtained (Subrogation Agreement and Attorney Hire

individual policies have coordination of benefit provisions because they are filed with the states as *group* plans for legal and administrative convenience (a Mississippi or Rhode Island Trust, e.g.), As such, they are subject to being made primary, usually to the surprise of the insured who bought what was believed to be a true individual policy.

Internal Revenue Audit Concerns. One of the big areas of current concern is employee *look-alikes* such as leased employees and independent contractors.

Self-Funded Plan Fraud. The national clearinghouse organization is the National Health Care Anti-Fraud Association, Washington, D.C., (202) 659-5955. Fraud is estimated to add 10% to the national cost of health care. High tech claims processing may well add to the fraud problem.

COB Problem. The handling costs of COB are inordinately high. Several solutions:

- Revise the plans to outlaw double coverage (i.e., anti-duplication provision).
- Revise the plans to where the plan, if secondary, will pay 20% of the first \$5,000 of covered expenses, without regard to what the primary plan pays.

Contributory plans Forcing Out Medicaid Eligibles. The employer may force a 50% cost of participant coverage on the participant, hoping some participants will elect out. This may not work as intended. Reason: Medicaid is alerted to its option to pay such premium for the participants. By electing the option, the Medicaid agency will exercise severe selection against the plan.

Different physician Billing Practices. Where

person direct such covered person's attorney in any legal action instituted by such covered person, to represent both the interest of such covered person and the interest of the plan. The plan reserves the right to appoint an attorney in its own right as an alternative to its using such covered person's attorney."

TPA Operating Tips.

Individual Policy or Group Certificate. Many there is no problem.

Qualified Trust (See IRC §501 (c)(9))

- Must be IRS-approved (IRS Form 1024).
- Advance funding is acceptable limited by IRC §419A.
- Investment income tax-exempt.
- Special discrimination rules by IRC §505.
- Tax filing by IRS Form 990.

Non-Qualified Trust (See IRC §419)

- Need not be IRS-approved.
- Advance is acceptable limited by IRC §419A.
- Investment income is taxable.
- No special discriminations rules.
- Tax filing by IRS Form 1041

The burden of maintaining qualification along with the hazards of the special set of discrimination rules administered by the IRS, even after the trust has been terminated do not offset the advantage of having the interest tax-exempt.

Note: in some instances (self-funding plans of Medicare/Medicaid providers and VEBAs), an IRC §510 (c)(9) trust is mandated by statute.

Waiver of Waiting Periods. The plan supervisor should obtain, as part of its due diligence with the stop-loss carrier, an agreement or understanding (formal or informal) that the following rules shall automatically apply to all waiting period waivers:

- Request for waiver be set forth in writing by the employer.
- Plan document will be amended for each such waiver, with such requests going

the physician has two fee schedules (one for insured and one for non-insured patients), the physician is guilty of fraud.

Trust Form. Where a trust is mandated by law or desired by the plan sponsor for whatever reason, this question arises: Should the trust be *qualified* or *non-qualified*: With the greatly limited use of the trust to be as a tax shelter, the qualified trust has become a *solution for which* And not employer general practices.

- Such waiver amendments will be part of the plan supervisor's recordkeeping department, as opposed to being part of its documents unit.

Where such rules are followed, the stop-loss carrier will be expected to approve the waiver amendment after the fact.

through regular procedures.

- No waiver in excess of ninety (90) days will be made.
- Such waivers will be employer exceptions