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Expiration Date Extended for Model Exchange Notices

The Department of Labor (DOL) recently extended the expiration date on its model Exchange notices through May 31, 2020. These model notices (or a modified version)—which the DOL calls "Model Notices to Employees of Coverage Options"—may be used to comply with the Exchange notice requirement under the Affordable Care Act (ACA).

What is the requirement?
The ACA requires all employers that are subject to the Fair Labor Standards Act to provide a written notice to their new employees about the ACA's Health Insurance Exchanges (known as Exchanges or Marketplaces). The notice must be provided to all new hires within 14 days of the employee's start date. However, there is no requirement to provide the Exchange notice to current or existing employees on an annual basis.

Extended Expiration Date
The content of the DOL's model notices has not substantively changed, and the expiration date does not mean that the model notice is out-of-date or that employers should stop using it. The expiration date is included on the model notices largely as an administrative function for the DOL, and does not impact the notices' applicability or an employer's ability to use them. Employers can continue to use and rely on DOL model notices after the expiration date has passed.

The expiration date on the model notices refers to a federal process where agencies receive approval from the federal Office of Management and Budget (OMB) for certain information collections. Approved information collections must display an OMB control number and an expiration date, which is usually set three years from when the OMB grants approval. This means that federal agencies must periodically ask for an extension of OMB approval. Often, OMB approval is not received before the expiration date passes.

Action Steps
Although employers should provide an Exchange notice to their new hires, the DOL asserted in an FAQ that there is no fine or penalty under the ACA for failing to provide the notice. This means that employers cannot be fined for failing to provide employees with notice about the ACA's Exchanges.

OWEN-DUNN
Insurance Services

IRS and DOL Provide Guidance on AHPs

Both the IRS and Department of Labor (DOL) have issued new compliance guidance for association health plans (AHPs). On June 21, 2018, the DOL published a final rule that expands the ability of employers to join together to form AHPs. According to the DOL, these changes will expand access to affordable, high-quality health insurance coverage for small businesses.

What is an AHP?
An AHP is covered under the Employee Retirement Income Security Act of 1974 (ERISA) and is a type of group health plan that is sponsored by a group or association of employers (instead of a single employer) to provide health coverage to employees of the AHP's members. Under ERISA, an AHP is both a group health plan and a multiple employer welfare arrangement (MEWA).

What is the new guidance?
The new guidance issued by the IRS and DOL provides that:

- Participating in an AHP

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does not cause a small employer to become subject to the Affordable Care Act's (ACA) employer shared responsibility rules.

- An AHP is a group health plan and a MEWA that is subject to ERISA's requirements.

Under the new rule, AHPs may be established as follows:

- All associations (new or existing) may establish a fully insured AHP starting on **Sept. 1, 2018**.
- Associations that sponsored a self-insured AHP on or before June 21, 2018, may expand within the context of the new AHP rule starting on **Jan. 1, 2019**.
- All other associations (new or existing) may establish a self-funded AHP starting on **April 1, 2019**.

Action Steps
Small employers that are considering joining an AHP should understand their compliance obligations with respect to this type of plan. Although AHPs may avoid some ACA reforms for the small group market, these plans remain subject to many other legal requirements, including any applicable state regulations.

Limits for HSAs and HDHPs Will Increase for 2019

On May 10, 2018, the IRS released Revenue Procedure 2018-30 to announce the inflation-adjusted limits for health savings accounts (HSAs) and high deductible health plans (HDHPs) for 2019. These limits include:

- The maximum HSA contribution limit
- The minimum deductible amount for HDHPs
- The maximum out-of-pocket expense limit for HDHPs

2019 Limits
These limits vary based on whether an individual has self-only or family coverage under an HDHP. The IRS limits for HSA contributions will increase for 2019. The HDHP maximum out-of-pocket limits will also increase for 2019. The HSA contribution limits will increase effective Jan. 1, 2019, while the HDHP limits will increase effective for plan years beginning on or after Jan. 1, 2019.

The 2019 limits are as follows:

- HSA contribution limit
  - Self-only—$3,500 (up $50 from 2018)
  - Family—$7,000 (up $100 from 2018)
- HDHP minimum deductible
  - Self-only—$1,350 (no change)
  - Family—$2,700 (no change)
- HDHP maximum out-of-pocket expense limit
  - Self-only—$6,750 (up $100 from 2018)
  - Family—$13,500 (up $200 from 2018)

There will **not** be a change to the catch-up contribution limit that applies to HSA-eligible individuals who are age 55 or older as it is not adjusted for inflation. That limit will remain at $1,000.

Action Steps
Remember, these limits apply to plan years beginning on or after Jan. 1, 2019. Because the cost-sharing limits for HDHPs will change for 2019, employers that sponsor these plans may need to make plan design changes for plan years beginning in 2019. Also, if an employer communicates the HSA contribution limits to employees as part of the enrollment process, these enrollment materials should be updated to reflect the increased limits that apply for 2019.

Please contact us today if you would like more information regarding these changes or if you would like access to employee communication materials.

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Final Rule Expands Short-term, Limited-duration Insurance

On Aug. 3, 2018, the Departments of Labor, Health and Human Services (HHS), and the Treasury (Departments) published final regulations amending the definition of short-term, limited-duration insurance for purposes of the Affordable Care Act (ACA).

What is this type of insurance?
Short-term, limited-duration insurance is a type of health insurance coverage that is designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to another plan or coverage. Specifically, existing regulations defined short-term, limited-duration insurance as "health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract."

Although short-term, limited-duration insurance is not an excepted benefit, it is specifically exempt from the definition of "individual health insurance coverage" and, therefore, is not subject to the ACA's market reform requirements. However, the Departments have become aware that short-term, limited-duration insurance is being sold as a primary form of health coverage, in some instances.

What is included in the final rule?
On Oct. 31, 2016, the Departments published final regulations revising the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage. Following the 2016 final regulations, there was concern that shortening the permitted length of short-term, limited-duration insurance would drastically reduce affordable coverage options for consumers. As a result, the Departments issued the 2018 final regulations to lengthen the maximum period of short-term, limited-duration insurance, in an effort to provide more affordable consumer choice for health coverage.

The final regulations amended the definition of short-term, limited-duration insurance so that it may offer a maximum coverage period of less than 12 months after the original effective date of the contract, consistent with the original definition (that is, the final rule expanded the potential maximum coverage period by nine months). Under this definition, the expiration date specified in the contract takes into account any extensions that may be elected by the policyholder without the issuer's consent, provided that it has a duration of no longer than 36 months in total (taking into account renewals or extensions).

In addition, the final rule revised the required notice that must appear in the contract and any application materials, due to concern that short-term, limited-duration insurance policies lasting almost 12 months may be more difficult to distinguish from ACA-compliant coverage (which is typically offered on a 12-month basis).

More Information
Please contact us for more information regarding this final rule.