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Introduction

On March 5, 2014, the Administration announced a variety of updates related to the Affordable Care Act, including:

1) Revisions and final regulations for the Risk Corridor programs, which includes the transitional reinsurance fee that employers and insurance carriers are required to pay.
2) The final rules regarding employer and insurance carrier reporting related to the Employer Shared Responsibility (i.e. Employer Mandate) provisions of the ACA, known as the Section 6055 and 6056 reporting.
3) An extension to the timeframe during which individuals can continue to renew plans that otherwise would have been cancelled due to non-compliance with the ACA.
4) A delay in the requirement for SHOP Exchanges to offer the "employee choice" model of coverage.
5) A confirmation that the initial open enrollment period for the Exchanges will close down at the end of March, 2014.

Risk Corridor Provisions

Most of the risk corridor final regulations deal with tweaks and adjustments to the various formulae that define how the various risk corridor calculations work. In practical terms, these tweaks incorporate various comments from the public and ultimately the way the government will calculate the amount of money it needs to collect in order to fund the risk corridor program. In the end, the amount required to fund the program for 2014 and 2015 has not changed. The amount for 2016 has not yet been calculated.

Consistent with proposed regulations that were issued earlier, these final regulations incorporate the decision that self-funded, self-administered group health plans are exempt from the transitional reinsurance program fees. In order to qualify as a "self-administered" plan, the plan cannot use a TPA to evaluate and process claims and reimbursements, nor to handle claim claims appeals. However, plans can continue to lease networks without disqualifying for this relief.

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Section 6055 and 6056 Reporting

These are the reporting requirements that were delayed for 2014, thus delaying the penalties associated to the Employer Mandate. The final regulations allow for a single, combined form for information reporting. This is especially beneficial for self-insured employers who will now have a streamlined way to report both under the insurer and employer reporting requirements.

What Information Is Reported?

The statute calls for employers, insurers, and other reporting entities to report the following information:

- Section 6055
  - Information about the entity providing coverage, including contact information
  - Which individuals are enrolled in coverage, with identifying information and the months for which they were covered
- Section 6056
  - Information about the employer offering coverage (including contact information and number of full-time employees)
  - For each full-time employee, information about the coverage (if any) offered to the employee, by month, including the lowest employee cost of self-only coverage offered

In the interest of streamlining the information, the final rules omit certain data in the statute that are not necessary in understanding the coverage offered and providing. Those include items such as:

- The length of any waiting period
- Employer's share of the total allowed costs of benefits provided under the plan
- The amount of advance payments of the premium tax credit and cost-sharing reductions.

Single, Combined Reporting

The final regulations also provide a single, consolidated form that employers will use when reporting to the IRS and to employees under sections 6055 and 6056. This will simplify the process and help to avoid duplicate reporting, thus reducing the administrative time needed to satisfy the reporting requirements. The combined form with have two sections: the top half will be for the information required for the 6056 reporting, while the bottom half will contain the 6055 information.

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Employers that have few than 50 full time employees, including full time equivalents (FTEs), are exempt from the ACA employer shared responsibility provisions and the reporting requirements.

Employers that have over 50 full time employees, including FTEs, are subject to employer responsibility and, thus, the reporting requirement. Those that self-insure will complete both parts of the combined form to report their information.

Employers that are subject to employer responsibility and do not self-insure will complete only the top section of the combined form for the 6056 reporting. Insurers and other health coverage providers will report via 6055 and use a separate form for that purpose. Insurers are not required to report on enrollees in the Health Insurance Marketplace, since the Marketplace will already have that information.

Simplified Option for Employer Reporting

For employers that provide a "qualifying offer" to any of their employees, the final rules provide a simplified alternative to reporting monthly, employee-specific information on those employees. A qualifying offer is an offer of minimum value coverage that provides employee-only coverage at a cost to the employee of no more than about $1,100 in 2015 (9.5% of the Federal Poverty Level), combined with an offer of coverage for the employee's family.

For employees who receive a qualifying offer all 12 months of the year, employers only need to report the names, addresses, and tax ID numbers of those employees along with the fact that they received a year-long qualifying offer. Employers will then give employees a copy of that simplified report or a standard statement indicating that the employee received the qualifying offer for a full year.

If an employee receives a qualifying offer for less than 12 months, employers will be able to simplify the reporting to the IRS and employees for each of those months by entering a code that will indicate that a qualifying offer was made.

To provide for a phase-in of the simplified option, employers certifying that they have made a qualified offer to at least 95% of their full-time employees (plus an offer to their families) will be able to use an even simpler alternative reporting method for 2015. Those employers will be able to use the simplified, streamlined reporting method for their entire workforce, including for any employees who did not receive a qualifying offer for the full year. Those employers will provide employees with standard statements relating to their possible eligibility for premium tax credits.

The final regulations also give employers the option to avoid identifying in the report which of its employees are full time and instead just include in the report those employees who may be full time. To take advantage of this option, the employer must certify that it offered affordable, minimum value coverage to at least 98% of the employees on whom it is reporting.

Marketplace Open Enrollment

The administration confirmed that the March 31 deadline for consumer's to sign up for health insurance through the Marketplace will not be extended. The next open enrollment will be from November 15, 2014 through February 15, 2015. This is a one month extension from the previous deadline of January 15, 2015. In addition, states have until June 15, 2014 to decide whether or not they want to run their own exchanges in 2015.

SHOP Marketplaces

Additionally, the administration delayed the "employee choice" option for the federal small-business exchanges until the fall of 2015. This feature allows small business employers to better control their healthcare costs as well as provide them with more flexibility in their offerings to employees. Employers would be able to set an amount they would pay towards an employee's plan and then choose a single plan or multiple plans through the SHOP Exchange that they would help pay for.

Currently, small business employers are only able to see their plan options online, but are required to send in a paper application if they wish to sign up for coverage. At this time, the online enrollment option has not been delayed any further and should be ready by fall of 2014.

Extension to Keep Cancelled Plans

In November of 2013, President Obama gave an extension to individuals and small groups to keep non-compliant plans for an additional year; the administration has extended this delay until 2016. Any small group or individual policies that begin on or after October 1, 2016 can remain in effect, even if it is not compliant with Healthcare Reform. Essentially a non-compliant plan can be in use through September of 2017. As with the November 2013 extension, there is a caveat: it is still up to states and insurers to decide whether or not to continue those plans. In addition, this extension also applies to large businesses that are currently purchasing their insurance in the large group market that will be considered a small group as of January 1, 2016 (50-99 full time/ full time equivalent employees). They will also have the option, as long as their policies continued to be offered, to continue their policy through plan years beginning on or after October 1, 2016.

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Conclusion

The 500+ pages of regulations released on March 5th are indicative of the administration's continued march towards full implementation of the ACA. Many details of the reporting requirements in particular have been long awaited, and while there is significant relief from duplicate reporting requirements, employers will want to pay particularly close attention to the requirements to ensure they have all the required tracking and logistical elements in place in order to comply with these reports. Assurance is in the process of developing a guide for our clients to assist them in understanding how best to comply with these new rules. Expect further information soon from your Assurance team.