STATE EMPLOYMENT LAWS

Provided By Sullivan Benefits

Health Care Reform

In April 2006, the **Massachusetts Health Care Reform Act** (Act) was signed into law to provide nearly universal health care coverage for residents of Massachusetts. To carry out this objective, the Act created an individual mandate, employer coverage requirements, government subsidies and expanded insurance options.

In March 2010, the federal health care reform bill, the **Affordable Care Act** (ACA), was signed into law. The ACA includes numerous reforms aimed at improving the U.S. health care delivery system, controlling health care costs and expanding health coverage.

This Employment Law Summary provides an overview of Massachusetts' health care reform law and selected ACA reforms to be implemented by state governments.

MASSACHUSETTS HEALTH CARE REFORM ACT

Individual Mandate

The Act requires all Massachusetts residents **age 18 and older** to have health coverage if affordable coverage is available. The coverage must meet "minimum creditable coverage" (MCC) standards. This generally means that a plan must cover a broad range of medical services, limit a subscriber's out-of-pocket costs and impose no limits on certain benefits. Employers and insurers can apply for MCC Certification if they have a comprehensive health plan that does not quite meet all MCC requirements.

Residents without MCC may face **a tax penalty** for each month of noncompliance in the tax year. The penalty cannot exceed one-half of the least expensive monthly premium available through the Massachusetts Health Connector (Connector), an online exchange to help residents locate affordable health insurance. Also, the penalty does not apply to individuals with incomes less than 150 percent of the Federal Poverty Level (FPL) or those with a religious exemption.

The penalty amounts vary by age and income based on percentages of the FPL guidelines. For example, for 2014, penalties for individuals with incomes greater than 300 percent of the FPL are:

- Ages 18-30: $58/month and $696/year; and
- Ages 31 and above: $92/month and $1,104/year.

Employers with employees in Massachusetts should review their health plan coverage to determine if it meets the state's creditable coverage standards. If the coverage does not meet MCC standards, employers should consider filing for an MCC Certification.

In addition, the state's individual mandate requirement remains in effect for 2014 and later years, even though the ACA's individual mandate requirement became effective in 2014. The Board of the Connector has approved an approach for applying the state's individual mandate penalty so that an individual will not be required to pay the full state penalty when he or she is also subject to a federal penalty. Under this approach, an individual who is subject to both penalties will be able to offset the state penalty by the amount of the federal penalty and will only be responsible for paying the excess amount (if any) of the state penalty.

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Health Care Reform

Employer Coverage Requirements

Fair Share Contribution

The Act required certain Massachusetts employers to make a "fair and reasonable" contribution toward their employees' health coverage or pay a penalty of up to $295 per full-time equivalent employee.

On July 12, 2013, Governor Deval Patrick (D) signed into law a bill that **eliminated the state's "fair share contribution" requirement for employers, effective June 30, 2013**. This change was enacted to avoid duplication between the state's employer coverage requirements and the ACA's employer penalty rules.

Employer Medical Assistance Contribution

The law repealing the fair share contribution requirement also enacted a separate **Employer Medical Assistance Contribution** that applies to employers with more than five employees in a calendar year, regardless of whether or not the employer provides health insurance.

This fee became effective **Jan. 1, 2014**. It is designed to fund a state trust for uninsured residents, and is equal to 0.36 percent of the same wage base that applies for Massachusetts unemployment taxation purposes, which is currently $14,000.

Section 125 Plans

The Act required employers with **11 or more full-time equivalent employees** to offer a Section 125 plan. A Section 125 plan allows employees to pay for their health coverage with pre-tax dollars. Under the Act, individuals who were ineligible for employer-sponsored group health plan coverage must have been offered access to individual market coverage using pre-tax contributions under the employer's Section 125 plan. Employers that violated the state's Section 125 plan requirement were subject to a "**free rider" surcharge** if their employees (or their employees' dependents) obtained state-funded medical care.

The Section 125 plan requirement was not eliminated by the legislation that repealed the state's fair share contribution. However, because the Section 125 plan requirement is inconsistent with the ACA's reforms, Governor Patrick's administration pursued its repeal. According to Health Connector Administrative Bulletin 03-13:

- Employers that currently permit non-benefits eligible employees to use Section 125 plans to purchase individual plans on a pre-tax basis may leave those plans in place until the expiration of the plan year that started in 2013.
- For plan years starting in 2014, employers may no longer offer Section 125 plans that permit their non-benefits eligible employees to purchase their own non-group health insurance policies using pre-tax income. Section 125 plans can continue to be offered to employees for other purposes, such as the purchase of group health insurance or other benefits.

The Section 125 plan requirement and the free rider surcharge were repealed on March 17, 2014.

Government Subsidies

The Act expanded Massachusetts' Medicaid program (MassHealth) to cover children with family incomes up to 300 percent of the FPL. In addition, the Act created subsidized insurance (Commonwealth Care) for adults with income up to 300 percent of the FPL.

Effective for 2014, Massachusetts expanded MassHealth to cover households with incomes up to 138 percent of the FPL. Due to this expansion, Commonwealth Care will end. Some Commonwealth Care members will qualify for Medicaid under the MassHealth expansion, while other members may qualify for federal government subsidies under the ACA's insurance Exchanges.

Health Care Reform

Expanded Insurance Options

Massachusetts created the Connector, an insurance exchange, for individuals and small businesses to purchase health insurance. The Connector is an online marketplace where consumers can compare coverage options from Massachusetts' major insurers. The Connector provides a range of different types of insurance options, all of which have been approved by the Connector board as meeting certain cost and coverage standards.

In addition, the Act merged the small group and individual insurance markets to pool insurance risk and allow for more variety in insurance products.

FEDERAL HEALTH CARE REFORM LAW

In addition to the state health care reform requirements, Massachusetts employers must also comply with the ACA. The ACA's reforms have staggered effective dates, with many key reforms taking effect in 2014.

The ACA is a federal law, which means that federal agencies, namely the Departments of Labor, Health and Human Services and the Treasury, are primarily responsible for the law's overall enforcement. However, the ACA also creates significant responsibilities for state governments. A number of the ACA's key health care reforms will be carried out at the state level.

Health Insurance Exchanges

The ACA requires each state to have a health insurance exchange (Exchange) to provide a competitive marketplace where individuals and small businesses can purchase affordable private health insurance coverage, effective Jan. 1, 2014. The Exchanges opened for enrollment on Oct. 1, 2013.

According to the Department of Health and Human Services (HHS), the Exchanges make it easier for individuals and small businesses to compare health plan options, receive answers to health coverage questions, determine eligibility for tax credits for private insurance or public health programs and enroll in suitable health coverage.

Individuals and small employers are eligible to participate in the Exchanges. Under the ACA, a "small employer" is an employer with not more than 100 employees. However, for plan years beginning before Jan. 1, 2016, a state may elect to define "small employer" as an employer with not more than 50 employees. Beginning in 2017, states may allow businesses with more than 100 employees to participate in the Exchanges.

States had three options with respect to their Exchanges. A state could choose to:

- Establish its own state-based Exchange;
- Have HHS operate a federally facilitated Exchange (FFE) for its residents; or
- Partner with HHS so that some FFE Exchange functions are performed by the state.

In addition, a state could elect to partner with HHS so that the state runs the Exchange's small business health options program (SHOP) component and HHS runs the Exchange's individual market component.

In states that did not move forward with their Exchange planning or select the partnership model, HHS operates the FFE.

Massachusetts created the Connector after the state's health insurance reform law was passed in 2006 to help individuals find affordable health coverage. The Connector served as a model for the ACA's Exchanges. Massachusetts has received federal grants to bring the Connector in line with federal requirements. Also, in 2012, Governor Patrick signed laws to certify the Connector as a state-based Exchange under the ACA and to give it authority to perform key tasks. On Dec. 7, 2012, Massachusetts received conditional approval from HHS for its state-based Exchange (Connector).

Due to technical problems with its Exchange, Massachusetts considered joining the federal Exchange for 2015. However, in August 2014, Governor Patrick confirmed that Massachusetts would proceed as a state-based marketplace and that it is "poised to offer consumers a streamlined, single-point-of-entry shopping experience for health care plans in time for fall 2014 Open Enrollment".

Health Care Reform

More information about the Connector is available at: www.mahealthconnector.org.

Medicaid Expansion

When it was passed, the ACA required states to expand Medicaid eligibility by providing coverage for adults between ages 18 and 65 with incomes up to **133 percent** of the federal poverty level, regardless of their age, family status or health. Because of the way this is calculated, it effectively includes individuals with incomes up to 138 percent of the federal poverty level. In 2012, the U.S. Supreme Court **made it optional** for states to expand their Medicaid eligibility.

In addition, the ACA provides tax credits or subsidies for people with incomes between 100 percent and 400 percent of the federal poverty level to buy health insurance through an Exchange. Employees who are eligible for Medicaid cannot receive Exchange subsidies.

Starting in 2015, applicable large employers (50 or more full-time employees, including equivalents) may be subject to a "pay or play" penalty if one or more full-time employees receives an Exchange subsidy. (Applicable large employers with fewer than 100 employees may be eligible for a one-year delay of the pay or play rules, until 2016). Employers with employees in states that opt out of the expanded Medicaid eligibility may face an increased risk of penalties under the pay or play rules because fewer employees will be ineligible for subsidies based on Medicaid eligibility.

Massachusetts expanded its Medicaid program in 2014 to cover households with incomes up to 138 percent of the federal poverty level. The federal poverty level guidelines for 2014 are available at: http://aspe.hhs.gov/poverty/14poverty.cfm.

Expansion of Small Group Market

To make health insurance coverage for small groups more affordable and apply additional consumer protections (for example, the restrictions on using health status factors in setting premium rates), the ACA expands the small group market. Under the ACA, a "small employer" is an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

However, for plan years beginning before Jan. 1, 2016, a state may elect to define "small employer" as an employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year. Thus, states have the option to delay the ACA's expansion of the small group market. Most states have defined a small employer as one with 50 or fewer employees.

Under Massachusetts law, the small group market is defined as a group with 50 or fewer employees on at least fifty percent of its working days during the preceding year. To comply with the ACA, Massachusetts must expand its small group market by 2016 to include employers with 100 or fewer employees.

Insurance Rate Review

To help hold insurance companies accountable for their proposed rate hikes, the ACA requires HHS to establish a process to review the reasonableness of certain premium increases.

Effective Sept. 1, 2011, insurers seeking rate increases of **10 percent or more** for non-grandfathered plans in the individual and small group markets must publicly disclose the proposed increases, along with justification for the increases. After 2011, states may work with HHS to set state-specific thresholds for disclosure of rate increases, using data and trends that reflect cost trends particular to a state.

The proposed increases must be reviewed by either state or federal experts to determine whether they are unreasonable. States with effective rate review systems will conduct their own reviews, but if a state does not have the resources or authority to conduct rate reviews, HHS will conduct them.

According to HHS, Massachusetts has an effective system for reviewing insurance rates. The Massachusetts Division of Insurance conducts rate reviews for the individual and small group markets.

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Medical Loss Ratio Rules

The ACA established the medical loss ratio (MLR) rules to help control health care coverage costs and ensure that enrollees receive value for their premium dollars. The MLR rules became effective on Jan. 1, 2011. Under the MLR rules, health insurance issuers in the large group market must spend at least 85 percent of premiums on medical care and health care quality improvement activities. Issuers in the small group and individual markets must spend at least 80 percent of premiums on these items.

Issuers that do not meet the applicable MLR standard must provide rebates to consumers. Rebates must be paid by August 1 of each year.

The ACA allows states to request a temporary adjustment in the MLR ratio for up to three years, to avoid disruptions to coverage in the individual market. Under the ACA, states also have the flexibility to set higher MLR standards than the federal 80/85 percent thresholds.

Massachusetts has a higher MLR threshold of **88 percent** for merged markets, a combination of the individual and small group markets, which increased to **90 percent** for policies issued or renewed on or after Jan. 1, 2012. Even if Massachusetts issuers meet the federal MLR thresholds, they still need to pass the state's merged market requirements to avoid issuing rebates.

Essential Health Benefits

Beginning in 2014, the ACA requires non-grandfathered plans in the individual and small group markets, both inside and outside of the Exchanges, to offer a core package of items and services. This core package is known as essential health benefits (EHBs).

Under the ACA, EHBs include items and services in 10 general benefit categories, including hospitalization, maternity and newborn care, mental health and substance use disorder services, and prescription drugs.

The ACA also directs that EHBs should be equal in scope to benefits offered by a typical employer health plan. To meet this requirement in every state, HHS further defines EHBs based on a state-specific benchmark plan. States could select a benchmark plan from among the following options:

- The largest plan by enrollment in any of the three largest products by enrollment in the state's small group market;
- Any of the largest three state employee health benefit plans options by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or
- The HMO plan with the largest insured commercial non-Medicaid enrollment in the state.

If a state did not select a benchmark, HHS selected the largest plan by enrollment in the largest product by enrollment in the state's small group market as the default benchmark plan.

The selected benchmark plans have been finalized for benefit year 2014. Massachusetts selected a plan from the largest small group product (HMO) as its benchmark—Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. More information on Massachusetts' benchmark plan is available on The Center for Consumer Information & Insurance Oversight (CCIIO) website.

Enforcement of Insurance Market Reforms

Effective for 2014, the ACA requires health plans and health insurance issuers to comply with an additional set of insurance market reforms. For example, effective for plan years beginning on or after Jan. 1, 2014, health plans and issuers cannot impose pre-existing condition exclusions on any enrollees.

States have traditionally been the primary regulators of their health insurance markets. The ACA allows states to continue in this role, but does not require states to enforce the ACA's reforms. If a state chooses not to enforce the ACA's insurance reforms, the federal government will assume that role. Although states have varied significantly in their approaches to implementing the ACA, many states have enacted laws related to the market reforms.

Health Care Reform

The Massachusetts legislature has enacted laws to implement the ACA's insurance market reforms. Massachusetts is also taking an active role in enforcing the ACA's market reforms. State regulators perform functions such as collecting and reviewing policy forms for compliance, responding to consumer inquiries and complaints and taking enforcement action as necessary.

Dependent Coverage Requirements

Effective for plan years beginning on or after Sept. 23, 2010, the ACA requires group health plans to extend dependent coverage up to **age 26**. Some states may have laws that go beyond the federal minimums established by the ACA. For example, some states extend dependent coverage beyond age 26.

In Massachusetts, group insurance policies with family coverage must cover a dependent child until age 26 or until two years after the end of the calendar year in which the child no longer qualifies for dependent status under the Internal Revenue Code, whichever occurs first. Also, Massachusetts law allows disabled dependents to stay on their parent's coverage without regard to age.

The ACA amended the federal tax code so that the value of coverage provided by an employer to an employee's child is excluded from income for federal tax purposes through the end of the year in which the child turns age 26. Since Massachusetts amended its tax laws to conform to the tax treatment imposed by federal law, the cost of dependent coverage of adult children up to age 26 is tax-free at the state level. Also, coverage for a disabled dependent that lasts beyond the end of the tax year in which the dependent reaches age 26 will be tax-free if the child qualifies as the employee's tax dependent.

External Review Process

The ACA requires non-grandfathered group health plans to follow minimum requirements for **external review** of claims appeals. Insured plans must comply with their state's external review process if it includes certain minimum consumer protections. If a state's external review process does not include the required minimum consumer protections, health insurers in the state must comply with a federal process for conducting external reviews, effective Jan. 1, 2012. HHS determines whether a state's external review process includes the minimum consumer protections.

HHS has concluded that the Massachusetts external review process includes the minimum consumer protections. Thus, insured health plans in Massachusetts must conduct external appeals in accordance with the state's external review process.

Premium Rating

The ACA's premium rating restrictions apply to issuers in the individual and small group markets, effective for plan years beginning on or after **Jan. 1, 2014**. Under the federal standards, these issuers are generally prohibited from determining premium rates based on health status, gender or other factors. Issuers may only vary premium rates based on the following factors:

- Age (may not vary by more than 3:1 for adults);
- Rating area;
- Individual or family enrollment; and
- Tobacco use (may not vary by more than 1.5 to 1).

The ACA's premium rating restrictions do not apply to issuers in the large group market, unless states elect to offer large group coverage through their insurance exchanges beginning in 2017. In addition, the premium rating restrictions do not apply to insurance coverage that has grandfathered status.

Massachusetts law allows issuers to consider a range of factors when setting premium rates. To assure stability in the marketplace as the state is required to transition away from its wider range of rating factors, HHS provided Massachusetts with additional time to comply with the ACA's rating restrictions. HHS first provided a three-year transition period for the new premium rating restrictions. Then, on April 24, 2014, HHS granted an additional year to complete the transition to the new premium rating factors. **Thus, Massachusetts has until 2017 to fully transition to the ACA's premium rating factors**.

Health Care Reform

MORE INFORMATION

More information on the Massachusetts health care reform law is available at: www.mahealthconnector.org.

More information on the federal health care reform law is available at: www.healthcare.gov.