

The Massachusetts Employer's Comprehensive Guide to National Health Reform



MASSACHUSETTS
HEALTH CONNECTOR



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Chapter One: Introduction and About this Guide

Introduction

This guide provides an overview of major components of National Health Reform (the Patient Protection and Affordable Care Act or ACA) that affect Massachusetts employers, highlighting areas of intersection with key elements of the state's health care reform. While there are many new policies that employers need to be aware of as a result of the ACA, Massachusetts employers are well positioned to navigate these changes. They have been key partners in the successful implementation and ongoing success of Massachusetts' own health reform, and are among the most generous and engaged in the nation when it comes to offering and promoting health coverage. The primary focus of this guide is on how the national reform law will affect Massachusetts employers so that they can continue to be informed and prepared for the implementation of the ACA.

About This Guide

This guide is intended to provide a comprehensive overview of the aspects of national health reform that affect employers. It is written to be a tactically useful resource for Massachusetts business owners, human resources professionals, brokers, consultants, advocates, legislators and legislative staff, among others. Our primary audience is small and mid-size *fully-insured* employers and the human resources and policy professionals that work with them. There are some provisions of the ACA that only affect *self-insured* employers, but this guide includes these in a separate section so as not to over-complicate the landscape for the small and mid-size fully-insured employers (which are the majority of employers in Massachusetts) for whom those policies do not apply.

The guide is organized by certain key themes around employer-related national health reform policies and is intended to illustrate and tell the story of how – together – these key pieces are intended to help promote the law's overall goal of improving access to affordable and comprehensive coverage and generally improving the health insurance market. While the guide touches upon several major aspects of the reform, there is greater attention and detail provided to those areas that will have the most direct impact on employers. We focus primarily on policies taking effect in 2014 and beyond, and each thematic category is introduced with a short description of the context, so as to help readers appreciate how each policy fits into the larger framework of the law and its purpose. We also include some sections devoted to information that will still be relevant for employers, but perhaps less central to a typical employer's immediate focus (such as insurance market reforms and changes in the subsidized insurance landscape), as well as Frequently Asked Questions, and a list of already-in-effect ACA employer-related policies. Additionally, a section is included that is entirely devoted to providing the latest information on state-level health reform policies that have affected employers (e.g., Fair Share Contribution, Health Insurance Responsibility Disclosure requirements, etc.), as some changes have been made in this area in light of ACA implementation in the spirit of simplification and streamlining.

Though every effort is being made to simplify what implementation of national health reform means for employers and consumers, it is likely that Massachusetts employers and others may still have questions or need help navigating what all this means for them. As such, this document provides information on the various entities that are available to provide employers and others necessary assistance and support as well as where additional information can be found.

This guide was written by the Massachusetts Health Connector, with support from a number of other state agencies including the Executive Office of Administration and Finance, Executive Office of Health and Human Services, Center for Health Information and Analysis, Department of Revenue, the Department of Unemployment Assistance, the Division of Insurance, and the Group Insurance Commission.

Overview of National Health Reform

The ACA was signed into law by President Obama on March 23, 2010. This law makes changes across the health care system in the United States with the goal of increasing access to affordable and comprehensive coverage. The national health reform law is in many ways modeled after Massachusetts' own health reform law passed in 2006, and they both include the following key elements:

- Assistance to help make insurance more affordable for low and middle-income individuals;
- The establishment of a health insurance Marketplace (in Massachusetts, the Health Connector) to help individuals determine if they qualify for help paying for insurance and to help individuals and small businesses more easily compare and enroll in health insurance plans;
- Provisions to encourage “shared responsibility” among employers and individuals with regard to health insurance coverage. These pieces are also referred to as the “employer shared responsibility” and the “individual mandate” requirements, respectively; and
- Certain health insurance market reforms.

Because these fundamental components are the same, many of the key achievements experienced as a result of Massachusetts health reform will remain in place. However, there are also some important distinctions between the two laws that will result in some significant changes for individuals, employers, insurers, and others in the Commonwealth.

Collectively, the changes brought about by the ACA are designed to improve the health insurance coverage landscape in the United States. In the Commonwealth, the changes will build on the strides already made with respect to expanding access to coverage and making it even easier for many individuals, families and small businesses to access and maintain affordable health insurance. However, it is important to note that some of these changes are complex and that while many people and businesses will see instant benefits, there may be some challenges for others, particularly during the initial transition years. A solid understanding of the changes ushered in by the ACA will help all parties involved – individuals, employers, and others – leverage the new opportunities and navigate the changes along the way.

National Health Reform and Employers

From a practical viewpoint, the pieces of ACA policy that affect employers may look “piecemeal” given that they can range from direct changes regarding HR-related aspects of how employers offer health insurance to some more indirect changes that will affect employers but do not require any action on their part (for example, changes to what types of benefits must be covered in a small group plan do not require any action on the small employer’s part, but will ultimately affect the coverage that the employer provides to its employees). However, any changes that will affect employers – either directly or indirectly – all stem from the basic goal and guiding principle of the entire health reform law: To improve **access** to health insurance, make health insurance coverage more **comprehensive**, and provide supports to individuals and small business that can, in some cases, help make coverage more **affordable**.

Broadly speaking, the employer-related provisions that come into effect in 2014 and beyond generally fall into three main categories:

1. Incentives to Promote and Provide Access to Private Coverage
2. Transparency and Competition
3. Reforms to the Health Insurance Market

In order to make the employer-related provisions of the ACA more understandable, we have organized this guide using these categories as a way of explaining the new changes most relevant to employers that will come into effect in 2014 and beyond.

Incentives to Promote and Provide Access to Private Coverage	Transparency and Competition	Reforms to the Health Insurance Market
<ul style="list-style-type: none">• Small Business Tax Credit• Employer Shared Responsibility (ESR)• Automatic Enrollment for Employees	<ul style="list-style-type: none">• Marketplaces and SHOP• Employer Noticing Requirements	<ul style="list-style-type: none">• Rating Factor Changes• Changes to Definition of Small Group• Other Procedural Changes to Merged Market

Reconciling Massachusetts’ Health Reform with National Health Reform

The fact that Massachusetts introduced its own health reform law in 2006 certainly adds another dimension of potential confusion for many employers – a dynamic that does not exist in other states that are “starting from scratch.” As such, this guide takes care to provide clarification on places where state and federal law will interact.

Although the themes of the laws and their aims for employers and employer-based coverage are similar, the technical details vary, and the ACA includes many new policies for employers that do not have a “counterpart” in Massachusetts’ own health reform law. In Chapter Six we dive into substantial detail on this subject by providing an overview of the status of all the employer-related policies that were included in Massachusetts’ health reform law.

Chapter Two: ACA Policies Effective 2014 and Later

Category 1: Incentives to Promote and Provide Access

Key Context: One of the main aims of the Affordable Care Act is to promote access to health insurance, a key component of which is the promotion of private, employer-based health insurance. The law supports this goal through the creation of a number of provisions that help promote employer-sponsored health insurance in their own specific ways. They range from the creation of tax credits for eligible small employers to help making offering private, employer-based coverage more affordable to financial consequences for larger employers that do not offer affordable, sufficient health insurance.

Small Business Insurance Tax Credit

In 2014, employers with up to 25 employees who pay average annual wages below \$50,000 and provide health insurance will be eligible for up to a 50 percent tax credit if they purchase health insurance coverage for their employees through a Marketplace like the Massachusetts Health Connector. This tax credit is also available for tax years prior to 2014 for any eligible small employer (regardless of whether they purchase through a Marketplace, but the credit amount is not as great as it will be in 2014).

This tax credit is available to small employers that pay at least half of the cost of individual coverage for their employees and is designed to help small businesses and tax-exempt organizations that primarily employ low and middle-income workers. This tax credit is meant to offset some of the costs associated with offering health insurance coverage and is available to both qualified employers who currently offer coverage and those that want to begin offering coverage.

The maximum credit is available to employers with ten or fewer full-time equivalent (FTE) employees who earn average annual wages of \$25,000 or less.¹ Partial credits are available to employers with up to 25 FTEs who earn average annual wages up to \$50,000. The eligibility rules take into account the number of FTEs, not the number of employees. **In other words, businesses with part-time workers may qualify even if they employ more than 25 people.**

Eligible small businesses can claim the credit as part of the general business credit by using new [IRS Form 8941 to calculate the amount of the credit](#).² Tax-exempt organizations can claim the credit on [IRS Form 990-T](#).³

¹ Under this provision of the ACA, the number of employer full-time equivalent employees (FTEs) during a tax year is equal to the total number of hours for which employees were paid wages by the employer divided by 2,080. Only the first 2,080 hours of each employee's wages are taken into account, hours in excess of this are not counted. This is a 40 hour per week standard.

² <http://www.irs.gov/pub/irs-dft/f8941--dft.pdf>

³ <http://www.irs.gov/pub/irs-pdf/f990t.pdf>

Tens of thousands of Massachusetts businesses are estimated to be eligible for this tax credit. However, to date, it appears that many employers that might be eligible have not yet taken advantage of this credit, so it is important for small employers to learn more about it in order to find out if they can benefit from this provision of the ACA.

For More Information

The IRS has resources to help employers determine their eligibility and obtain the Small Business Tax Credit.

- Overview: <http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-w-for-Small-Employers>
- YouTube Video: <http://www.youtube.com/watch?v=tHqvtPYHfVk>
- One-page flyer: <http://www.irs.gov/pub/irs-pdf/p4862.pdf>
- FAQ: <http://www.irs.gov/newsroom/article/0,,id=220839,00.html>
- 3-step Guide: http://www.irs.gov/pub/irs-utl/3_simple_steps.pdf
- Detailed Guidelines: <http://www.irs.gov/pub/irs-drop/n-10-44.pdf>

The Massachusetts Health Connector has a “tax credit calculator” on its website that provides preliminary estimates to determine eligibility and calculate potential savings for your business.

- Calculator Link: MAhealthconnector.org under “Employers” Tab.

Effective Date: Already effective but credit amount increases for January 1, 2014

Employer Shared Responsibility

Large employers will be subject to the Employer Shared Responsibility (ESR) provisions of the ACA. This policy is designed to create financial consequences for a large employer that either does not offer coverage or offers substandard coverage to full-time workers, and then has full-time workers qualify for and receive publicly-subsidized coverage at a health insurance Marketplace.

This provision of the ACA was originally scheduled to become effective as of January 1, 2014, but the US Treasury announced in July 2013 that the federal penalty assessments would be *postponed until 2015* in order to allow employers additional time to come into compliance with employer reporting requirements related to the ESR provision.

How might a large employer become liable for a penalty assessment?

Under these provisions, if large employers do not offer affordable health coverage that provides a minimum level of coverage to “substantially all” full-time employees, they may be subject to an ESR assessment if *at least one* of their full-time employees receives a premium tax credit for purchasing individual coverage through a health insurance Marketplace (e.g., the Massachusetts Health Connector).

What is the penalty assessment?

Beginning in 2015, a large employer’s liability for any ESR penalty assessment will depend on whether

the large employer offers any coverage to its full-time employees and whether any full-time employee of the employer is eligible for a tax credit for coverage purchased in a Marketplace. There are two possible penalties:

- **The “no offer” penalty** – If the employer offers no health coverage or offers coverage to less than 95% of its full-time employees, and at least one full-time employee receives a premium tax credit to help pay for coverage purchased from a Marketplace:
 - The annualized penalty is \$2,000 (\$167 monthly - computed separately for each calendar month) multiplied by the number of **actual full-time employees** (not equivalent employees) (minus the first 30 full-time employees) for that month.
- **The “unaffordable” penalty** – If the employer offers health coverage to at least 95% of its full-time employees, and at least one full-time employee receives a premium tax to help pay for coverage purchased from a Marketplace (because the coverage offered was not affordable or did not provide minimum value):
 - The annualized penalty is \$3,000 (\$250 monthly - computed separately for each calendar month) times the number of **full-time employees who receive a premium tax credit for that month** (but not to exceed the payment that employer would owe if it did not offer any coverage at all).

How does an employee become eligible for a premium tax credit?

Employees become eligible for premium tax credits (which can trigger a penalty assessment for a large employer) if:

- Their household income is below 400% of the federal poverty level (which is approximately \$46,000 for a household of one and \$94,000 for a family of four, using 2013 guidelines) but they do not qualify for Medicare, Medicaid or other government programs; and
- They are not offered affordable, minimum value health insurance by their employer, meaning:
 - they are not offered any health insurance by their employer; or
 - their premium contribution for the employer-sponsored self-only coverage would cost more than 9.5% of their household income; or
 - the coverage offered does not meet the minimum value standard by covering at least 60% of the total allowed cost of benefits⁴

(More information on federal premium tax credits can be found on page 30)

⁴A minimum value calculator has been made available by the IRS and the Department of Health and Human Services (HHS) to allow employers to input certain information about the coverage they offer, such as deductibles and co-pays, which then generate a determination as to whether the plan provides minimum value by covering at least 60% of the total allowed cost of benefits. It can be found here: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm>. SBCs also include MV.

Who is considered a large employer for the purposes of being subject to the ESR provisions?

To be a large employer subject to the ESR provisions, an employer must have an average of at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees during the preceding year. Employers with 50 or more full-time employees in the prior year are considered “Applicable Large Employers” (ALEs) in the current year.

Very small employers with fewer than 50 total employees in the prior year will not be considered ALEs in the current year, except when a small employer is a member of a controlled group of corporations or businesses under IRS rules. All employees of the controlled group are aggregated together when determining whether the 50 full-time employee threshold is reached.

Calculating the average number of full-time employees involves counting employees for each month of the year and finding the average of the months in the year as follows:

- **Count full-time employees for each month.** A full-time employee is an employee who is employed an average of at least 30 hours of service per week with an employer. For this purpose, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week.
 - When looking at hours of service for employees, leased employees, a sole proprietor, a partner in a partnership, or a 2-percent S corporation shareholder is not considered an employee.
- **Add part-time employee hours for each month.** To the monthly full-time employee count, add all part-time hours in the month (but not more than 120 hours of service for any employee) converted to a full-time equivalent (by dividing the aggregate monthly part-time hours by 120).
- **Take an average of all the months of the year to determine the annual count.**

Who is considered a full-time employee?

A full-time benefit eligible employee under the ESR provisions means an employee who averages at least 30 hours of service per week for a calendar month.

- 130 hours of service in a calendar month is the equivalent of at least 30 hours of service per week (1,560 hours of service annually).

Full-time (FT) employee is not the same as a full-time equivalent (FTE) employee used to determine employer size and whether the employer meets the ESR threshold.

An employee's hours of service include time paid for: vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

- For hourly employees: the actual hours of service must be tracked.
- For non-hourly employees (*i.e.*, exempt or salaried employees): an employer may track actual hours of service using one of two equivalency methods to measure hours.

In an effort to provide greater flexibility for employers, the IRS offers employers a number of "Safe Harbor" options which allow employers to choose a method for determining employee classifications. It was recognized that determining full-time employee status on a monthly basis may cause practical difficulties for some employers. These difficulties may include uncertainty and inability to predictably identify which employees are full-time employees to whom coverage must be provided to avoid a potential liability. This challenge may be particularly acute if employees have varying hours or employment schedules (for example, employees whose hours vary from month to month). A month-by-month determination may also result in employees moving in and out of employer coverage (and potentially Marketplace coverage) as frequently as monthly. This result would be undesirable from both the employee's and the employer's perspective, and would also create administrative challenges for the Marketplaces.

To address these concerns, and to give employers flexible and workable options and greater predictability, current proposed ESR rules outline a potential optional look-back measurement method as an alternative to a month-by-month method of determining full-time employee status.

The IRS Safe Harbor determination periods follow a 3-step methodology that applies to ongoing employees and to new variable hour or seasonal employees. While the 3-step methodology is basically the same, the time periods they relate to are different.

- Look back "Measurement Period" (MP) is a period chosen by the employer for counting hours of service to determine FT employee status – that is, eligibility for group health plan coverage.
- "Stability Period" (SP) is a period chosen by the employer during which coverage is provided based on FT status in the Measurement Period (regardless of actual employee status during the Stability Period).
- "Administrative Period" (AP) is a period chosen by the employer to allow time for enrollment and disenrollment between MP and SP.

Ongoing employee measurement periods usually relate to the plan year and annual enrollment period for the plan.

New variable hour or seasonal employee measurement periods will relate to the new variable hour/seasonal employee's date of hire.

As a result, health plan eligibility for those large employers subject to the ESR provisions will likely be more complicated than simply stating that those who work 30 hours per week will be eligible.

While those with 30 or more hours of service on average for a calendar month will be considered full-time employees for purposes of the ESR provisions of the ACA, some working 30 or more hours will not reach full-time employee status unless and until they have met those average hourly requirements over the applicable measurement period adopted by the employer. Therefore, if an employer adopts any safe harbor measurement, stability and administrative periods for ongoing, new variable hour and seasonal employees, then those periods are technically part of the medical plan's eligibility requirement and should be included in the employer's plan documents.

To whom must an employer offer affordable coverage meeting the minimum value standard in order for the employer to avoid a penalty assessment?

Full-time employees and their dependents need to be offered coverage. If they are not offered coverage, and one of them below 400% of FPL qualifies for and utilizes a tax credit at a Marketplace (in Massachusetts, the Health Connector), the employer could be subject to a penalty assessment.

Employers are not required to provide coverage for dependents in 2014, but must provide affordable dependent coverage meeting a minimum value in 2015 for the purposes of the ESR provisions. A dependent means a dependent child to age 26, as required by the ACA, and does not mean the employee's spouse.

What is considered affordable health coverage in order for a large employer to avoid a penalty assessment?

Household income is used by the Marketplace to determine who is eligible for a tax credit. The ACA defines "household income" to mean "modified adjusted gross income of the employee and any members of the employee's family (including a spouse and dependents) who are required to file an income tax return." Employer-sponsored insurance is considered "affordable" to an employee if an individual plan for which that employee is eligible for costs no more than 9.5% of their household income.

Recognizing that employers would generally not know their employees' household incomes, the proposed ESR rules permit employers to instead use one of three safe harbors as proxies to household income:

- **The Form W-2 Safe Harbor** - based on the Form W-2, Box 1 income for months during which the employee was eligible for coverage
 - Applied at the end of the year and on employee by employee basis
 - W-2 amounts and employee contributions are adjusted for employee who did not work the entire year for the employer
- **Rate-of-pay Safe Harbor** - based on rate of pay as of the beginning of the plan year. Salaried employee's monthly salary, OR hourly employee's rate of pay X 130 hours for months during which the employee was eligible for coverage
 - Only available if employer does not reduce the employee's wages during year; or
- **Federal Poverty Line Safe Harbor** - based on FPL for a single individual. For 2013, FPL = \$11,490 for a single individual. This may be higher in 2014.

Thus, according to the proposed ESR rule, coverage is affordable for ESR purposes (*i.e.*, no penalty for a large employer) IF:

- the cost to the full-time employee of self-only coverage for the least expensive option offered by the employer does not exceed 9.5% of the employee's "safe harbor income," irrespective of whether the employee qualifies for some other level of coverage (e.g., self-plus dependents, family) and irrespective of whether the employee qualifies for a tax credit from the Marketplace based on household income.

If coverage is affordable for ESR purposes using one of the IRS Safe Harbor methods of determining income of full-time employees, then the employer will NOT incur the \$3,000 penalty assessment (\$250/month for each full-time employee receiving a tax credit) even if one or more full-time employees qualifies for a tax credit in the Marketplace based on household income for the employee's family size.

Will there be a way for employers to know if any of their employees are utilizing tax credits at a Marketplace?

All employers will receive a notice from Marketplaces if and when their employees qualify for and enroll in tax credits, beginning in 2014. Receipt of such a notice does not mean that the employer will be assessed. There are numerous circumstances in which an employee receiving a tax credit will have no bearing on any possible assessment to the employer. For example, even small employers (those with fewer than 50 FTEs, which are not even subject to the assessment) will receive a notice if an employee qualifies for and enrolls in a tax credit. For larger employers, it may be the case that employees qualifying for and enrolling in tax credits are part-time employees, and therefore their usage of a tax credit has no bearing on the employer's potential liability for an assessment (since a potential assessment can only be triggered by full-time employees that qualify for and utilize tax credits). Marketplaces are required by law to provide these notices, and it is important for employers to understand that they are for informational purposes only, and do not mean that an assessment has been issued.

What are the reporting requirements associated with this policy?

The US Treasury's announcement in July 2013 that it will delay for one year the penalty assessments under the ESR provisions indicated that new associated mandatory reporting requirements for employers and health insurers would also be delayed for a year. The Treasury indicated that the delay in reporting requirements under tax code sections 6055 and 6056 would create time for the administration to propose simplified reporting requirements at a later date.⁵

⁵ IRS Notice 2013-45. The reporting was to apply to health insurance coverage provided on or after Jan. 1, 2014. The first information returns were to have been filed in 2015. In Notice 2013-45, Treasury encouraged employers and health insurers to implement the reporting requirements voluntarily in 2014 to prepare for mandatory reporting in 2015.

Effective Date: Technically, still January 1, 2014. However, Employer Shared Responsibility penalty assessments and certain employer reporting requirements have been delayed until 2015.

Automatic Enrollment for Employees of Large Firms

Employers with more than 200 full-time employees that offer health coverage will be required to automatically enroll full-time employees in the employer's health plan, unless the employee actively opts out.

New full-time employees must be enrolled in an employer's plan automatically, after any waiting waiting period. Current employees will continue to remain enrolled. **However, the automatic enrollment process must provide adequate notice and the opportunity for an employee to opt out of any coverage.**

The US Department of Labor (DOL) has yet to issue required regulations and until such regulations are issued, employers are not required to comply with this provision. A Frequently Asked Questions guidance document on this provision indicates that DOL intends to publish the regulations by 2014.

Effective Date: Effective sometime after issuance of guidance by the DOL, as stated in the future guidance.

For More Information

- Frequently Asked Questions from Employers Regarding Automatic Enrollment
<http://www.dol.gov/ebsa/newsroom/tr12-01.html>
- Employers looking for new guidance that may be issued on this provision of the ACA may want to check the Department's website on Affordable Care Act policies within its purview: <http://www.dol.gov/ebsa/healthreform/> -- on the right-hand side of the page, employers can sign up for email alerts to receive notifications of updated guidance by clicking on "subscribe to this page."

Category 2: Transparency and Competition

Key Context: While many of the most notable and widely publicized components of the Affordable Care Act are those that explicitly expand coverage to individuals or promote employer-sponsored insurance, the law also seeks to transform the health insurance market by promoting enhanced transparency and competition. It does this by providing new tools that enhance consumer and employer awareness of health care costs and making it easier for consumers and businesses to shop for value and understand their options (thereby enhancing competition among health insurance companies). A key mechanism for promoting this enhancement of consumer-driven competition is the creation of health insurance Marketplaces, which are largely online-based marketplaces that help organize health insurance choices for consumers and small businesses. Massachusetts already has such a Marketplace, the Massachusetts Health Connector, which will be described below. However, there are other tools and new requirements that call on employers to help enhance general transparency in the health insurance market – specifically by showing employees the full cost of their health insurance premium on their W2 forms and also notifying employees about the existence of Marketplaces.

New and Improved Health Insurance Marketplace (the Health Connector) and the Small Business Health Insurance Options Program (SHOP)

Small employers (businesses with 50 or fewer eligible employees) will be able to utilize a Marketplace to purchase small group coverage for their employees, benefitting from a streamlined and easy-to-understand shopping experience, and leveraging new tools for savings and benefit selection.

What is a Marketplace?

Massachusetts' Marketplace is the Health Connector. A health insurance Marketplace (also sometimes referred to as a health insurance Exchange) is a market for private health insurance products for both individuals and small businesses – it is primarily a website-based comparison and shopping tool, but there are also ways for people to shop and purchase health insurance over the phone or with in-person assistance. Anyone who has ever tried to purchase health insurance knows it can be a confusing and overwhelming process. The value of a health insurance Marketplace is its ability to provide a structure to help organize and narrow down high-quality options that can be easily compared so that the shopper can feel confident that they fully understand what is available to them and select the plan that is right for them. Informed and supported consumers help promote competition and transparency, which benefits the whole health insurance market.

What is SHOP?

A key component of the ACA is the creation of the Small Business Health Insurance Options Program (SHOP), a marketplace for small businesses to obtain group health insurance coverage for their workers. Although the Health Connector has offered small group coverage for the last several years, there are a number of key benefits afforded by the ACA that will improve and enhance what is available for small businesses looking to provide the highest value coverage to their employees.

The Massachusetts Health Connector now has almost 100 high-quality, affordable health plans available for small businesses from the state's leading health insurance carriers. Through the Health Connector, businesses with 50 or fewer eligible employees can shop online and compare plans in an easy-to-understand, side-by-side format. To get a price quote, brokers and business owners enter basic data about their workforce and an array of plans and premiums will display within seconds. Every plan has been awarded the Massachusetts Health Connector Seal of Approval, which denotes that the plans meet the Health Connector's standards for high value. There are no membership or monthly fees required to participate.

The Health Connector's SHOP, which will continue to be known as Business Express, will be the marketplace for small businesses in Massachusetts (until 2016, defined as those with 50 or fewer eligible employees – see page 24 for changes to the small group market in 2016) and will build on the components of our small business marketplace that work best for small businesses and their brokers, while also adding new tools and benefits.

What changes will take place at the Massachusetts Health Connector for small businesses?

- **Additional levels of coverage:** The ACA introduces new “levels” of coverage, so small businesses can shop for plans from the Platinum, Gold, Silver, or Bronze level. These metallic tiers are a way of grouping health plans by the richness of their benefits (so higher metallic tier levels like Platinum and Gold, for example, mean lower point-of-service cost sharing in exchange for relatively higher premiums).
- **New ways of offering coverage:** Later in 2014, SHOP will offer small businesses an ability to select a health insurance carrier, but offer employees a choice of benefit richness within that carrier's offerings – this allows small businesses and their employees even more ability to pick the plan that is right for them. (This is referred to as a “Dual-Triple Option.”) Later in 2014, a plan known as Employee Choice will become available, which will allow employees to take a contribution set by their employer and shop across the Marketplace for the coverage that is right for them and their family.
- **Dental coverage:** The Health Connector is expanding its product shelf to include dental plans starting in 2014. A variety of stand-alone dental plans, including pediatric only plans, will be available to individuals and small businesses. This will allow small businesses who use the SHOP for health insurance to also provide dental coverage to their workers – and will allow small businesses to select a coverage type that fits their budget and their employees' needs.
- **Increased small business insurance tax credits:** Small businesses with fewer than 25 employees earning average annual wages below \$50,000 may be eligible for federal tax credits of up to 50% of the employer's contribution towards coverage costs when they purchase health insurance through the Health Connector. This tax credit is only available to small businesses that purchase group coverage through Marketplaces (in Massachusetts, the Health Connector). This tax credit has been in existence for the past several years, but the magnitude of the credit increases in 2014 and is only available to businesses that purchase coverage through Marketplaces. See page 9 for more information.

- **More businesses will become eligible to use SHOP in 2016:** Beginning in 2016, the ACA permits SHOP Marketplaces to offer small group health insurance to small businesses with 100 or fewer employees, which will allow for a larger number of employers in Massachusetts to use the Health Connector as a source for group coverage.

Please note: There will be some changes to the Health Connector for employers that have previously enabled their non-benefits eligible workers to purchase individual coverage from the Health Connector using Section 125 Plans.

As background, Massachusetts law requires employers with 11 or more full-time equivalent employees to establish Section 125 plans that allow both benefits eligible and non-benefits eligible employees to purchase health insurance using pre-tax income. Employees who work for companies with Voluntary Plan accounts with the Health Connector have been able to use a Section 125 plan to purchase an individual health insurance policy through the Health Connector using his or her own pre-tax earnings to pay 100% of the premium cost of a plan of their choosing.

Under the ACA, employees will not be able to buy individual (*i.e.*, non-group) policies of health insurance through a Marketplace (such as the Health Connector) on a pre-tax basis using a Section 125 plan. This rule does not affect the tax treatment of contributions by benefits-eligible employees of small employers that offer employer-subsidized group health benefits through a Marketplace like the Health Connector. The Health Connector is transitioning its Voluntary Plan as a result of this change and is in direct contact with the employers affected by this change so as to assist them through this transition.⁶

Effective Date: Open enrollment will begin October 1, 2013 for coverage effective January 1, 2014.

For more information on the Health Connector and Business Express/SHOP, please visit: MAhealthconnector.org.

⁶ Employers should still offer Section 125 plans to their non-benefit-eligible employees – and are still required to do so under state law – but must do so through channels other than the Health Connector.

Employer Noticing Requirements

Employers have new responsibilities to report to their employees about the value of health insurance coverage, as well as information regarding health insurance options.

W-2 Reporting

The ACA requires employers to report the aggregate annual cost of employer subsidized health coverage on an employee's W-2. This requirement does not change the tax treatment of employer subsidized health coverage. The aggregate annual cost generally includes both the portion of the cost paid by the employer and the portion of the cost paid by the employee, regardless of whether the employee paid for that cost through pre-tax or after-tax contributions. Health coverage includes not only the group insurance plan, but also the cost of other employer-provided coverage to the extent provided in interim guidance from the IRS.⁷

This requirement is intended to help promote transparency and an awareness of health care costs among employees, who may not be aware of the full cost of their health insurance premiums as the employer is often footing the majority of the premium bill.

There is an exception for smaller employers. In the case of the 2012 Forms W-2 (and Forms W-2 for later years unless and until further guidance is issued), an employer is not subject to the reporting requirement for any calendar year if the employer was required to file fewer than 250 Forms W-2 for the preceding calendar year. (This rule is based upon the tax rule that exempts employers from filing returns electronically if they file fewer than 250 returns.) Therefore, if an employer was required to file fewer than 250 2011 Forms W-2, the employer was not be subject to the reporting requirement for 2012 Forms W-2.

Additional resources regarding employer provided health coverage informational reporting requirements are available at: www.irs.gov/uac/Employer-Provided-Health-Coverage-Informational-Reporting-Requirements:-Questions-and-Answers.

Effective Date: Originally effective for tax years beginning in 2011. However, IRS guidance made 2011 Form W-2 reporting voluntary and delayed compliance with the W-2 reporting requirement until 2012 Forms W-2 (that is, the forms required for the calendar year 2012 that employers are generally required to give employees by the end of January 2013 and then file with the SSA).

⁷ IRS Notice 2012-09.

Marketplace and Tax Credit Notices to Employees

The ACA requires employers to issue a Marketplace Notification to current employees by October 1st, 2013, and to new hires within 14 days of the employee's start date. The purpose of this requirement is to help employees understand health insurance Marketplaces, which are designed to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector.

Employers can read more about this requirement and the content that the notices must contain, here: <http://www.dol.gov/ebsa/pdf/tr13-02.pdf>.

At a high level, the notices must inform employees of the following:

1. Of the existence of Marketplaces including a description of the services provided by the Marketplaces, and the manner in which the employee may contact the Marketplaces to request assistance;
2. That the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code if the employee purchases a qualified health plan through a Marketplace and the employer does not offer a plan, the employer plan's cost is more than 9.5% of the employee's household income, or the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs; and
3. That they may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes if the employee purchases a qualified health plan through an Marketplace.

The Health Connector has developed a streamlined, Massachusetts-specific template that Massachusetts employers can use to satisfy the ACA marketplace notification requirement. The use of this particular form is entirely optional for Massachusetts employers. It was developed to help make compliance with this requirement easier for businesses in the Commonwealth. Employers also have the option of developing their own notices, or using the federally-developed templates that were released by the US Department of Labor (available here: www.dol.gov/ebsa/healthreform).

The template created by the Health Connector helps to communicate required information in a clear and straightforward manner to employees. Employers may customize the Massachusetts ACA Marketplace Notice template by filling in the blank fields with information specific to their business. It includes information for employees about any health insurance plans that you offer, including any pre-tax contribution health plans that meet the state's Section 125 requirement. Employers that use this template will also satisfy the state requirement that they provide notice to their employees about whether or not the company is in compliance with the state's Section 125 requirement.

<http://bettermahealthconnector.org/marketplace-notice/> as well as MAhealthconnector.org

The Health Connector also created an optional appendix to the Marketplace Notice that employers can use to provide additional information to employees. This appendix is not required to satisfy the ACA requirement, but may prove helpful to employees.

Effective Date: October 1, 2013. (Existing employees must be provided this notice by October 1, and employees hired after October 1, 2013 must be provided timely notification).

Revised Federal COBRA Continuation Coverage Election Notice

Under federal COBRA, a group health plan must provide qualified beneficiaries with an election notice, which describes their rights to continuation coverage and how to make an election. The election notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event.

The US Department of Labor acknowledges that some qualified beneficiaries may want to consider and compare health coverage alternatives to COBRA continuation coverage that are available through the Marketplace. Qualified beneficiaries may also be eligible for a premium tax credit to help pay for some or all of the cost of coverage in plans offered through the Marketplace.

The DOL's model election notice that plans may use to satisfy the COBRA election notice requirement has been revised to help make qualified beneficiaries aware of other coverage options available in the Marketplace.

The revised model election notice (redline version to show May 2013 changes) is available in modifiable, electronic form from the Department of Labor's website at:

<http://www.dol.gov/ebsa/modelelectionnoticeredline.doc>

Category 3: Reforms to the Health Insurance Market

Key Context: The Affordable Care Act makes a number of changes to the way that the small group health insurance market works and how health insurance premium prices are set within it. Some of the changes included in the law have already existed in Massachusetts for some time, whereas others are new. Even in many places where they are new, however, we have had similar policies in Massachusetts already in place, and the new national health reform law changes or enhances their application in certain ways. As context, in Massachusetts, we have what is called a “merged market” which means that the individual (or “non-group”) health insurance market and the small group health insurance market are combined as one “risk pool” and are generally subject to the same premium rating rules and consumer protections. The fact that we have a merged market will mean that some of the changes required by the ACA for the non-group market will also affect small group coverage as well. None of these changes require direct action on the part of a small business – they are merely included to the extent that it is useful for employers to appreciate changes that are going on “underneath” their premium rates.

Changes to Small Group Rating Factors

Massachusetts’ 2006 state health reform legislation led to the merger of the state’s individual and small group health insurance markets. As a result, health insurance premiums for individuals (or “non-group” coverage) and small group (businesses with 50 or fewer workers eligible for coverage) plans have been rated, or priced, using the same rules, with a few specific exceptions. The ACA, however, will usher in some changes to what rating factors can and cannot be used for pricing health insurance premiums in this market. The types of rating factors currently used in the state that will no longer be allowable include those that relate to certain account group size, industry, participation rate, and intermediary and small group purchasing cooperatives factors. Assuming no changes in coverage, these changes may result in premium increases for some individuals and small groups, while resulting in premium decreases for other individuals and small groups. *These changes do not add costs to the Massachusetts merged (individual and small group) market* – they merely redistribute costs according to new rules around the way health insurance premiums can be priced.

Governor Patrick and his Administration have sought to mitigate the likelihood of price disruption in the Massachusetts marketplace. The Administration worked with the federal government during the spring of 2013 and obtained a transition period for Massachusetts to phase out certain state rating factors currently in place for premiums in the small group market – rather than have these pricing changes occur overnight. This request was granted (making the Commonwealth the only state in the nation to be allowed a transition period) and will allow the Massachusetts merged market to adjust to these changes over a three year period from 2014 through 2016, smoothing premium impacts that may occur as a result and mitigating market disruption. The transition period allows for the gradual elimination of the following state rating factors – account group size, industry, participation rate, and enrollment through an intermediary or small group purchasing cooperative – that are otherwise disallowed under the ACA. During this period, Massachusetts will work to apply the following transition rules for these factors:

- For policy years beginning on or after January 1, 2014 but before January 1, 2015, small group market issuers may use 2/3 of the disallowed factors;
- For policy years beginning on or after January 1, 2015 but before January 1, 2016, small group market issuers may use 1/3 of the disallowed factors; and
- For policy years beginning on or after January 1, 2016, small group market issuers must be.

Effective Date: Changes begin January 1, 2014 but as described above, will be gradually phased in

Change to Definition of Small Group

Currently, employers with 50 or fewer eligible employees are defined as a small group in Massachusetts and therefore eligible to purchase a group health plan available through the merged market and/or at the Health Connector. The ACA modifies the definition of a small group to include employers with 100 or fewer employees, although states may choose to delay implementation of this definition and limit Marketplace participation to employers with 50 or fewer employees until 2016. Massachusetts plans to implement the changed definition in 2016.

Effective Date: January 1, 2016

Chapter Three: Employer-Related Policies Already in Effect

Key Context: As noted in the introduction, the ACA is a sweeping law that ushers in a number of changes to the health care delivery system, and includes numerous discrete policies that affect everyone from consumers to employers to insurance companies to health care providers. Most of the key provisions will go into effect in 2014, but a number became effective upon the signing of the law in 2010, and some others became effective in the months and years between the law's passage and now. This chapter outlines the employer-related policies that are already in effect.

Reasonable Break Time and Space for Nursing Mothers

The ACA requires employers to provide employed nursing mothers with adequate break time and space to express breast milk.

Specifically, employers must provide “a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.” These accommodations must be provided to the breastfeeding employee until the employee’s child’s first birthday. This requirement applies to employers of all sizes.

The break time requirement became effective when the ACA was signed into law on March 23, 2010. To assist employers with complying with the new law, the US Department of Labor has issued Wage and Hour Fact Sheet 73: “Break Time for Nursing Mothers under the FLSA” at <http://www.dol.gov/whd/regs/compliance/whdfs73.htm>. The Department has also posted Frequently Asked Questions (FAQs) on its website that reiterate the information provided in the Fact Sheet. Until the Department issues final guidance, the Department's enforcement will be based on the statutory language and the guidance provided in the Fact Sheet and the associated FAQs.

The Department of Labor has indicated that it expects that nursing mothers will typically need two-to-three breaks to express milk during an eight hour shift, with longer shifts requiring additional breaks.

Exemptions

There is an undue hardship exemption from this provision that is only available for employers with fewer than 50 employees that meet certain conditions. The employer bears the burden of proof to show that compliance with the nursing mothers break time provision would impose “an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer’s business.” At this time, the Department of Labor will not grant prospective undue hardship exemptions to employers.

Effective Date: March 23, 2010

For More Information

- Department of Labor Website on Nursing Mothers Provision and Other Resources: <http://www.dol.gov/whd/nursingmothers/>

- Department of Labor Request for Information: <http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=24540&AgencyId=14>
- Department of Labor Fact Sheet: <http://www.dol.gov/whd/regs/compliance/whdfs73.pdf>

Simple Cafeteria Plans

The ACA amended Section 125 of the Internal Revenue Code to establish simple cafeteria plans. Simple cafeteria plans adopted by eligible small employers are deemed to comply with nondiscrimination rules applicable to cafeteria plans under Section 125 and the component plans offered through the cafeteria plan.

Section 125 plans (or “cafeteria plans”) enable employees to benefit from tax savings when they elect health plan coverage (or other permitted benefits) using pretax income deducted from their pay by their employer. A simple cafeteria plan is a plan sponsored by an eligible small employer that satisfies specified minimum eligibility, participation, and employer contribution requirements. These plans are deemed to comply with the Section 125 cafeteria plan nondiscrimination rules as well as the nondiscrimination requirements for life insurance, health plan and flexible spending account benefit options offered through the cafeteria plan. As a result, eligible small employers can save the time and administrative cost associated with conducting annual nondiscrimination testing. As noted on page 19, Section 125 plans may not be used to pay for non-group insurance policies purchased through a government Marketplace (in Massachusetts, the Health Connector).

Eligible Small Employer

An eligible small employer is an employer with an average of 100 or fewer employees during either of the preceding two years. An eligible small employer that establishes a simple cafeteria plan will remain eligible until its average number of employees reaches 200 or more.

Minimum Eligibility, Participation, and Contribution Requirements

Eligibility. Eligible employees are ALL those who have worked at least 1,000 hours for the employer in the preceding year (approximately 20 hours per week).

Participation. Once eligible, the employee may elect any benefit available under the plan, subject to any terms and conditions that are applicable to all plan participants.

Contributions. The employer must make a contribution on behalf of every non-highly paid employee⁸ eligible to participate in the plan whether or not the employee makes a salary reduction contribution. The employer’s minimum contributions must be at least:

⁸The term “highly compensated employee” means any employee who (A) was a 5 percent owner at any time during the year or the preceding year, or (B) for the preceding year (i) had compensation from the employer in excess of \$110,000 (for 2010), and (ii) if the employer elects the application of this clause for such preceding year, was in the top paid group of employees for such preceding year. An employee is in the top paid group of employees for any year if such employee is in the group consisting of the top 20 percent of the employees when ranked on the basis of compensation paid during such year.

- i. a uniform percentage (but not less than 2%) of the employee's compensation for the plan year,
or
- ii. an amount that equals or exceeds the lesser of:
 - a. 6% of the employee's compensation for the plan year, or
 - b. twice the employee's salary reductions (i.e., amounts contributed to the cafeteria plan at the election of the employee on a pre-tax basis).

Effective Date: Plan years beginning after December 31, 2010. No specific simple cafeteria plan guidance has been issued to date.

Special Transition Relief for Salary Reduction Elections for Health Coverage Made under Section 125 Plans with Non-Calendar Year Plans Beginning in 2013

The availability of health plan coverage through a Marketplace beginning in 2014 does not constitute a change in status under current cafeteria plan rules. Therefore, employers subject to the Employer Shared Responsibility (ESR) requirements are permitted to amend their written Section 125 plans to permit one or both of the following changes to salary reduction elections made in 2013:

- An employee who elected to salary reduce through the Section 125 plan for health plan coverage with a fiscal plan year beginning in 2013 may prospectively revoke or change his or her health plan election once, during that plan year, without regard to whether the employee experienced a change in status event.
- If an employee missed the deadline for making a salary reduction election through his or her employer's cafeteria plan for health plan coverage with a fiscal plan year beginning in 2013, that employee is allowed to make a prospective salary reduction election for health plan coverage on or after the first day of the 2013 plan year of the cafeteria plan, without regard to whether the employee experienced a change in status event.

The written Section 125 plan document must be amended by December 31, 2014 to reflect this transition relief and be effective retroactively to the first day of the 2013 plan year.

Changes to Tax Treatment and Financing of Certain Health Care and Health Care Purchasing Vehicles

The ACA changed the way in which some types of health care and health care insurance are financed and paid. For example, the law includes a number of changes to the tax treatment of various kinds of health savings accounts and other payment mechanisms.

A series of new federal rules for health savings accounts, flexible spending accounts, and health reimbursement accounts took effect in 2011. The below provisions went into effect on January 1, 2011 unless otherwise noted.

Over-the-Counter Medication: Over-the-counter drugs purchased on or after January 1, 2011, with the exception of insulin, are not eligible for reimbursement from a flexible spending account (FSA), health savings account (HSA), health reimbursement arrangement (HRA), or Archer medical savings account (MSA), unless the drug is prescribed.

A drug is prescribed when there is a written or electronic order for the drug issued by a person legally authorized to write a prescription.

Originally, the IRS did not support the use of FSA and HRA debit card systems to purchase over-the-counter medicines on or after January 16, 2011.⁹ However, the IRS subsequently released new guidance supporting continued use of FSA and HRA debit cards to purchase over-the-counter medications for which the individual has a prescription in certain circumstances.¹⁰

Increased HSA Withdrawal Penalties: The tax penalty for HSA withdrawals that are not used for qualified medical expenses was increased from 10% to 20%, and the tax penalty for unqualified withdrawals from Archer MSAs was increased from 15% to 20%.

Maximum Salary Reduction for Health Flexible Spending Accounts: For plan years beginning in 2013, the maximum annual salary reduction contribution an employee may make to a health FSA is capped at \$2,500 (indexed for inflation in future years). The ACA's \$2,500 limit applies only to salary reduction contributions under a health FSA and does not apply to certain employer non-elective contributions (sometimes called flex credits), to any types of contributions or amounts available for reimbursement under other types of FSAs, health savings accounts, or health reimbursement arrangements, or to salary reduction contributions to cafeteria plans that are used to pay an employee's share of health coverage premiums. In addition:

- If a cafeteria plan has a short plan year beginning after 2012, the \$2,500 limit must be prorated based on the number of months in the short year.
- In the case of a cafeteria plan that provides a "grace period" (of up to 2½ months after the close of the plan year) during which incurred claims may still be reimbursed from the prior year's contributions, any FSA balance carried over into the grace period will not count against the \$2,500 limit for the following plan year.
- The \$2,500 limit applies on an employee-by-employee basis, regardless of the number of dependents who might have medical expenses reimbursed from the health FSA. Therefore, a husband and wife may each contribute up to \$2,500 to his or her own health FSA, even if both participate as employees in the same health FSA sponsored by the same employer.

⁹ IRS Notice 2010-59.

¹⁰ IRS Notice 2011-5.

- All plans have until the last day of calendar year 2014 to adopt any plan amendment required to reflect the \$2,500 limit (including a retroactive amendment, regardless of their plan year), provided the plan operates in accordance with the new \$2,500 limit for plan years beginning after December 31, 2012.

Elimination of Deduction for Medicare Part D Subsidy

Medicare Part D provides a subsidy to businesses that cover prescription drugs for their retirees. The subsidy is 28 percent of allowable drug costs for retiree drug costs between \$250 and \$1,000. Beginning in 2013, businesses will no longer be allowed to deduct prescription drug expenses that are covered by the Medicare Part D retiree drug subsidy.

The subsidy itself will not be eliminated, only the businesses' tax deduction of the subsidy. This provision became effective January 1, 2013.

Medicare Payroll Tax for Highly Compensated Employees

Beginning in 2013, there is an additional 0.9% Medicare tax on individual filers whose earnings exceed \$200,000 and joint filers whose earnings exceed \$250,000. The additional tax will only be imposed on the employee portion of the Medicare tax, not on the employer portion. Employers may wish to inform employees of this tax change as the date to file 2013 taxes approaches.

Chapter Four: Access to Subsidized Coverage for Individuals

One of the most significant aspects of the ACA is the expansion of subsidized health insurance options for low- and middle-income individuals and families. While these programs are designed for individuals for whom affordable private, employer-based health insurance is not available, it is important for employers to understand the changes in these programs so that they can help their non-benefits eligible workers find access to the care they need and any subsidies for which they may be eligible. Even the most generous employers who offer coverage to their full-time workers may have part-time employees, contract workers, or others who may not qualify for group benefits, and yet such employers can still provide a “benefit” to these workers by helping direct them to the right resources to obtain coverage.

The ACA expands access to coverage by making health insurance more affordable for individuals through an expansion of Medicaid (MassHealth) and the availability of tax credits and cost-sharing reductions (CSRs) through Marketplaces (in Massachusetts, the Health Connector). Massachusetts has also developed additional state-based assistance to certain individuals and families, as well. These expansions will modify and improve the subsidized insurance landscape in Massachusetts for coverage effective in January of 2014.

Medicaid (MassHealth) Expansion

Massachusetts will expand Medicaid eligibility to childless adults aged 21-64 with income up to 133% Federal Poverty Level (FPL). MassHealth will also be expanding coverage for young adults aged 19 and 20 with incomes up to 150% FPL.

This means that citizens and qualified aliens **including legal permanent residents who entered the U.S. at least 5 years ago** with income at or under 133% FPL and citizen, qualified alien and lawfully present immigrant 19 and 20 year olds with income at or under 150% FPL, who were previously eligible for benefits through the Health Connector (Commonwealth Care) and other programs will now be eligible for MassHealth programs and will transition into MassHealth as a result of the ACA. MassHealth programs will also be streamlined to make MassHealth coverage easier to understand, and a new web-based integrated eligibility system will make it easier for people to find out if they qualify.

Individuals who enroll in MassHealth will not trigger any potential penalty for employers. In some circumstances, individuals who meet MassHealth eligibility criteria and who are enrolled in or have access to employer-sponsored insurance may receive premium assistance to help them enroll in their employer plan, again without any penalty or liability accruing to the employer.

Tax Credits and Cost Sharing Reductions

Individuals between 133% to 400% of FPL (0%-400% for Aliens with Special Status [AWSS]) may be eligible for federal premium tax credits and cost sharing reductions for non-group coverage purchased through the Health Connector. Tax credits will lower the cost of a premium for an individual or family that qualifies, and cost sharing reductions will lower the out-of-pocket costs (e.g., co-payments) for eligible enrollees. Those who qualify for tax credits can take the tax credit in the form of an advance payment to lower their monthly health plan premiums for their selected plan (known as a Qualified Health Plan or QHP). These tax credits can trigger penalties for large employers (as explained on page 10), but only if full-time workers utilize them. There are no financial consequences for small employers with employees utilizing these tax credits, and there are no financial consequences for large employers on account of having part-time employees utilizing these tax credits.

“ConnectorCare” Plans and Additional State-Based Assistance

In addition to tax credits that will be available to eligible individuals with incomes up to 400% FPL through the Health Connector, Massachusetts will also be offering additional subsidies to help keep health insurance premiums for those below 300% FPL as affordable as possible (at roughly the same level as the previous program for this population, Commonwealth Care). These additional savings will only be available when applied to certain health insurance carriers and these plans will be called ConnectorCare plans.

Real-Time Eligibility Determination

Beginning with the Open Enrollment period for 2014 coverage that begins October 1, 2013, the Health Connector will serve as the Commonwealth’s streamlined access point for individuals and families to determine eligibility for all subsidized health insurance coverage (including MassHealth and the Health Connector plans). To that end, the Health Connector, in collaboration with the Executive Office of Health and Human Services (EOHHS) and UMass Medical School, has developed a new IT system for eligibility and enrollment with enhanced functionality including real-time eligibility determination. Specifically, the Health Connector will have the capability to assess an individual or a family's Modified Adjusted Gross Income (MAGI), as required by the ACA, which will be used to determine eligibility for certain MassHealth programs and for tax credits and cost sharing reductions. Individuals and families interested in learning what types of subsidies they may be eligible for can visit MAhealthconnector.org starting October 1, 2013 to instantaneously determine their options.

Individuals who would like to learn what subsidies they might qualify for (either through MassHealth or the Health Connector) should visit: MAhealthconnector.org

Effective Date: January 1, 2014

Initial Open Enrollment Period: October 1, 2013 – March 31, 2014.

Chapter Five: Health Insurance Market Reforms

As noted in the introduction, the overarching goals of the ACA are to promote access to health insurance, to help make the purchase of health insurance more affordable, and to improve the comprehensiveness of health insurance coverage. The third goal in particular is promoted by ensuring that health insurance covers important benefits. Many such changes have already gone into effect, but others will become effective in 2014.

While most of the federal requirements are similar in spirit to state laws and regulations that govern the Massachusetts health insurance market, there are important new requirements that will change the way health plans are administered in Massachusetts. These changes and reforms are designed to enhance consumer protections and make health insurance more equitable.

Many of the more coverage-oriented health insurance market reforms required by the ACA, such as allowing young adults to stay on their parents' insurance plan until they turn 26, are already in effect in Massachusetts to some extent – although in some cases, the requirement gets expanded to a wider number of market segments (e.g., in the case of children being able to stay on parents' plans until age 26, the ACA requires this for both fully insured and self-insured plans, whereas the Massachusetts requirement previously only required it of fully insured plans).

Most changes described in this section do not require any action on the part of employers but are included here to the extent they are of interest or help employers to understand ACA-based changes to the coverage that they obtain for their employees.

Already Effective Insurance Market Reforms

Coverage for Preventive Care: A health plan must cover certain preventive services without cost-sharing. Cost-sharing includes deductibles, coinsurance, copayments, and similar charges. Cost-sharing does not include premiums or balance-billing amounts for non-network providers. This requirement will apply to new plans and existing plans that are not “grandfathered.”¹³

Insurers in Massachusetts have historically been permitted to charge co-pays or other fees for preventive care, so this has been a new requirement. Final regulations on the preventive services subject to this ACA provision are available at:

www.healthcare.gov/center/regulations/prevention/regs.html.

Coverage for Older Children: Health plans must offer coverage for a child on a parent's health plan until the child reaches age 26, regardless of dependent status.¹⁴ An adult child will qualify for coverage under the federal law even if he or she is married, not living with a parent, is not a dependent on a parent's tax return, or is no longer a student. In Massachusetts, health plans have

¹³ For more information about “grandfathered” plans, please visit:

<http://www.familiesusa.org/assets/pdfs/health-reform/Grandfathered-Plans.pdf>

already been required to allow a child to be covered on a parent's plan until the child reached age 26 or two years after the child loses dependent status, whichever came first. However, the requirement now applies to all non-grandfathered plans, including self-insured plans, which had not been subject to the Massachusetts requirement prior to the ACA.

The ACA does not require that the covered adult child's spouse (if any) or children be offered coverage on a parent's (grandparent's) employer-sponsored health insurance plan. However, in Massachusetts, a child of a covered dependent must be offered coverage on the date of birth and thereafter, as long as the dependent is covered.

The ACA provides an exception for grandfathered group plans. For plan years beginning before January 1, 2014, a grandfathered health plan is not required to extend coverage to age 26 in cases where the adult child is eligible to enroll in another employer-sponsored health plan that is not the grandfathered health plan of a parent.

IRS provisions in the ACA extend the general federal tax exclusion for reimbursements for medical care expenses under an employer-sponsored health plan to the child of an employee who has not attained age 27 as of the end of the taxable year. In Massachusetts, employers no longer need to determine imputed income for children covered under parents' employer-sponsored health insurance plans, including those children who had been covered for the two years after losing dependent status.

Even though children of covered employees must be offered coverage up to age 26, an employer may continue covering the child beyond his or her 26th birthday if permitted by the group insurance policy. For example:

- An employer's health plan will renew or expire by January 1.
- A child turned 26 in August, before January 1 and the start of a new plan year.
- The employer may allow that child to stay covered through the remaining months of the plan year if permitted by the group insurance policy.

In this example, the value of the child's benefits is excluded from the enrolled employee's income for the entire taxable year in which the child turned 26.

Coverage for Pre-Existing Conditions: The ACA prohibits any pre-existing condition exclusion from being imposed by group health plans or group health insurance coverage. This prohibition generally is effective with respect to plan years beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition becomes effective for plan years beginning on or after September 23, 2010. Massachusetts already prohibited health plans from denying health insurance coverage to anyone because of a pre-existing condition.

Limits on Lifetime Benefits: The ACA prohibits group health plans and health insurance issuers offering group health insurance coverage from imposing lifetime limits on the dollar value of the essential health benefits (EHBs) (described below) an enrollee may receive. Most health plans sold in Massachusetts do not have lifetime limits. The ACA requires that new or existing plans cannot impose

¹⁴For purposes of the age 26 extension and the federal tax exclusion, "child" is defined in section 152(f)(1) of the Internal Revenue Code as the son, daughter, stepchild, adopted child (including a child placed for adoption), and foster child of the taxpayer.

lifetime limits on EHBs for plan years beginning on or after September 23, 2010. Benefits that are not considered EHBs, however, may be subject to lifetime limits.

Limits on Annual Benefits: The ACA prohibits annual limits on the dollar value of essential health benefits (EHB) generally, but allows “restricted annual limits” with respect to EHB for plan years beginning before January 1, 2014. Restricted annual limits on the dollar value of EHB may not be less than the following amounts for plan years beginning before January 1, 2014:

- For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000;
- For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1.25 million; and
- For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2 million.

Generally speaking, health plans with annual caps do not meet the current Massachusetts’ Minimum Creditable Coverage (MCC) regulations developed under Massachusetts health reform, so this change may not require employers with Massachusetts employees to make substantive changes. Annual caps will be allowed on benefits that are not considered EHBs.

Restrictions on Rescission of Coverage: Under the ACA, a group health plan, or a health insurance issuer offering group health insurance coverage, must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage with only a prospective effect is not a rescission, and neither is a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Massachusetts already prohibits retroactive cancellations except in certain limited instances, including fraud. The new ACA rescission standard applies to plan years beginning on or after September 23, 2010.

Market Reforms Effective in 2014

Essential Health Benefits (EHBs): The ACA requires health plans offered in the individual and small group markets, both inside and outside of the Marketplaces (in Massachusetts, the Health Connector), to offer a comprehensive package of items and services, known as “essential health benefits.” Essential health benefits must include items and services in at least the following 10 categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services (including chronic disease management), and pediatric services (including oral and vision care).

Each state was permitted to select its own “benchmark” plan that would set the framework for what its EHB requirements would entail, within the broad categories required by the ACA. Massachusetts selected HMO Blue 2000 Deductible from Blue Cross and Blue Shield of Massachusetts as its EHB benchmark plan, with supplemental dental coverage for children. For more information, visit: <http://www.mass.gov/ocabr/docs/doi/ma-essential-benchmark-plan.pdf>

Chapter Six: How Massachusetts State Law and ACA Policies for Employers Will Work Together

Massachusetts passed landmark health reform legislation in 2006 (Chapter 58 of the Acts of 2006: An Act Providing Access to Affordable, Quality, Accountable Health Care). This law called on all segments of the Massachusetts community – consumers, employers, and the public sector – to come together in support of expanding health insurance access to our residents. The main policy tool brought to bear by this important law was an individual mandate, which required adults in the state with access to affordable health insurance to purchase it, thereby encouraging personal responsibility and getting as many of our residents as possible covered.

Employers were also asked to do their part, as reflected in the enactment of the Fair Share Contribution (FSC), Health Insurance Responsibility Disclosure (HIRD) requirements, the Section 125 requirement, and the Free Rider Surcharge. Beyond just quickly meeting these new requirements (which the vast majority of employers did), Massachusetts employers stepped up to meet the spirit of the law, as well. Massachusetts employers maintained and even increased their rates of offering health insurance to their workers, outpacing their national peers. Furthermore, employers were essential to helping spread the message to their employees (and their families) about the individual mandate and other changes taking place as a result of state health reform. These actions, as well as a number of other tools, including the expansion of subsidies to low-income residents, led to the Commonwealth's reaching the highest levels of health insurance coverage in the nation – currently at 97%.

In many ways, the success of Massachusetts' health reform helped lead the way for national reform. But as this guide indicates, there are many technical details that differ between the two laws, and it is important for our employers and residents to understand these differences so Massachusetts can continue to succeed in ensuring coverage for as many residents as possible, thereby continuing to lead the way for the rest of the nation. This guide has, up to this point, focused on exactly what the ACA calls on employers to do, but here we focus on what the implementation of the ACA will mean for the employer policies included in our original state-based reform from 2006.

In many ways, the passage and implementation of national reform has provided Massachusetts with a unique opportunity to take a fresh look at its own state-level health reform policies to ensure that we streamline requirements where possible, only keeping those that remain truly necessary and provide a substantial public benefit. This section of the guide is intended to highlight some of the key areas where state and federal health reform policy will mesh, and where certain state-level policies will be altered in the spirit of simplification and efficiency.

Fair Share Contribution

Policy: The FSC policy required employers with 11 or more FTEs to make a “fair and reasonable” contribution towards the health care costs of its workers or pay a \$295 assessment per FTE.

Reconciliation Decision: Eliminated effective 7/1/2013

Background: The final 2014 budget signed by Governor Patrick included a provision, similar to the one he proposed in January of 2013, that eliminated the Fair Share Contribution. The Patrick Administration held a number of discussions with stakeholders from the employer and advocacy communities over the course of 2011 and 2012 to consider whether it would make sense to preserve or discontinue FSC, given that the ACA included a penalty for certain large employers that did not provide affordable or substantial coverage to full-time employees. Ultimately it was decided that it would be appropriate to repeal FSC and allow employers some time to come into compliance with the ACA employer penalty provisions.

In addition to the desire to ensure that employers would not be subject to two penalties, the Patrick Administration felt that Massachusetts employers consistently “do the right thing” with respect to offering health insurance coverage to workers for business reasons as well as based on a sense of civic responsibility. As such, repealing Fair Share, even in light of the delay in the ACA’s Shared Responsibility for Employers policy announced by the US Treasury in July 2013, would not be expected to erode the Commonwealth’s high levels of employer-based health insurance.

Other Notes: The repeal of Fair Share became effective on July 1, 2013, but there are some important updates for Massachusetts employers that may have questions about what this repeal means for any remaining filing or reporting responsibilities:

- Any employer who is sent an FSC Notice to File (NTF) for FSC Quarter 3 (4/1/13 – 6/30/13) needs to complete this filing by the 8/15/13 due date.
- Employers who have been sent FSC Notice to File (NTF) letters for prior periods and have not yet filed for any/all of those periods should do so immediately.
- Enforcement and collection of FSC liability for all periods prior to 6/30/13 will continue.
- No employer needs to file FSC reports with DUA for quarters beginning 7/1/13 or after.

Employer HIRD

Policy: This policy requires an online report that employers with 11 or more FTEs submit on a quarterly or annual basis regarding their Section 125 offering as well as other information about health insurance benefits that they offer.

Reconciliation Decision: Will remain in effect (but temporarily suspended as Health Connector builds new filing application). Frequency will move to annual for all subject employers.

Background: This reporting requirement responsibility was recently moved from the Division of Health Care Finance and Policy (now the Center for Health Information and Analysis, or CHIA) to the Health Connector, and the reporting requirement itself has been put on hold while the Health Connector establishes the new reporting application. This new reporting requirement is expected to become effective again later in 2014. Employers looking for information about when it will become effective again can check MAhealthconnector.org and can also sign up for email alerts from the Health Connector to be informed of when the requirement will resume (as well as other updates about employer-related Health Connector regulations and programs).

Employee HIRD

Policy: This required form must be collected by all employers with 11 or more FTEs when an employee declines participation in a Section 125 plan or an employer's group health plan. Signed forms must be kept on file for three years.

Reconciliation Decision: Repealed effective 7/1/2013, but will be replaced with new noticing requirement to be prescribed by the Health Connector.

Background: These forms previously had to be collected from all employees that declined their employer's offer of Section 125 participation or employer sponsored insurance participation and kept on file for three years. This requirement is no longer in effect. (However, all forms currently on file should be retained for the requisite time period.) In its place, employers will be required to issue a notice to employees about their eligibility to participate in a Section 125 plan or the company's employee sponsored insurance (but unlike the Employee HIRD form requirement, this notice would not need to be signed by the employee and kept on file by the employer). The Health Connector plans to issue regulations regarding this new responsibility during fall of 2013. However, employers that utilize the Health Connector-generated Marketplace Notice templates (which includes some information about Section 125 requirement compliance, explained on page 21) will satisfy this noticing requirement, as well.

Section 125 Requirement

Policy: Employers with 11 or more FTEs are required to offer all employees, including those not eligible for group benefits, the opportunity to make contributions towards health insurance using pre-tax deductions through a Section 125 plan.

Reconciliation Decision: The Section 125 requirement will remain in place. However, it is important for employers to be aware that the Health Connector's Voluntary Plan program (which was a mechanism for providing pre-tax coverage to non-benefits eligible workers) will be closing at the end of 2013, as mandated by the ACA. For more information, please see page 19.

Background: This requirement provides a distinct benefit for Massachusetts employees, allowing their contributions towards health insurance to be made with pre-tax income, thereby making coverage more affordable.

Free Rider Surcharge

Policy: This surcharge is an assessment that can be levied in the event that an employer with more than 11 FTEs fails to comply with the Section 125 requirement and has employees (or employees' dependents) that utilize more than \$50,000 worth of Health Safety Net charges.

Reconciliation Decision: The Free Rider Surcharge will remain in place.

Background: As a result of dialogues with stakeholders over the course of the last several years regarding the optimal way to reconcile state-based employer-related health reform policy and those included in the ACA, the Patrick Administration concluded that the Section 125 requirement continues to provide a substantial benefit to Massachusetts residents through their employers.

For More Information on These Policies

The Massachusetts Health Connector oversees the regulations of all the remaining Chapter 58 employer-related policies. For more information on any of these policies, as well as to receive updates to any changes to these policies, please visit MAhealthconnector.org.

Chapter Seven: For More Information

There are many websites and resources available that can provide additional detail on the policies described in this guide.

Massachusetts Health Connector (Massachusetts' Health Insurance Marketplace)

- Website for Massachusetts Health Connector (Massachusetts' health insurance Marketplace) to find information on health insurance coverage options, subsidy eligibility determinations, as well as policy information for employers, individuals, families, researchers, and the public: MAhealthconnector.org

Information on Massachusetts Affordable Care Act implementation

- Website with information on state implementation activities including stakeholder meeting materials, grant awards, comment letters in response to federal regulations, and weekly updates on ACA guidance and news, as well as the opportunity to sign up to receive the weekly updates by email. mass.gov/nationalhealthreform

Federal Sources of Information:

- “One Stop Shop” on ACA and Businesses: Business.USA.gov/healthcare
- National Health Reform Website: healthcare.gov
- Center for Consumer Information and Insurance Oversight: cciio.cms.gov/
- US Department of Labor Webpage on ACA Policies: dol.gov/ebsa/healthreform/
- Internal Revenue Service Webpage on ACA Policies: irs.gov/uac/Affordable-Care-Act-Tax-Provisions

Other Sources of ACA Information:

- National Association of Insurance Commissioners and Center for Insurance Policy and Research: http://www.naic.org/index_health_reform_section.htm
- Henry J. Kaiser Family Foundation: <http://kff.org/health-reform/>
- National Academy for State Health Policy: <http://www.nashp.org/aca-implementation-state-health-reform-0>
- Blue Cross Blue Shield of Massachusetts Foundation: bluecrossmafoundation.org

Appendices

Appendix 1: Provisions Effective Beyond 2014-2015

Excise Tax on High Cost Coverage

In 2018, the ACA will introduce an excise tax on employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. These amounts will be indexed for inflation.

A 40% tax will be imposed on the coverage provider for the value of the “excess benefit,” or the health coverage that exceeds the threshold amount.¹⁵ The threshold amount is \$10,200 for an individual health insurance plan and \$27,500 for a family plan. These amounts will be adjusted to account for various factors such as whether health care costs increase more than expected.

Effective Date: January 1, 2018

¹⁵ The “coverage provider” could be an insurer, employer, or a plan administrator.

Appendix 2: Common Scenarios and Questions (FAQ)

General Questions

1. I am a small employer with 10 employees. I am having a hard time finding health insurance I can afford. What are my options?

Small employers and their brokers might consider checking out the Health Connector (MAhealthconnector.org) to explore their options for high-value group health plans for their workers. There are many savings opportunities to be realized by shopping for the best fit for your workers, as well as other savings opportunities your small business might be eligible for (such as the federal small business insurance tax credit and/or the Wellness Track discount).

2. I have 40 FTEs. What policies from Massachusetts state health reform law will still apply to me in 2014?

The remaining state-level health reform policies that apply to your company includes the Section 125 requirement (and the associated Free Rider Surcharge, which can be assessed on employers not offering Section 125 plans and who have workers and/or their dependents who use Health Safety Net services that exceed a set threshold). The Employer HIRD requirement will also remain in effect in Massachusetts, although the requirement is on hold right now as the revised application is being built by the Health Connector. Check back at MAhealthconnector.org for updates and details.

The Fair Share Contribution and Employee HIRD requirements from Massachusetts health reform have been repealed and, as such, Massachusetts employers are no longer subject to them. Please see page 36 for more details.

3. I have 75 employees. Can I buy coverage through the Health Connector?

Possibly. Right now, the Health Connector offers small group health coverage to small businesses with fewer than 50 eligible employees. So an employer with 75 employees might be able to offer small group coverage through the Health Connector if the number of employees who are benefits-eligible are 50 or fewer individuals (for example, if 30 of the 75 workers were part-time and therefore not benefits eligible).

In 2016, the ACA requires states to expand their small group market to groups of up to 100 full-time employees, so there will be an even larger number of employers that can benefit from shopping for group coverage through the Health Connector.

4. I am a small business owner with 12 employees. I've heard about the small business insurance tax credit that can help me pay for health insurance for my workers. How do I find out if I qualify? What do I have to do to get the credit?

In 2014, employers with up to 25 full-time equivalent (FTE) employees who pay average annual

wages of less than \$50,000 and provide health insurance will be eligible for up to a 50 percent tax credit if they purchase health coverage for their employees through a Marketplace like the Massachusetts Health Connector.

The maximum credit goes to employers with ten or fewer FTE employees who earn average annual wages of \$25,000 or less. Partial credits are available to employers with up to 25 FTEs who earn average annual wages up to \$50,000.

Here is what this could mean for you. If you pay \$50,000 a year toward workers' health care premiums – and if you qualify for a 15 percent credit, you save \$7,500. If you save \$7,500 a year from tax year 2010 through 2013, that's total savings of \$30,000. If, in 2014, you qualify for a slightly larger credit, say 20 percent, your savings go from \$7,500 a year to \$12,000 a year.

To find out more information, please visit:

<http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers>

5. What is the Marketplace Notice requirement I've been hearing about?

The ACA requires employers to issue a Marketplace Notification to current employees by October 1st, 2013, and to new hires within 14 days of the employee's start date. The purpose of this requirement is to help employees understand health insurance Marketplaces, which are designed to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector.

You can read more about this requirement and the content that the notices must contain, here: <http://www.dol.gov/ebsa/pdf/tr13-02.pdf>.

6. Are there resources to help me with the ACA Marketplace Notice requirement?

Yes. The Health Connector has developed a streamlined, Massachusetts-specific template that Massachusetts employers can use to satisfy the ACA marketplace notification requirement. The use of this particular form is entirely optional for Massachusetts employers. It was developed to help make compliance with this requirement easier for businesses in the Commonwealth. Employers also have the option of developing their own notices, or using the federally-developed templates that were released by the US Department of Labor (available here: www.dol.gov/ebsa/healthreform).

The template created by the Health Connector helps to communicate required information in a clear and straightforward manner to your employees. You may customize the Massachusetts ACA Marketplace Notice template by filling in the blank fields with information specific to your business. It includes information for your employees about any health insurance plans that you offer, including any pre-tax contribution health plans that meet the state's Section 125 requirement. Employers that use this template will also satisfy the state requirement that they provide notice to their employees about whether or not the company is in compliance with the state's Section 125 requirement.

<http://bettermahealthconnector.org/marketplace-notice/> and MAhealthconnector.org

The Health Connector also created an optional appendix to the Marketplace Notice that you can use to provide additional information to employees. This appendix is not required to satisfy the ACA requirement, but may prove helpful to your employees.

Questions about Employer Shared Responsibility Provisions – Portions Delayed Until 2015

1. I am a large employer. Will I be penalized if I don't offer any health insurance to any of my employees?

Not necessarily. The ACA's shared responsibility for employers provision does not immediately or necessarily penalize any large employer that chooses not to offer coverage. An employer generally will be liable for a penalty assessment if the employer does not offer health coverage or offers coverage to less than 95% of its full-time employees and at least one of the full-time employees receives a federal premium tax credit to help pay for coverage purchased from a health insurance Marketplace (e.g., the Massachusetts Health Connector) – which can only happen if they are at or below 400% FPL.

2. I am a large employer. I offer coverage, but I am not sure if it will be considered affordable to all of my full-time employees. Will I be penalized?

Not necessarily. The penalty assessment can only be activated by a full-time employee qualifying for and utilizing a federal premium tax credit. However, if you do offer health coverage, and you still have full-time employees that become eligible for a federal premium tax credit because the coverage you offer is unaffordable to them (employee's monthly contribution for self-only coverage is over 9.5% of their household income) or does not meet minimum value standards, you may be subject to a penalty assessment. Since most employers do not have any way of knowing the household income of their employees, the IRS has provided guidance indicating that employers may use one of three safe harbor methods of measuring the income of full-time employees who are purchasing individual market coverage in a Marketplace to determine if a penalty will be assessed.

3. I am an employer with 60 workers. How do I find out if I am large enough to have the Employer Shared Responsibility assessment apply to my company? In other words, how do I find out if my 60 workers is equal to our greater than the federal definition of 50 full-time employees?

It depends on the number of full-time employees you have and the number of part-time hours worked by other employees who are not full-time. An applicable large employer is an employer that employed at least an average of 50 full-time employees during the previous calendar year. The 50 full-time employee threshold is a combination of full and part-time employees, and is based on a 30 hour work week. For example, two employees who work 15 hours per week would count as one full-time worker for the purposes of determining the size of your business to see if you meet the 50 full-time employee threshold and are therefore an "applicable large employer." The annual calculation is an average across the calendar months of the previous calendar year.

This calculation is used solely to determine the employer's size for purposes of the 50+ full-time employee threshold and is not used to calculate any penalty assessment amounts.

4. I own a small business with 20 workers. Does the ACA require me to offer health insurance?

No. There are no penalty assessments under the ACA applicable to small businesses (those with fewer than 50 full-time and full-time equivalent workers as defined on page 12) for choosing not to offer health coverage.

5. I am a large employer with 200 workers. A lot of my employees are on MassHealth. Will I face a penalty for that?

No. Employers are not subject to any penalty assessments for having employees (full-time or otherwise) on MassHealth coverage. The penalty assessment is only triggered by utilization of federal premium tax credits by full-time employees purchasing coverage in the Marketplace. Individuals who are eligible for MassHealth, Medicare or other government health programs are not eligible for federal premium tax credits.

6. I own a restaurant. Sometimes when I hire a new employee, I don't know what their hours will be and if they will be above or below the full-time definition in the ACA. How do I know whether or not I have to offer health insurance to this worker?

If an employee is "reasonably expected" to be employed on average 30 hours or more per week for a calendar month, the employee will be considered full-time and the employer must offer coverage to be effective at or before the end of the employee's first 90 days of employment. The ACA contains special eligibility rules that employers may adopt if the employee is a seasonal employee or if the employer is unable to determine if the new employee, as of his start date, is reasonably expected to be employed on average 30 hours or more per week.

7. I am an employer on Cape Cod and the size of my workforce fluctuates depending on the time of year. How do I know if I might be subject to the Employer Shared Responsibility provisions of the ACA?

If your company employs more than 50 full-time employees for no more than three months of the year, the shared responsibility provision may not apply to you. An employer whose workforce exceeds 50 full-time employees for 120 or fewer days during a calendar year is not a large employer IF the employees in excess of 50 during those 120 days were seasonal workers.

8. I offer self-only coverage to my workers (but do not offer coverage to their spouses or kids). Will this be a problem under the ACA?

Possibly. Beginning in 2015, an applicable large employer may be subject to a penalty assessment if the employer does not offer its full-time employees (*and their dependents*) the

opportunity to enroll in Minimum Essential Coverage health coverage. However, the ACA defines “dependents” (in this context) as an employee’s child(ren) who are under 26 years of age. The term “dependents” for this purpose does not include an employee’s spouse and therefore an offer of coverage to an employee’s spouse is not required by the ACA. If a child of a full-time employee, or the full-time employee him/herself, qualified for and utilized a tax credit to get coverage via the Marketplace, the employer may be subject to a penalty assessment.

9. I employ some low-income full-time workers. How will I know if the coverage I am offering them is considered “affordable”?

A potential penalty could be triggered if a full-time employee is required to pay more than 9.5% of their household income towards self-only coverage for the lowest cost health plan offered by the employer. As a hypothetical example, if you offer coverage to a full-time employee with a household income of about \$34,000 and the employee is asked to contribute \$100 each month towards that coverage, that would cost that employee about 3.4% of their household income. So you would know that that employee’s contribution would safely be considered “affordable” since it is well below the 9.5% threshold. Since this employee is being offered affordable health insurance (and provided it meets minimum value standards), this employee would not qualify for a tax credit at the Health Connector (and therefore would in no way trigger any kind of assessment for their employer).

As noted in question 2, since most employers don’t have any way of knowing the household income of their employees, the IRS has provided guidance indicating that employers can use one of three safe harbor methods of measuring the income of full-time employees, as a proxy for household income, to determine if a penalty will be assessed. The three optional IRS Safe harbors available to employers to measure income for any reasonable category of full-time employees are:

- Form W-2 – Form W-2, Box 1 income for months during which the employee was eligible for coverage
 - Applied after year end and on employee by employee basis
 - Adjusted if employee is not employed the entire year
- Rate of Pay – Salaried employee’s monthly salary, OR hourly employee’s rate of pay as of 1st day of the plan year times 130 hrs for months during which the employee was eligible for coverage
 - Only available if employer does not reduce the employee’s wages during year
- Federal Poverty Line – FPL for a single individual. For 2013, FPL = \$11,490
 - May use most recent FPL guidelines as of 1st day of the plan year

10. How do I know if the coverage that I offer to my full-time employees meets the federal minimum value standard?

For most fully-insured health plans, your health insurance company will be able to tell you if your coverage meets the minimum value standard. In other cases, such as for self-insured health plans, there is a “minimum value calculator” available online that allows employers to input certain information to verify that the coverage they offer meets the 60% minimum value standard. It can be found here:

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm>

Appendix 3: Information for Specific Types of Employers

Information for Self-Insured Employers

Some provisions of the ACA only apply to self-insured employers (i.e., employers that assume the risk for covering their workers and pay claims directly). Some of these provisions overlap with provisions that affect health insurance carriers. While self-insured employers are not the primary audience of this guide, we've culled out the provisions that self-insured employers may wish to ensure they are informed of and taking steps to comply with.

Summary of Benefits and Coverage

The ACA requires health insurance issuers and plan sponsors of group health plans (both fully insured and self-funded benefit arrangements) to provide, in a culturally and linguistically appropriate manner, a Summary of Benefits and Coverage (SBC) for each plan or benefit option the employer makes available to applicants and enrollees. Fully-insured employers will receive the SBC from the applicable health insurance issuer and may have the distribution requirement fulfilled by the health insurance issuer as well.

The standard SBC must not exceed eight pages in length (four pages double sided) using no smaller than 12 point font, and must include information related to definitions of insurance terms; a description of the coverage; coverage exceptions, reductions, and limitations; cost-sharing provisions; renewability and continuation of coverage provisions; a coverage facts label that includes examples of common benefit scenarios; and a contact number. For plan years beginning on or after January 1, 2014, the SBC must also include a statement of whether the plan provides minimum essential coverage and a statement of whether the plan meets minimum value standards (that is, covers at least 60% of total allowed costs).

The requirements to provide an SBC apply:

- the first day of the first open enrollment period that begins on or after September 23, 2012 for disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees). This could be as early as October 1, 2012 for a calendar year plan.
- the first day of the first plan year that begins on or after September 23, 2012 for disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees). This could be as early as October 1, 2012 for a fiscal year plan beginning October 1.

To the extent a plan or policy implements a mid-year change that is a material modification, that affects the content of the SBC and that occurs other than in connection with a renewal or reissuance of coverage, the SBC regulations require a notice of modification to be provided to participants and beneficiaries at least 60 days in advance of the effective date of the change.

SBC templates, instructions, and related materials authorized for implementing the SBC disclosure

provisions for the first year of applicability (that is, for SBCs provided with respect to coverage beginning before January 1, 2014) were made available in February 2012.¹⁶

An updated SBC template (and sample completed SBC) for use with coverage beginning on or after January 1, 2014, and before January 1, 2015, which is referred to as “the second year of applicability,” was made available in April 2013.¹⁷

The updated SBC template and the sample completed template for the second year of applicability can be found at the following links:

- www.dol.gov/ebsa/correctedsbctemplate2.doc
- www.dol.gov/ebsa/CorrectedSampleCompletedSBC2.doc

PCORI Fee

The Patient-Centered Outcomes Research Trust Fund fee is a fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI), created by the ACA as a private, non-profit corporation. This program began in 2012 and will run for seven years into 2019. The institute will assist in making informed health decisions by advancing the quality and relevance of evidence-based medicine. The institute will compile and distribute comparative clinical effectiveness research findings.

Insurers pay the PCORI fees on behalf of insured health plans. However, employer/plan sponsors pay the fees on behalf of self-insured health plans.

- The initial annual fee is \$1 per covered life for policy/plan years ending before October 1, 2013; increasing to \$2 per covered life for policy/plan years ending before October 1, 2014 and then to an amount indexed to national health expenditures for policy/plan years beginning on or after October 1, 2014 until fees end in 2019.
- Covered lives include participants, spouses and dependents.
- Fees are considered excise taxes that are reported and paid annually on IRS Form 720 Quarterly Federal Excise Tax Return. Employer/sponsors will not file a Form 720 unless they sponsor a self-insured plan, including an HRA.
- Fees are due by the July 31 of the year following the last day of the policy or plan year.
 - *E.g.*, for a calendar year policy/plan ending December 31, 2012, the fee must be paid by July 31, 2013.
 - *E.g.*, for a fiscal year policy/plan ending March 31, 2013, the fee must be paid by July 31, 2014.

For more information, please visit: <http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers> or refer to the final PCORI regulation.¹⁸

¹⁶ 77 Federal Register 8668 (February 14, 2012)

¹⁷ Frequently Asked Questions (FAQs) About Affordable Care Act Implementation Part XIV; (April 23, 2013)

Transitional Reinsurance Fee

The ACA establishes a Transitional Reinsurance Program to help stabilize premiums for coverage in the individual market during calendar years 2014 through 2016, requiring all health insurers (in the individual, small group and large group markets) and self-insured group health plans to make contributions under this program to support payments to individual market insurers (both inside and outside the Marketplaces) that cover high-cost individuals. These stabilization payments are intended to protect individual market insurers against adverse selection as insurance market reforms are implemented.

Each state may establish its own reinsurance program. If a state does not establish its own program, then HHS will operate a reinsurance program for that state. Massachusetts has elected to default to the federal program. In either case, HHS will collect the reinsurance contributions annually from contributing entities using a uniform national per capita contribution rate and then distribute the proceeds accordingly.

In order to simplify the collection and administration of the Transitional Reinsurance Program a uniform contribution rate will be determined for each year of the program by the Department of Health and Human Services (HHS). HHS has determined that the national annual per capita contribution rate will be \$63.00, or \$5.25 per month, per covered life for 2014. Covered lives include participants, spouses and dependents.

Insurers pay the contributions on behalf of those to whom they provide insurance coverage. Employer/plan sponsors of self-insured health plans are liable for the reinsurance contribution. However, the employer/plan sponsor may use a third party administrator (TPA) to transfer the reinsurance contributions to HHS on their behalf.

With regard to the timing, HHS will collect and pay out reinsurance funds on an annual basis from all states, as follows:

- By November 15 of each year (2014, 2015 and 2016), the insurer or employer/sponsor is required to submit the annual enrollment count of the number of covered lives subject to the reinsurance contribution to HHS.
- By December 15, or within 15 days of submission of the annual enrollment count, whichever is later, HHS will notify the insurer or employer/sponsor of the total contribution amount to be paid.
- The insurer or employer/sponsor will be required to submit its payment to HHS within 30 days of notification of the amount due.

For more information, please refer to the final Transitional Reinsurance Program regulation.¹⁹

¹⁸ 77 FR 72721; <https://federalregister.gov/a/2012-29325>

¹⁹ Final Rule; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; CMS-9964-F (March 1, 2013).

Information for Sole Proprietors

Changes to the Classification of Sole Proprietors in the Health Insurance Market

The ACA requires that sole proprietors be treated as individuals, rather than as small groups. As such, sole proprietors may be eligible for a federal premium tax credit by shopping for coverage as an individual through a Marketplace (in Massachusetts, the Health Connector). Sole proprietors should be aware, however, that during a two-year transition period granted by the federal government for 2014 and 2015, Massachusetts will permit sole proprietors to continue to purchase products outside the Marketplace according to merged market rules as a small group, if they choose to do so.



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