

2018 Massachusetts Employer Mandate

This guide is intended to summarize the various requirements in Massachusetts (“MA”) that affect employers that have employees residing in the state.

BACKGROUND

On July 1, 2007, the Massachusetts Health Care Reform Act became effective. Components of this act included:

- An individual mandate, requiring residents of MA to have Minimum Creditable Coverage (“MCC”) or pay a penalty on their state income tax return.
- Various requirements on employers (most of which were repealed), including:
 - ↪ An annual fee of \$295 per full-time employee when the employer did not make sufficient contributions toward health care coverage. This was known as the Fair Share Contribution (“FSC”).
 - ↪ A surcharge in the event 5 or more uninsured employees or dependents used state-provided health care more than 3 times a year if the employer did not adopt a cafeteria plan that allowed employees to contribute on a pre-tax basis toward health care coverage of the employer.
 - ↪ Various reporting and disclosure requirements.

MA health care reform became the blue-print upon which the Federal government crafted national reform under the Obama administration, known as the Affordable Care Act (“ACA”). The ACA was enacted March 23, 2010.

After passage of the ACA, MA recognized the duplicative nature of the federal and state rules on employers and decided to remove many of the state-laws that applied to employers regarding offers of health insurance coverage that were now included in the Federal law.

However, in 2017 the Trump administration changed aspects of the ACA, including repealing the individual mandate. Because of the change in administration and the rising costs of public sector health insurance, MA enacted new laws and regulations that reinvent an employer mandate for employers with employees residing in MA.¹

WHAT’S REQUIRED OF EMPLOYERS IN 2018

1. The Employer Medical Assistance Contribution (“EMAC”)

In 2014, after repeal of the MA Fair Share Contribution requirement MA created EMAC. EMAC applies to employers with **more than five (5) employees in MA** and applies regardless of whether the employer offers health coverage to its employees.

For wages paid in the years 2018 and 2019, the EMAC contribution is 0.51%² up to the annual wage cap of \$15,000. The potential maximum cost per employee is \$77 per year. This increase will first be reflected on the quarterly statement issued in April 2018. This is a temporary increase scheduled to end after December 31, 2019.

¹ An Act Further Regulating Employer Contributions to Health Care <https://malegislature.gov/Bills/190/H3822>;
Final Employer Medical Assistance Contribution Supplement Regulations
<https://www.mass.gov/files/documents/2018/01/02/Final%20EMAC%20Supplement%20Regulations.pdf>

² Prior to 2018, the EMAC rate was 0.34% up to \$15,000 – with a potential maximum of \$51 per employee per year.

2. The Employer Medical Assistance Contribution Supplement ("EMAC Supplement")

The EMAC Supplement applies to employers with **more than five (5) employees in MA**³ whose non-disabled employees obtain health insurance from either MassHealth (excluding the premium assistance program)⁴ or subsidized coverage through MA's Marketplace known as the ConnectorCare program. This is a temporary program that is in effect beginning January 1, 2018 through December 31, 2019.

The contribution is 5% of annual wages for each non-disabled employee up to a maximum of \$15,000 in wages. The potential maximum per employee is \$750 per year. *Note, this is significantly more than the \$295 under the original FSC.*

This supplemental cost assessed on employers only applies to those employees receiving state subsidized coverage. Because the calculation is based on wages (up to \$15,000), any employee (regardless of part-time or full-time status) can trigger an assessment if the employee:

- earns at least \$500 in wages from the employer in a quarter, and
- is covered by MassHealth or receives a subsidy through ConnectorCare for a continuous period of at least **56 days (8 weeks)**.

An employer will not be subject to the EMAC Supplement if MassHealth or ConnectorCare coverage is a secondary payer because the employee is also enrolled in an employer-sponsored group health plan.

Payment of the EMAC Supplement is required quarterly, and is due and payable on or before the last day of the first month succeeding the quarter in which wages were paid and reported. Any payment owed is included on the statement showing the employer's Unemployment Insurance liability issued from the Department of Unemployment Assistance ("DUA"). If applicable, an employer may see the first assessment on the April 2018 statement.

WHAT'S REQUIRED OF MA RESIDENTS & EMPLOYER CONSIDERATIONS

All MA residents age 18 and older must maintain Minimum Creditable Coverage ("MCC") or pay a penalty on their state income tax return. While redundant in some ways (e.g., preventive care covered at no cost, no annual dollar limits), MA's MCC requirements are generally more onerous than the federal requirement to have MEC to avoid a federal tax penalty. With the passage of national tax reform, the penalty associated with the federal individual mandate goes away as of January 1, 2018.

What is MCC?

To qualify as MCC, a health plan must meet the following requirements:

- Provide core services and a broad range of medical benefits to all persons who are covered under the plan (this includes anyone who receives coverage as a dependent of the primary insured).

A broad range of medical benefits includes, at a minimum, coverage for:

- Ambulatory patient services, including outpatient, day surgery and related anesthesia;
- Diagnostic imaging and screening procedures, including x-rays;
- Emergency services;

³ <https://www.mass.gov/news/updates-in-employer-health-care-contributions-and-experience-rate-schedule-adjustments-for>

⁴ The MassHealth Premium Assistance Program can help employees remain on or join their employer-sponsored health plan through direct premium assistance payments. Note that employees enrolled in MassHealth's premium assistance program will not subject their employer to the contribution detailed above. More information for employers and employees who are interested in utilizing this program can be found at <https://www.mass.gov/service-details/other-health-insurance-and-masshealth-premium-assistance>, or by calling the Premium Assistance Hotline at 1-800-862-4840.

- ↪ Hospitalization (including at a minimum inpatient acute care services which are generally provided by an acute care hospital for covered benefits in accordance with the member's subscriber certificate or plan description);
 - ↪ Maternity and newborn care, including prenatal care, post-natal care, and delivery and inpatient services for maternity care (this includes services to the pregnant daughter of the policy holder if she is covered by the medical plan);
 - ↪ Medical/surgical care, including preventive and primary care;
 - ↪ Mental health and substance abuse services;
 - ↪ Prescription drugs; and
 - ↪ Radiation therapy and chemotherapy.
- A health benefit plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers. Exclusions and limitations on benefits should be identified in plain language and non-discriminatory in their design and application.
- A health benefit plan may impose varied levels of co-payments, deductibles and co-insurance, provided that:
 - ↪ The deductible, co-pays and co-insurance amounts in-network and out-of-network are disclosed;
 - ↪ Any deductible for in-network covered services shall not exceed \$2,000 for an individual and \$4,000 for a family (subject to inflation) and;
 - ↪ If applicable, any separate deductible for prescription drugs may not exceed \$250 for an individual and \$500 for a family.
- For plans with up-front deductible or co-insurance on core benefits, the annual maximum on out-of-pocket spending (OOPM) may not exceed the ACA OOPM limits (for 2018, \$7,350 self-only, \$14,700 family).⁵
- May not impose a cap on total benefits for a particular illness or for a single year.
- Cannot be a policy that only covers fixed dollar amount per day or stay in a hospital.
- Cover preventive care on an annual basis without a deductible (non-grandfathered plans must cover all federally mandated preventive care benefits without any deductible, copay or coinsurance).
- To meet the "broad range of benefits" definition multiple health benefit plans may be aggregated. This means, for example, a health benefit plan with carved out pharmacy or mental health benefits can be aggregated as a combined health plan to determine MCC status.
- A health benefit plan that has deductibles or out-of-pocket maximums exceeding the limits described above (but within other applicable federal limits) may be combined with a Health Reimbursement Arrangement (HRA) so that together the "net" deductible or out-of-pocket maximum of the combined health plan does not exceed the required limits to meet MCC.⁶
- A qualified high deductible health plan (HDHP) will meet MCC if it:
 - ↪ complies with all federal requirements to qualify as an HDHP;
 - ↪ the carrier or plan sponsor facilitates access to a Health Savings Account (HSA) to enable the covered individual to establish and fund a HSA; or
 - ↪ the plan sponsor establishes and maintains a HRA in combination with the qualified HDHP.

IMPORTANT EMPLOYER NOTES.

While employers are not required to provide health plans that meet MCC, their MA resident employees need MCC to avoid significant penalties. Employers with MA employee-residents will want to know whether their coverage options meet the MCC requirements. In many cases self-funded plans and insured plans written in

⁵ This must include any expenditure, including deductibles, co-insurance, co-payments, or similar charges, on behalf of an enrollee with respect to Essential Health Benefits.

⁶ Care must be taken to ensure a non-grandfathered plan does not exceed the federal out-of-pocket limits of \$7,350 self-only and \$14,700 as a similar aggregation does not apply at the federal level. In other words, under federal law a non-grandfathered health plan with a \$15,000 OOPM and a \$5,000 HRA violates the \$14,700 limit on OOPM as the HRA is not counted toward the OOPM.

states outside of MA will not contain all of the benefits and parameters to meet MCC. It is important to know this up front and disclose it to MA employees.

Some employers will implement a separate MA insured contract for MA resident employees to ensure coverage meets MCC.

Residents of MA should receive a Form MA 1099-HC following the close of the calendar year. This will document for state income tax purposes the resident's MCC for the year. Employers with self-funded plans and/or carriers situated outside of MA will need to determine whether the carrier and/or TPA will provide this document to MA residents or if the employer will need to be responsible.

Specifically, for self-funded plans and insured plans with out-of-state carriers, employers will want to coordinate with TPA's to determine responsibility for electronically filing information on Forms MA 1099-HC with the MA Department of Revenue ("DOR").

Failures to issue the Form MA 1099-HC may result in a penalty of \$50 per individual to which the failure relates, to a maximum of \$50,000. Penalties can be abated for reasonable cause, but inadvertent oversight does not meet the reasonable cause standard.⁷

⁷ For more information, including the specific details on this filing visit <http://www.mass.gov/dor/individuals/health-care-reform-information/employers/frequently-asked-questions-employers.html> (last visited 1/5/2018)