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Massachusetts and New Jersey Enact State-Level Health Coverage Mandates

The change in the federal government's health care policy following the 2016 elections has resulted in increased legislative and regulatory activity at the State level, as certain States have adopted or are actively considering rules that they believe will preserve the policy goals of the Affordable Care Act ("ACA"). Two recent health coverage mandates in Massachusetts and New Jersey impose potentially significant financial and administrative requirements on employer plan sponsors and insurance carriers that operate in those States.

In Massachusetts, new legislation temporarily increases the existing Employer Medical Assistance Contribution ("EMAC") and imposes an additional EMAC supplement on employers whose employees receive Medicaid or subsidized coverage through Massachusetts' ConnectorCare program. The legislation took effect on January 1, 2018 and is set to continue through December 31, 2019.

In New Jersey, the state legislature established an individual health care mandate that requires New Jersey residents to obtain health coverage or pay a penalty. In doing so, New Jersey became the first state in the country to respond to the effective repeal of the ACA's individual mandate by enacting its own individual mandate. The New Jersey law takes effect on January 1, 2019 and entails reporting requirements that will generally track the federal ACA reporting requirements.

A more in-depth discussion of these two laws follows.

Massachusetts' EMAC and EMAC Supplement

Since 2014, employers with six or more employees in Massachusetts have paid a per-employee contribution called an EMAC as part of their unemployment insurance taxes. This assessment applies regardless of whether the employer offers health coverage to its employees and is determined by multiplying the first \$15,000 of each employee's annual wages by a statutory rate.

New Massachusetts legislation that took effect this year increases Massachusetts' EMAC assessment and establishes a new temporary tax called the "EMAC supplement." Because the new legislation increases the statutory rate of the EMAC assessment from 0.34% to 0.51%, the per-employee maximum EMAC is now \$77 per year, up from \$51 per year. Employers subject to the EMAC must pay the increased rate until it expires in 2019, at which point it will either be extended or revert back to the previous, lower rate.

Perhaps more significantly, employers in Massachusetts are now subject to a new temporary assessment—the EMAC supplement—that applies, beginning in the first quarter of 2018, when non-disabled employees obtain health insurance from either MassHealth (*i.e.*, Massachusetts' state Medicaid program) or the ConnectorCare (*i.e.*, subsidized coverage for

people with household incomes of 300% of the federal poverty line (“FPL”) or less). The EMAC supplement applies to Massachusetts employers with six or more employees in Massachusetts in any calendar quarter in which at least one employee was enrolled in MassHealth or ConnectorCare for a continuous period of at least 56 days during the quarter. The contribution is five percent of annual wages for each employee, up to the annual wage cap of \$15,000, for a maximum of \$750 per affected employee per year. The contribution does not apply to employees who earn less than \$500 in wages per quarter. This measure is intended to defray the cost of publicly-subsidized health care coverage, which in recent years has risen sharply as more and more individuals have shifted from commercial to public health coverage. The new EMAC supplement is scheduled to expire at the end of 2019.

Employers subject to the EMAC assessment (including the supplement) must pay the assessment quarterly. After the employer submits its quarterly wages, the Massachusetts Department of Unemployment Assistance (“DUA”) calculates the employer’s quarterly supplement using information received from both MassHealth and ConnectorCare. The EMAC assessment then appears on the employer’s quarterly unemployment insurance statement, at which point the employer can either pay the assessment or appeal.

If an employer believes it has been wrongly assessed – for example, because the DUA erroneously determined that an employee’s health coverage triggered an EMAC supplement assessment – the employer may appeal the assessment within ten days of receiving notice of the DUA’s determination. In making its appeal, the employer must request a hearing in writing and identify the specific reasons for the appeal (*i.e.*, why it believes the DUA’s determination was erroneous). The DUA will then either affirm, adjust, or withdraw its initial determination, after which point the employer may appeal within 30 days of the date of the decision to the Massachusetts superior court. Employers must still make timely payments while an appeal is pending.

The appeals process is particularly important because the EMAC supplement’s mechanics have generated considerable confusion. For example, in order to enroll in ConnectorCare – and thus potentially trigger an employer’s EMAC supplement assessment – an employee’s household income must remain at or below 300% of the federal poverty level *and* the employee cannot qualify to enroll in her employer’s affordable, comprehensive health care coverage (including plans the employee has been offered, but has not enrolled in) under the ACA’s Advance Premium Tax Credit rules. Understandably, employers often conclude that if an employer makes an employee an offer of minimum value, affordable coverage, the employee is ineligible for ConnectorCare and thus should not trigger any EMAC supplement liability (unless the employee is eligible for and enrolls in MassHealth).

However, DUA guidance provides that if an employee “waives an employer’s offer of insurance” and enrolls in ConnectorCare, the employer’s “offer of insurance” does not preclude an EMAC supplement assessment. In other words, the DUA’s guidance does not specify whether an employer’s offer of insurance must constitute affordable, comprehensive (*i.e.*, minimum value) health care coverage. There may be instances in which employees who were offered affordable, comprehensive coverage by their employer may nonetheless be able to enroll in ConnectorCare (even though they should not be eligible), triggering an EMAC supplement assessment. The employer’s only recourse would then be to appeal the decision, specifying that the employer offered affordable coverage that met minimum value and, therefore, the individual was ineligible for ConnectorCare, should not have been enrolled in ConnectorCare subsidized coverage, and, therefore, that the employer should not be subject to a related EMAC supplement assessment. It is unclear, however, whether DUA or Massachusetts courts would accept this argument.

In any event, the new EMAC supplement imposes meaningful, albeit potentially temporary, financial and administrative burdens on employers in Massachusetts. Employers subject to the supplement should scrutinize the DUA’s quarterly assessments closely, ensuring that both the application and calculation of the supplement are accurate. To the extent an assessment is incorrect, employers should appeal swiftly.

New Jersey's Individual Health Insurance Mandate

On May 30, 2018, New Jersey Governor Phil Murphy signed into law a bill that will make New Jersey the second state in the country to adopt a state-level individual health insurance mandate. The new law is scheduled to take effect on January 1, 2019 when the federal individual mandate penalty – which Congress eliminated as part of its tax reform package last fall¹ – is set to expire. New Jersey now becomes the first state in the country to respond to the effective federal repeal by enacting its own individual mandate.

The ACA's individual "shared responsibility" provision was designed to provide a financial incentive for individuals to maintain health insurance, thus expanding the individual insurance risk pool and stabilizing premium costs. While technically it does not "mandate" that an individual maintain insurance, under this rule most taxpayers (unless subject to an exemption) are subject to a penalty for any months during which they or their dependents do not have "minimum essential coverage" as defined under the ACA. The ACA provides that the amount of the penalty is based on the greater of a flat dollar amount (per family member without coverage) or a percentage of the taxpayer's income, capped at the national average of the annual cost of a bronze level health insurance plan offered through the federal Exchanges. However, in connection with the Tax Cuts and Jobs Act, Congress reduced the penalty for the individual mandate to zero, effective January 1, 2019. (The shared responsibility penalties remain intact for 2018.)

While some taxpayers will no doubt welcome the elimination of the potential tax penalties, the Congressional Budget Office estimated that the effective repeal of the ACA's individual mandate penalties would lead to an additional 3 million uninsured people in 2019. It is also widely believed that, without the individual mandate penalties, fewer healthy people will enroll in insurance, thus increasing premium costs generally. As a result, some States have begun to look at implementing their own individual mandate requirements.

The New Jersey law (entitled the "New Jersey Health Insurance Market Preservation Act") largely mirrors the ACA's federal mandate by imposing a penalty on New Jersey residents who fail to obtain "minimum essential coverage," as defined under the ACA. Following the federal formula, individuals who fail to obtain coverage must pay either 2.5% of their household income or a per-person charge (*i.e.*, \$695 per adult and \$347.50 per child), whichever is greater. The maximum penalty based on household income, much like the ACA, is capped based on the state average annual premium for bronze-level plans. Individuals for whom coverage is considered unaffordable may obtain a "hardship" exception, which will be determined by the New Jersey State Treasurer in a manner consistent with the ACA. Similar exemptions exist for individuals who either object to obtaining health insurance based on religious conscience, are enrolled in a health care ministry, or are incarcerated. Revenues collected through enforcement of the individual mandate will be used to fund New Jersey's new reinsurance program, which was enacted through a different piece of state legislation and was officially approved by the federal Department of Health and Human Services ("HHS") in August.

Under the new state law, entities that provide minimum essential coverage to New Jersey residents also have a reporting obligation to the covered individual and the New Jersey State Treasurer. The reporting requirement mimics the ACA reporting requirement under Code section 6055, which currently requires providers of minimum essential coverage to report that coverage on Forms 1095-B and 1095-C. Although the precise mechanics are not fully known at this time, it appears that providers of minimum coverage will be able to satisfy the reporting requirements by submitting an annual return containing the names, addresses, Social Security numbers, and dates of coverage of each

¹ <https://www.groom.com/wp-content/uploads/2018/01/Tax Reform Series 1 Fringe Benefit and HW Provisions.pdf>.

New Jersey resident receiving minimum essential coverage under the plan. The reporting requirement may also be satisfied by submitting a return that includes at least the same information required to be reported under Code section 6055 (*i.e.* the Form 1095-B or 1095-C). Under the New Jersey law, this reporting requirement applies to employers that sponsor health coverage, insurance carriers, and the New Jersey Department of Human Services with respect to the NJ FamilyCare Program.

Whether New Jersey has the authority to compel employer plan sponsors to report as contemplated under this law could become a point of contention. This is because section 514 of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) directly preempts state laws that “relate to” ERISA plans. However, state laws that have an indirect impact on ERISA plans are not subject to preemption. The question raised by the New Jersey law is whether the state can compel ERISA plan sponsors to report on the coverage provided to plan participants and beneficiaries. Different federal courts have reached very different conclusions with regard to ERISA’s preemption principles. Notably, in 2016 the U.S. Supreme Court held that a Vermont law requiring employer-sponsored health care plans to report a significant amount of health care information to the State (including “all health care utilization, costs, and resources in [Vermont], and health care utilization and costs for services provided to Vermont residents in another state”) was preempted. *Gobeille v. Liberty Mutual Ins.*, 136 S. Ct. 936 (2016). The majority opinion noted that the Vermont law was preempted specifically because it involves “reporting, disclosure, and – by necessary implication – recordkeeping[.]” all “fundamental components of ERISA’s regulation of plan administration[.]” On the other hand, where a Michigan state law assessing a tax on medical claims paid had an ancillary reporting and recordkeeping requirement which applied to self-insured plans, the Sixth Circuit found that those obligations were “peripheral” and did not warrant preemption. *Self-Insurance Institute of America Inc. v. Snyder*, 827 F. 3d 549 (6th Cir. 2016). Therefore, New Jersey might be able to argue that this reporting requirement should not be preempted since it is simply ancillary to enforcing what amounts to a tax (the penalty for not maintaining health coverage).

One interesting element of the New Jersey law is that coverage provided through an association, trust, or multiple employer welfare arrangement (“MEWA”) is not considered “minimum essential coverage” unless it meets certain consumer protection requirements generally applicable to health plans offered in New Jersey. This is in reaction to the regulation recently finalized by the Department of Labor expanding the universe of arrangements that can qualify as an association health plan (“AHP”) and also applying large group treatment to qualifying AHP coverage.² There have been concerns that AHPs established under this regulation might provide coverage that does not reflect the ACA’s market reforms. New Jersey addresses this by requiring AHPs (and other MEWAs) to meet its state requirements in order to qualify as minimum essential coverage – presumably if AHP coverage does not meet these standards, it will have little or no value to consumers since enrollment in such products would not protect them from the state penalty.

While New Jersey is the first state to enact an individual mandate since Massachusetts in 2006, other states are beginning to follow suit. Vermont, for example, enacted legislation in May of this year that establishes an individual mandate effective for 2020, the details of which are scheduled to be settled during the 2019 legislative session. The District of Columbia also recently approved legislation similar to New Jersey’s individual mandate. Other efforts in Connecticut, Maryland, and Hawaii were proposed, but have failed to gain traction for the time being.

In the wake of the effective repeal of the ACA’s individual mandate, employers may now begin to confront a patchwork of state minimum coverage and reporting requirements. While many states might borrow heavily from

² <https://www.groom.com/resources/dol-finalizes-association-health-plan-rule-allowing-for-expanded-availability-of-association-health-plans/>.

the ACA in crafting their rules (like New Jersey), others might not. This could result in different rules concerning what constitutes minimum essential coverage and what employers must do in connection with that coverage – for example, rules concerning employee notification of available coverage and different state reporting regimes. The overlay of the existing federal rules and ERISA’s preemption principles add additional potential complexity.

Conclusion

As states confront the rising cost of publicly-subsidized health care coverage, particularly in light of the effective repeal of the individual mandate, states will likely continue to design initiatives that seek to incentivize enrollment and reduce costs. The new laws in Massachusetts and New Jersey are two of the earliest attempts at accomplishing those goals. As employers and carriers look ahead to 2019 and beyond, new approaches will likely emerge, entailing further administrative challenges. Interested parties should continue to monitor these state legislative efforts closely.

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