STATE EMPLOYMENT LAWS

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Health Care Reform

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Affordable Care Act (ACA). The ACA includes numerous reforms aimed at improving the U.S. health care delivery system, controlling health care costs and expanding health coverage. The ACA's reforms have staggered effective dates, with many key reforms taking effect in 2014.

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

This Employment Law Summary provides a high-level overview of selected ACA reforms to be implemented by state governments, and highlights the progress being made in New York.

HEALTH INSURANCE EXCHANGES

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

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

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

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

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

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

New York established its Exchange pursuant to an Executive Order issued by Governor Cuomo on April 12, 2012. New York's Exchange is called **NY State of Health**. On Dec. 14, 2012, New York received conditional approval from HHS for its state-based Exchange. More information on New York's Exchange is available at: http://healthbenefitexchange.ny.gov.

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ESSENTIAL HEALTH BENEFITS

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

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

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

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

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

The selected benchmark plans have been finalized for benefit year 2014. New York selected a plan from the largest small group product (Exclusive Provider Organization) as its EHB benchmark. More information on New York's benchmark plan is available on The Center for Consumer Information & Insurance Oversight (CCIIO) website.

MEDICAID EXPANSION

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

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

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

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

EXPANSION OF SMALL GROUP MARKET

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

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

Under New York law, the small group market is defined as a group with 50 or fewer employees. To comply with the ACA, New York must expand its small group market by Jan. 1, 2016 to include employers with 100 or fewer employees.

INSURANCE RATE REVIEW

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

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

The proposed increases must be reviewed by either state or federal experts to determine whether they are unreasonable. States with effective rate review systems will conduct their own reviews, but if a state does not have the resources or authority to conduct rate reviews, HHS will conduct them. According to HHS, New York has an effective system for reviewing insurance rates. The New York Department of Financial Services conducts rate reviews for the individual and small group markets.

MEDICAL LOSS RATIO RULES

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

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

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

New York has a higher MLR threshold in the small group and individual markets of 82 percent, and a large group MLR requirement of 85 percent. Even if New York issuers in the small group and individual markets meet the federal MLR thresholds, they still need to pass the state's MLR requirements to avoid issuing rebates.

ENFORCEMENT OF INSURANCE MARKET REFORMS

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

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

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

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DEPENDENT COVERAGE REQUIREMENTS

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

New York law requires insured health plans to maintain dependent coverage until age 26, similar to the ACA. New York law also requires insured health plans to maintain coverage for disabled dependents past the policy's limiting age. In addition, health insurance issuers are required to make dependent coverage up to **age 30** available to group policyholders. The group policyholder, or employer, decides whether to provide this benefit. Further, health plans must allow unmarried dependent children who satisfy certain eligibility criteria to elect to continue coverage past the policy's limiting age for dependent coverage up to **age 30**.

The ACA amended the federal tax code so that, for federal tax purposes, the value of employer-provided coverage for young adult dependents is excluded from the employee's gross income through the tax year in which the dependent child turns 26.

New York's tax laws automatically conform to changes in the federal tax code. Therefore, the value of employer-provided coverage for young adult dependents is excluded from the employee's gross income through the end of the tax year in which the dependent child turns age 26.

However, health coverage for an adult child after the year in which the child turns age 26 will be subject to federal and state tax, unless he or she qualifies as a tax dependent.

EXTERNAL REVIEW PROCESS

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

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