



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

September 29, 2014

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[MA-ACA Website](#)



These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Activity

For information about ACA grants awarded to and grant proposals submitted by the Commonwealth, visit the Grants page of the **Massachusetts National Health Care Reform website** at:

<http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html>

Guidance

9/18/14 IRS/Treasury issued final regulations called "Deduction Limitation for Remuneration Provided by Certain Health Insurance Providers."

The final regulations are about the application of the \$500,000 deduction limitation for remuneration provided by certain health insurance providers under section 162(m)(6) of the IRS Code, which was added by ACA §9014. The regulations affect certain health insurance providers providing remuneration that exceeds the

deduction limitation.

For taxable years beginning after December 31, 2012, section 162(m)(6) limits the deduction that certain health insurance providers can claim for the compensation of services provided by an individual. In addition, health insurance providers who deferred compensation for services performed in a taxable year after December 31, 2009 but before January 1, 2013 are also subject to the \$500,000 deduction limitation.

Read the rule (which was published in the Federal Register on 9/23/2014) at:

<http://www.gpo.gov/fdsys/pkg/FR-2014-09-23/pdf/2014-22317.pdf>

9/18/14 IRS/Treasury issued Notice 2014-49, which describes a proposed approach to the application of the look-back measurement method, which may be used to determine if an employee is a full-time employee for purposes of § 4980H of the Internal Revenue Code, in situations in which the measurement period applicable to an employee changes. This notice is intended to address the topics for which guidance was anticipated in section VII.G of the preamble to the final § 4980H regulations.

The Employer Shared Responsibility provisions under Section 4980H (which was added to the IRS Code by ACA §1513) state that "applicable large employers" must offer health coverage to their full-time employees or a shared responsibility payment may apply. For 2015 and after, "applicable large employers," those employers employing at least a certain number of employees (employers with 50 or more full-time employees*) must offer affordable health coverage that provides a minimum level of coverage (\$1501) to their full-time employees (and their dependents), or the employer may be subject to an employer shared responsibility payment if at least one of its full-time employees receives a premium tax credit (§1401, §1411) for purchasing individual coverage on one of the Affordable Insurance Exchanges (Marketplaces).

*Under the ACA, 50 full-time employees or a combination of full-time and part-time employees is equivalent to 50 full-time employees. A full-time employee is an individual employed on average at least 30 hours of service per week. An employer that meets the 50 full-time employee threshold is referred to as an applicable large employer.

Read the notice at: <http://www.irs.gov/pub/irs-drop/n-14-49.pdf>

9/18/14 IRS/Treasury issued Notice 2014-55, which expands the permitted election rules for health coverage under a Section 125 cafeteria plan and addresses two specific situations in which a Section 125 cafeteria plan participant is permitted to revoke his or her election under the Section 125 cafeteria plan during a period of coverage. The first situation involves a participating employee whose hours of service are reduced so that the employee is expected to average less than 30 hours of service per week but for whom the reduction does not affect the eligibility for coverage under the employer's group health plan. The second situation involves an employee participating in an employer's group health plan who would like to cease coverage under the group health plan and purchase coverage through a competitive marketplace established under ACA §1311.

The IRS defines a cafeteria plan as a written plan maintained by an employer under which all participants are employees, and all participants may choose among two or more benefits consisting of cash and qualified benefits.

Read the notice at: <http://www.irs.gov/pub/irs-drop/n-14-55.pdf>

9/18/14 IRS/Treasury issued Notice 2015-56, which provides the applicable dollar amount that applies for determining the PCORI fee for policy years and plan years ending on or after October 1, 2014 and before September 30, 2015.

Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes research and studies. The PCORI trust fund is funded in part by fees paid by issuers of certain health insurance policies and sponsors of certain self-insured health plans.

Read the notice at: <http://www.irs.gov/pub/irs-drop/n-14-56.pdf>

Prior guidance can be found at: <http://www.hhs.gov/healthcare/index.html>

News

9/19/2014 HHS announced that consumers and small employers have saved a total of \$1 billion on their health insurance premiums in 2013 alone as a result of the implementation of the medical loss ratio (MLR) requirements under ACA §10101.

The ACA's MLR rules establish the minimum dollar percentage that health insurance companies must spend of consumers' health insurance premiums on medical care, not on income, overhead or marketing. The ACA requires insurance companies in the individual and small group markets to spend at least 80% of collected premium dollars on medical care and quality improvement activities; insurance companies in the large group market are required to spend at least 85% on such activities. Insurance companies must report their MLR data to HHS on an annual basis so that residents of every state will have information on the value of the health plans offered by insurance companies in their state. Under the MLR rules, insurance companies that do not meet the MLR standard are required to provide rebates to their consumers.

Through this provision, in 2013 individuals and families saved \$290 million and small employers have saved \$703 million. Consistent with previous years since the rate review provision went into effect, the HHSs report shows that the implemented rate increases were smaller than what was originally requested across both the individual and small group markets.

The ACA has also provided states with funding in order to support their rate review programs, bringing more transparency to this process. These funds will improve state efforts to review health insurance rate increases, educate consumers, help hold insurance companies accountable, and scrutinize medical pricing data. In all, twenty one states will receive these awards, including one award going to Massachusetts totaling \$1,179,000 in funding.

To learn more about this report please visit, HHS.GOV

9/18/2014 CMS announced that, through the ACA, more people with Medicare have access to Medicare Advantage (MA) plans and increased benefit opportunities. Between 2010 and 2015, enrollment in MA plans is expected to increase 42% and premiums are expected to decrease by 6%.

MA plans offer supplemental benefits that traditional Medicare beneficiaries do not always receive, such as dental and vision benefits. Access to the MA program has continued to grow and 99% of Medicare beneficiaries now have access to plans, through what CMS describes as a transparent and competitive marketplace for Medicare health and drug plans.

According to CMS, seniors and individuals with disabilities enrolled in either traditional Medicare or in an MA plan are seeing reduced costs through both savings on covered brand-name and generic drugs and having access to certain preventive services at no cost sharing. Through July 2014, an estimated 18.6 million people with traditional Medicare took advantage of at least one preventive service with no cost sharing, and more than 2.6 million took advantage of the Annual Wellness Visit. Under ACA §4103 and §4104, certain preventive services are available to Medicare beneficiaries without cost sharing. The ACA eliminated coinsurance and the Part B deductible for preventive care such as annual wellness visits, cancer screenings, flu shots, mammograms and diabetes screenings.

MA Plans, sometimes called "Part C" are offered by private companies approved by Medicare and provide both Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision or dental and most include Medicare prescription drug coverage (Part D). Medicare pays a fixed amount for a member's care every month to the companies offering Medicare Advantage Plans and, per ACA §1102, plans can no longer charge higher cost sharing than what a member in traditional Medicare pays.

To learn more about this announcement, please visit CMS.GOV

9/18/14- 9/19/14 The Medicaid and CHIP Payment and Access Commission (MACPAC) met to discuss key issues in the Medicaid and CHIP programs, the interactions between Medicaid, the Children's Health Insurance Program (CHIP) and the Health Insurance Exchanges under ACA §1311(b), critical questions about the future of CHIP, including the reauthorization of the CHIP program, Premium assistance in Medicaid expansion, early experiences of new Medicaid enrollees and plans for a study on disproportionate share hospital payments.

MACPAC Commissioners discussed the challenges to states and enrollees who will need to renew their new Medicaid coverage this year, many of whom do not know that they need to do so. The Commission also found that most people who they studied said they didn't get a packet of information after they enrolled to help them understand how to use their coverage and that they also had questions about what services are covered, what their out-of-pocket costs will be, and how to find a physician. MACPAC recommends that states and outreach and enrollment educators increase their efforts so that consumers are not left without coverage and better understand their coverage.

MACPAC was established by the Children's Health Insurance Program Reauthorization Act and later expanded and funded through ACA §2801 and §10607. The commission consists of experts, government officials, executives and medical professionals. MACPAC is tasked with reviewing state and federal Medicaid and CHIP access and payment policies and making recommendations to Congress, the HHS Secretary, and the states on a wide range of issues affecting Medicaid and CHIP populations, including the implementation of health care reform.

View the agenda at: <http://www.macpac.gov/home/meetings/sept>

View the meeting materials at: <http://www.macpac.gov/home/meetings/2014-09>.

Bookmark the **Massachusetts National Health Care Reform website** at: [National Health Care Reform](#) to read updates on ACA implementation in Massachusetts.

Remember to check the Mass.Gov website at: [Dual Eligibles](#) for information on the "**Integrating Medicare and Medicaid for Dual Eligible Individuals**" initiative.

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