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# Health Care Reform Yesterday & Tomorrow: The Impact of State and Federal Law on Employers

Harvey D. Cotton & Leslie F. Arnould\*

## I. Introduction

The Patient Protection and Affordable Care Act (“PPACA”) was enacted on March 23, 2010.<sup>1</sup> While employers across the country immediately began to consider the practical impact of PPACA on their health benefits strategies, the first reaction from employers across Massachusetts most likely was: “Health care reform? Didn’t we do this already?”

In 2006, when Massachusetts enacted Chapter 58 of the Acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care (“MA Act”), the landscape was very different than it is today.<sup>2</sup> The regulation of health insurance was predominately within the purview of the states.<sup>3</sup> The primary federal law that governed the design and administration of most employer-provided health benefits was the Employee Retirement Income Security Act of 1974 (“ERISA”),<sup>4</sup> which was enacted to

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<sup>1</sup> Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in 42 U.S.C.). The PPACA legislation served as comprehensive reform to national health care policy, including provisions to expand coverage, contain health care costs, and improve health care delivery systems. *See id.*

<sup>2</sup> 2006 MASS. LEGIS. SERV. ch. 58 (West). Chapter 58, “An Act Providing Access to Affordable, Quality, Accountable Health Care” added Chapter 111M to the Massachusetts General Laws and revised several other provisions. *Id.*; MASS. GEN. LAWS ch. 111M (2008).

<sup>3</sup> BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 310 (6th ed. 2008). Nearly one thousand state statutes were passed in the 1990s to further regulate insurance and managed care organizations.

<sup>4</sup> Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (2010)).

provide for uniform federal regulation of employee benefit plans and for a guarantee of protected benefits for participants.<sup>5</sup> The Department of Labor (“DOL”), and to a lesser extent the Internal Revenue Service (“IRS”), issued most of the pertinent regulations applicable to employer-provided health benefits; ERISA itself, however, set forth few substantive benefit requirements for health and welfare plans.<sup>6</sup>

ERISA generally applies to any “employee benefit plan” that is established or maintained by, among others, any employer engaged in commerce.<sup>7</sup> While ERISA preempts state laws that relate to employee benefit plans,<sup>8</sup> it does not preempt state laws that regulate insurance.<sup>9</sup> States, therefore, retain the authority to regulate the health insurers they license, including certain aspects of health insurance coverage they provide, for example, by requiring coverage of dependents until a certain age.<sup>10</sup> PPACA, however, amends ERISA in some significant ways and federalizes to a substantial degree the regulation of health insurance.<sup>11</sup> As a result, all states, and Massachusetts in particular, must now consider to what extent PPACA affects their current insurance laws. Since Massachusetts was the only state to have enacted its own comprehensive health care reform prior to PPACA’s enactment, PPACA provides Massachusetts state legislators and regulators with a unique set of challenges, especially as they relate to PPACA’s impact on ERISA and state preemption.<sup>12</sup> This article is not intended to offer

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<sup>5</sup> Employee Retirement Income Security Act, 29 U.S.C. §§ 1001(a)-(b) (2010).

<sup>6</sup> When ERISA was enacted, it did not require “that plan sponsors offer specific benefits, nor did it dictate the substance of any benefit plan.” Daniel J. Schwartz, *Regulation of Insurance, in* FUNDAMENTALS OF HEALTH LAW 235, 268 (4th ed. 2008). ERISA initially only provided a “structure regarding how such plans operate, providing guidance on such matters as claims procedures and fiduciary responsibility.” *Id.*

<sup>7</sup> 29 U.S.C. § 1003; Employee Retirement Income Security Act of 1974 § 4(a) (both listing coverage requirements of ERISA).

<sup>8</sup> Employee Retirement Income Security Act of 1974 § 514(a); 29 U.S.C. § 1144(a) (stating the superseding effect ERISA has on any state law related to employee benefit plans).

<sup>9</sup> Employee Retirement Income Security Act of 1974 § 514(b)(2); 29 U.S.C. § 1144(b)(2)(A) (explaining “nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulated insurance . . .”).

<sup>10</sup> *See, e.g.*, N.Y. INS. LAW § 3221(r)(2)(D) (McKinney 2007) (expanding health insurance to children through age twenty-nine); N.Y. INS. LAW § 4321, 4322 (McKinney 2010) (detailing mandated insurance benefits); *see also* N.J. STAT. ANN. 17B:27-30.5 (West 2010); THE NATIONAL CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/default.aspx?tabid=14497> (last visited Mar. 29, 2011) (providing a complete list of states with expanded dependent coverage).

<sup>11</sup> *See* 29 U.S.C. § 1185(d) (2010) (stating all changes PPACA made to the Patient Health Service Act are now incorporated into ERISA); *see also infra* note 30 (stating PPACA added new provisions to ERISA, one of which was to adopt all changes PPACA made to the Patient Health Service Act, where PPACA made the majority of its amendments).

<sup>12</sup> *See infra* Section III.A (discussing generally certain provisions of the MA Act that may overlap

an in-depth analysis of ERISA preemption, a topic already the subject of many legal articles, but rather, the focus of this article is to provide a framework for considering the impact of PPACA on state health reform. Part I summarizes ERISA preemption and the landscape prior to PPACA; Part II explains PPACA's impact on ERISA; Part III discusses PPACA's impact on existing state insurance laws, with a specific focus on the tensions between PPACA and the MA Act; and Part IV identifies certain policy implications of PPACA and addresses the question of what happens now that federal reform has arrived.

## II. ERISA Preemption: Landscape Prior to PPACA

Prior to PPACA, employee welfare benefit plans, including most self-insured employee benefit plans,<sup>13</sup> were primarily governed by ERISA.<sup>14</sup> Only fully-insured plans,<sup>15</sup> however, were regulated under state insurance law. ERISA was enacted to provide uniform guidelines and minimum protected benefits for employee benefit plans at a time when there were few standards for what must be provided and little consistency from plan to plan and state to state. ERISA does not require an employer to provide health insurance to its employees, but if an employer establishes an employee benefit plan, ERISA regulates the operation of that plan and requires that certain standards be met.<sup>16</sup> Therefore, preemption of state laws is necessary to enable ERISA to fulfill its objectives.<sup>17</sup>

As mentioned above, ERISA supersedes "any and all State laws insofar as they

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with PPACA).

<sup>13</sup> A self-insured group health plan is a plan offered by employers who directly assume the risk of the health care claims incurred by participants in that plan. *See* BUREAU OF LABOR STATISTICS, DEFINITIONS OF HEALTH INSURANCE TERMS, available at [www.bls.gov/ncs/ebs/sp/healthterms.pdf](http://www.bls.gov/ncs/ebs/sp/healthterms.pdf). Most self-insured employers contract with third party administrators for claims processing and other administrative services and purchase stop-loss coverage to insure against large claims. *See id.*

<sup>14</sup> *See* 29 U.S.C. § 1002(1) (defining employee welfare benefit plans and welfare plans for the purposes of the ERISA statute).

<sup>15</sup> A fully-insured plan is one where the employer pays a premium to an insurer who assumes the financial risk and responsibility for the enrollees' medical claims and for all administrative costs. *See* BUREAU OF LABOR STATISTICS, *supra* note 13.

<sup>16</sup> *See* Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829, §§ 701-734 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (2010) (setting standards for group health plans).

<sup>17</sup> *Id.* § 514(a) (establishing that ERISA preempts state laws). *See generally* David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427 (1987) (further discussing ERISA preemption).

. . . relate to any employee benefit plan.”<sup>18</sup> In this context, “state law” is broadly defined to include “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.”<sup>19</sup> The term “relate to” has also been interpreted broadly to mean “any connection with or reference to such a plan,”<sup>20</sup> and as a result, ERISA can apply to laws that are not specifically designed to affect employee benefit plans and laws that only have an indirect effect on employee benefit plans.<sup>21</sup> ERISA, however, does not preempt state laws that “regulate insurance,”<sup>22</sup> which according to the Supreme Court includes laws that are specifically directed towards entities engaged in insurance and that substantially affect the risk pooling arrangement between an insurer and an insured.<sup>23</sup> Thus, merely because a law has an indirect effect on ERISA plans does not disqualify it as a law “specifically directed” towards the insurance industry.

An employee benefit plan cannot be deemed to be an insurance company for the purpose of state regulation,<sup>24</sup> which means that self-insured plans cannot be treated

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<sup>18</sup> See Employee Retirement Income Security Act of 1974 § 514(a); 29 U.S.C. § 1144(a).

<sup>19</sup> Employee Retirement Income Security Act of 1974 § 514(c)(1) (referencing the effect of ERISA on state laws).

<sup>20</sup> See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (defining “relate to” with respect to § 514(a) of ERISA).

<sup>21</sup> See, e.g., *Shaw*, 463 U.S. at 97. In *Shaw*, the Supreme Court held that New York’s Human Rights Law, which barred employment discrimination on the basis of gender, and New York’s Disability Benefits Law, which required employers to offer certain specific benefits, related to an employee benefit plan because a law which “prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy . . . and [a law], which requires employers to pay employees specific benefits, clearly ‘relate[s] to’ benefit plans.” *Id.* See also *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 139 (1990). In *Ingersoll-Rand*, although an employee brought a wrongful termination claim under state law alleging that he was discharged because his employer did not want to continue contributions into his pension fund, the Court held that ERISA preempted the state law so there was no cause of action. *Id.*

<sup>22</sup> Employee Retirement Income Security Act of 1974 § 514(b) (stating ERISA will supersede any state law which relates to an employee benefit plan, with certain enumerated exceptions, including that it does not preempt state laws that regulate insurance, banking, or securities). See also 29 U.S.C. § 1144 (b)(2)(A) (prohibiting exemptions under the law with respect to state regulations on insurance, banking, and securities).

<sup>23</sup> See *Kentucky Ass’n of Health Plans v. Miller*, 538 U.S. 329, 334-35 (2003). In *Kentucky Ass’n of Health Plans*, a health maintenance organization (“HMO”) brought suit seeking the determination that “Any Willing Provider” statutes were preempted by ERISA. *Id.* at 332-33. These statutes prohibited HMOs from limiting which providers could be covered under the plan if the providers were willing to meet terms and conditions for plan participation. *Id.* The Court held that the statutes were not preempted by ERISA because they were specifically directed toward entities engaged in insurance and did not impose any prohibitions or requirements on health care providers. *Id.* at 335.

<sup>24</sup> Employee Retirement Income Security Act of 1974 § 514(b)(2)(B) (establishing that no

as insurers under state law, and thus be subject to state insurance law and regulation.<sup>25</sup> Accordingly, an employer offering a self-insured health plan must comply with the requirements of ERISA, which include a number of disclosure and reporting obligations and, to a more limited extent, the coverage of certain substantive health care benefits.<sup>26</sup> This employer, however, has never had to comply with the potentially diverse insurance laws of the states in which it does business. It is in this way that one of ERISA's central purposes is achieved, namely to give a multi-state employer a means by which it can offer a uniform set of benefits to its employees regardless of the state in which those employees work.<sup>27</sup>

### III. PPACA's Impact on ERISA

With the enactment of PPACA, the framework for establishing health and welfare benefits has greatly changed. PPACA essentially federalizes the regulation of health insurance products, establishing uniform requirements that apply to health care coverage issued by health insurers and group health plans administered by employers.<sup>28</sup>

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employee benefit plan or trust may constitute an insurance company). *See also* 29 U.S.C. § 1144 (b)(2)(B) (stating “[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company”).

<sup>25</sup> *See, e.g.,* FMC Corp. v. Holliday, 498 U.S. 52 (1990).

<sup>26</sup> *See* Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, 112 Stat. 2681 (1998) (amending ERISA and expanding provisions and protections available to women breast cancer patients); Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 603, 110 Stat. 2874 (1996) (amending ERISA and expanding protections available to group health plan participants and beneficiaries, specifically birthing mothers and their newborn children); Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 712, 122 Stat. 3765 (2008) (amending ERISA and establishing limitations and guidelines for group health plan benefits with respect to mental health issues).

<sup>27</sup> *See* Deborah S. Davidson, *Balancing the Interests of State Health Care Reform and Uniform Employee Benefit Laws Under ERISA: A “Uniform Patient Protection Act,”* 53 WASH U. J. URB. & CONTEMP. L. 203, 213-14 (1998) (explaining that ERISA was enacted to alleviate the burden employers face with inconsistent standards regarding employee benefits). ERISA specifically includes a broad preemption clause for the purpose of creating uniformity of benefits, and courts have continued to interpret the clause broadly, upholding the uniformity ERISA was intended to promote. *See id.* at 214.

<sup>28</sup> *See* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 1301, 1302, 124 Stat. 119, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. §§ 18021, 18022) (setting forth the sections entitled “Qualified Health Plan” and “Essential Health Benefits Requirements”). These sections call for the Secretary to make an assessment of the benefits provided under a typical employer plan and then require employers to submit reports that their plans are “qualified health plans” under these requirements. *See id.*; Patient Protection and Affordable Care Act of 2010 § 2717 (to be codified as amended at 42 U.S.C. § 300gg-17) (laying out the requirement of

While the obligations imposed on ERISA-governed, self-insured group health plans are certainly fewer than those imposed on state-regulated, fully-insured health plans, self-insured plans must now adapt to a new scope of regulation.<sup>29</sup>

Although PPACA does not change one of the fundamental goals of ERISA—employers offering self-insured health plan benefits are still not subject to the insurance laws of the states in which they do business—it does amend ERISA. PPACA codifies its substantive rules primarily in the Public Health Service Act (“PHSA”) and the Internal Revenue Code (“Code”). PPACA directly added only a few new provisions to ERISA, one of which incorporates by reference in ERISA all of the statutory changes to the PHSA.<sup>30</sup> Through its amendments to the PHSA, PPACA imposes new requirements on group health plans and insurance carriers that reach virtually all employer-provided health programs for employees, including self-insured plans and any health insurance policies issued by an insurance carrier, whether for the individual or group market.<sup>31</sup>

Extensive federal regulation of health benefits raises the question of the continuing effect state law will have on these benefits. None of the changes to ERISA, express or incorporated, impact ERISA’s preemption provision. The three federal agencies charged with interpreting the statutory provisions of PPACA—the DOL, the Department of Health and Human Services (“HHS”), and the Department of the Treasury (together, the “Departments”)—have been rapidly issuing interim final rules and sub-regulatory guidance in the form of fact sheets and Frequently Asked Questions to help explain the nuances of the new requirements.<sup>32</sup> To date, the interim final rules

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reporting to the Secretary to ensure quality of care). Further sections lay out the responsibilities of employers, including a description of which employees are automatically enrolled, the notice employers must give to their employees regarding coverage, and the duty of employers to periodically report to the Secretary. *See* Patient Protection and Affordable Care Act of 2010 §§ 1511-1515 (to be codified as amended at 29 U.S.C. §§ 218A, 218B; 26 U.S.C. §§ 4980H, 6056, 125).

<sup>29</sup> *See* Employee Retirement Income Security Act of 1974 §§ 1181-1191(c) (providing requirements for group health plans). *Compare* Patient Protection and Affordable Care Act of 2010 §§ 1301, 1302, 2717, 1511-1515 (to be codified as amended at 42 U.S.C. §§ 18021, 18022, 300gg-17; 29 U.S.C. §§ 218A, 218B; 26 U.S.C. §§ 4980H, 6056, 125).

<sup>30</sup> *See* Patient Protection and Affordable Care Act of 2010 § 1562(e) (to be codified as amended at 29 U.S.C. § 1185d) (adding § 715 to ERISA to incorporate the changes made to the PHSA); Employee Retirement Income Security Act of 1974 § 715.

<sup>31</sup> *See* Patient Protection and Affordable Care Act of 2010 § 1301(b) (to be codified as amended at 42 U.S.C. § 18021) (defining group health plan and plans covered by PPACA).

<sup>32</sup> *See, e.g.*, Rules and Regulations for Group Health Plans, 29 C.F.R. § 2590.606-736 (2010); Affordable Care Act Implementation FAQs Part I (Sept. 20, 2010), *available at*

issued have specified that states may continue to apply state law requirements, except to the extent that such requirements prevent the application of the PPACA requirements.<sup>33</sup>

Since state insurance laws that are more stringent than the federal requirements are unlikely to “prevent the application of” PPACA, these state laws will likely not be preempted.<sup>34</sup> “Accordingly, states have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law.”<sup>35</sup> In practice, this means that any state law that does not meet the federal minimum standards will be preempted, and presumably one of the Departments will assume the authority to enforce those standards. If a state already has a requirement that at least meets the federal standards, or adopts one in the future, then the state would retain the authority to enforce that requirement.

#### IV. PPACA’s Impact on Current State Reforms

##### A. Tension Between PPACA and the MA Act

Since Massachusetts is the only state to enact its own comprehensive health care reform, a review of the Massachusetts health care reform legislation provides a unique opportunity to highlight the interplay between PPACA and state reform initiatives. PPACA and the MA Act regulate many of the same actors and issues, so certain

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<http://www.dol.gov/ebsa/pdf/faq-aca.pdf>; Fact Sheet: The Affordable Care Act: Protecting Consumers and Putting Patients Back in Charge of Their Care (July 22, 2010), *available at* <http://www.dol.gov/ebsa/pdf/fsaffordablecareact.pdf>; Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Businesses (2010), *available at* <http://www.dol.gov/ebsa/pdf/fsdependentcoverage.pdf>.

<sup>33</sup> See Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 29 C.F.R. § 2590 (2010) (explaining that “[s]tates may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking”); Interim Final Rules on Dependent Coverage for Children to Age 26, 29 C.F.R. § 2590.715-2714(b) (2010); Interim Final Rules on Internal Claims and Appeals and External Review Processes, 29 C.F.R. § 2590.715-2719(c) (2010).

<sup>34</sup> Interim Final Rules on Dependent Coverage for Children to Age 26, *supra* note 33. See *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963) (preemption exists when “compliance with both federal and state regulation is a physical impossibility”); ERWIN CHERMERINSKY, *CONSTITUTIONAL LAW PRINCIPLES AND POLICIES* § 5.2.4 (2d ed. 2002) (explaining when the federal government sets minimum standards, states may set higher standards which allow compliance with both laws).

<sup>35</sup> Interim Final Rules on Dependent Coverage for Children to Age 26, *supra* note 33.



provisions of the MA Act could potentially be preempted.<sup>36</sup> As noted earlier, the interim final regulations issued by the Departments thus far attempt to address state law preemption in limited circumstances,<sup>37</sup> but employers, insurance carriers, and individuals in Massachusetts need further guidance before they can fully understand their legal obligations. This section identifies issues that are addressed under both federal and Massachusetts law, sets out the relevant requirements under each law, and discusses, to the extent possible, how the tension between the two laws has been or is likely to be resolved, keeping in mind that certain provisions of PPACA are not yet effective and more guidance is forthcoming.

### 1. *Mandates: Individual and Employer*

Both PPACA and the MA Act include an individual mandate that requires most individuals to have health insurance. Under PPACA, beginning on January 1, 2014, individuals must maintain “minimum essential coverage” or pay a monthly shared responsibility penalty.<sup>38</sup> The penalty will phase in and will eventually equal the lesser of either: (a) the national average premium for coverage provided through a health care exchange; or (b) the greater of (i) \$695 per individual (family maximum of \$2,085) or (ii) two and a half percent of household income in excess of the federal income tax return filing threshold.<sup>39</sup> This individual mandate, however, does not apply uniformly across the board to all individuals: individuals with low household incomes may qualify for a premium tax credit or cost sharing assistance, and individuals with sincerely held religious beliefs that would preclude them from seeking medical care are exempt from the mandate.<sup>40</sup> An employee is not eligible for the premium tax credit in any month in which he or she is enrolled in employer-sponsored minimum essential coverage that pays for at least sixty percent of the full value of benefits provided by such coverage and does not require the employee to pay a contribution more than nine and a half percent of the employee’s household income.<sup>41</sup>

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<sup>36</sup> See *infra* Sections III.A.1 – 6 for a discussion of the provisions in PPACA and the MA Act that regulate the same actors and issues.

<sup>37</sup> See Interim Final Rules on Dependent Coverage for Children to Age 26, *supra* note 33.

<sup>38</sup> Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1501, 124 Stat. 119, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 18091) (I.R.C. § 5000A (outlining the requirement that an applicable individual must maintain “minimum essential coverage” beginning in 2014).

<sup>39</sup> I.R.C. § 5000A(c).

<sup>40</sup> I.R.C. § 5000A(d)(2), (e).

<sup>41</sup> Patient Protection and Affordable Care Act of 2010 §§ 1401, 10105(b) (to be codified as amended at 26 U.S.C. §§ 36, 36B); I.R.C. § 36B(c)(2)(C).

PPACA does not require an employer to provide health insurance to its employees, but under certain circumstances, beginning on January 1, 2014, the employer may be required to pay penalties if it does not offer coverage or if the coverage offered is too costly.<sup>42</sup> If an employer with fifty or more full-time equivalent employees does not offer minimum essential coverage and one or more full-time employees qualifies for the premium tax credit, the employer will be required to pay a fee of \$2,000 per year per full-time employee, excluding the first thirty full-time employees.<sup>43</sup> If an employer with fifty or more full-time equivalent employees does offer minimum essential coverage and one or more of the full-time employees qualifies for the premium tax credit, then the employer will be required to pay a fee of \$3,000 per full-time employee who receives a credit, excluding the first thirty full-time employees.<sup>44</sup>

In Massachusetts, individuals must demonstrate on their state tax returns that they had “minimum creditable coverage” during all months of the previous year or pay a penalty for the months that they did not have such coverage.<sup>45</sup> The penalty will not exceed fifty percent of the cost of the minimum insurance premium for creditable coverage available to the individual through the Commonwealth Health Insurance Connector Authority (“Connector”), an independent state agency responsible for helping Massachusetts residents find health care coverage.<sup>46</sup> Employers in Massachusetts with more than ten full-time equivalent employees must either make a “fair and reasonable premium contribution” for their employees or pay a per-employee contribution into the Commonwealth Care Trust Fund.<sup>47</sup> The definition of “fair and

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<sup>42</sup> Patient Protection and Affordable Care Act of 2010 § 1513 (to be codified as amended at 26 U.S.C. § 4980H); I.R.C. § 4980H (2010).

<sup>43</sup> Patient Protection and Affordable Care Act of 2010 § 1513 (to be codified as amended at 26 U.S.C. § 4980H) (outlining the shared responsibility provisions for employers); I.R.C. § 4980H (defining a “large employer” and discussing the necessary calculations to determine when an employer will be deemed a “large employer”).

<sup>44</sup> Patient Protection and Affordable Care Act of 2010 § 1513 (to be codified as amended at 26 U.S.C. § 4980H); I.R.C. § 4980H.

<sup>45</sup> 2006 MASS. LEGIS. SERV. ch. 58, § 12 (West) (adding MASS. GEN. LAWS ch. 111M). “Creditable coverage” is described as coverage under an acceptable health plan or as a named beneficiary under another’s health plan “with no lapse of coverage for more than 63 days.” *Id.*

<sup>46</sup> 2006 MASS. LEGIS. SERV. ch. 58, § 13(b). The Connector is “an independent state agency that helps Massachusetts residents find health insurance coverage and avoid tax penalties.” *See* About the Health Connector, <https://www.mahealthconnector.org/portal/site/connector/menuitem.dc4d8f38fdd4b4535734db47e6468a0c> (last visited Mar. 29, 2011).

<sup>47</sup> 2006 MASS. LEGIS. SERV. ch. 58, § 47. The Commonwealth Care Trust Fund pays for the Commonwealth Care health insurance program, a program offering low or no-cost health insurance to qualifying Massachusetts residents. *See* Mass Budget, Budget Monitor, [http://www.massbudget.org/documentsearch/findDocument?doc\\_id=606&ds\\_id=507](http://www.massbudget.org/documentsearch/findDocument?doc_id=606&ds_id=507) (last

reasonable premium contribution” depends on the employer’s size. An employer with no more than fifty full-time employees satisfies the “fair share contribution” test if twenty-five percent or more full-time employees are enrolled in an employer-sponsored group health plan at the end of the quarter for which a fair share contribution filing is made, or the employer pays at least thirty-three percent of the cost of the individual premium for its full-time employees no more than ninety days after the date of hire.<sup>48</sup> An employer with more than fifty full-time employees must satisfy both prongs of the test or demonstrate that at least seventy-five percent of its full-time employees were enrolled in an employer-sponsored group health plan at the end of each quarter.<sup>49</sup> The per-employee contribution into the Commonwealth Care Trust Fund is capped at \$295 per full-time employee.<sup>50</sup>

With mandates under both PPACA and the MA Act, it is difficult for an individual or an employer to determine its compliance obligations and to understand the consequences of non-compliance. Since the PPACA mandate will not become effective for several more years, questions about whether it will be necessary to comply with one or both mandates will hopefully be resolved. Currently, there is no provision under which the federal mandate would preempt the Massachusetts individual mandate or employer fair share contribution requirements. Furthermore, Massachusetts employers subject to state penalties, but who employ less than fifty full-time equivalent employees, will be exempt from federal penalties.<sup>51</sup> These penalties will, however, likely affect only a very small percentage of Massachusetts firms.<sup>52</sup> Notably, comparatively few

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visited Mar. 29, 2011).

<sup>48</sup> 2006 MASS. LEGIS. SERV. ch. 58, § 47; 114.5 CMR §§ 16.00 *et seq.*

<sup>49</sup> *Id.*

<sup>50</sup> *Id.* § 47(10).

<sup>51</sup> See MASS. GEN. LAWS ch. 149, § 188(b) (2008) (imposing penalties on employers that have more than eleven employees and do not provide health care); Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1511, 124 Stat. 119, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 29 U.S.C. § 218A) (defining a “large employer” as an employer with more than two hundred full time employees); Patient Protection and Affordable Care Act of 2010 § 1513 (to be codified as amended at 26 U.S.C. § 4980H) (revising the Code to impose a penalty on large employers that do not provide their employees with health care coverage).

<sup>52</sup> See Robert W. Seifert & Andrew P. Cohen, *Re-Forming Reform – What the Patient Protection and Affordable Care Act Means for Massachusetts*, CENTER FOR HEALTH LAW AND ECONOMICS, UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL 20 (June 2010), *available at* [http://bluecrossfoundation.org/~media/Files/Publications/Policy%20Publications/062110N\\_HRReportFINAL.pdf](http://bluecrossfoundation.org/~media/Files/Publications/Policy%20Publications/062110N_HRReportFINAL.pdf). Data from the Massachusetts Division of Health Care Finance and Policy (“DHCFFP”) shows that in 2009, 98% of Massachusetts businesses with more than fifty employees offered those employees health insurance. See *Employers Who Had Fifty or More*

Massachusetts employers have actually been subject to state penalties.<sup>53</sup>

## 2. *Level of Coverage*

PPACA requires that individuals have “minimum essential coverage” to satisfy the individual mandate. A group health plan or group health insurance coverage offered by an employer that is either a governmental plan or any other plan or coverage offered in a large or small group market within a state, including a grandfathered health plan, will satisfy minimum essential coverage requirements.<sup>54</sup>

In contrast, the MA Act requires individuals to maintain “minimum creditable coverage.”<sup>55</sup> While minimum creditable coverage consists of coverage provided under any “health benefit plan,” which includes fully-insured plans issued by Massachusetts-licensed insurance companies and self-funded plans that provide “medical, surgical or

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Employees Using MassHealth, Commonwealth Care, or the Health Safety Net in State FY09, MASSACHUSETTS DIVISION OF HEALTH CARE FINANCE AND POLICY, 3 (June 2010). Additional DHCFC data indicate that in 2008, only 824 employers were liable for the fair share contribution assessment, of which only 116 employed more than fifty full-time employees. *See* MASSACHUSETTS DIVISION OF HEALTH CARE FINANCE AND POLICY, *supra* at 18-21.

<sup>53</sup> *See* MASSACHUSETTS DIVISION OF HEALTH CARE FINANCE AND POLICY, *supra* note 51, at 18-21.

<sup>54</sup> Patient Protection and Affordable Care Act of 2010 § 5000A(f) (to be codified as amended at 26 U.S.C. § 5000A).

<sup>55</sup> *See* MASS. GEN. LAWS ch. 111M (2008). According to the Massachusetts Department of Health and Human Services:

Minimum Creditable Coverage is a standard that the health insurance of a Massachusetts adult must meet by January 1, 2009. This standard includes certain benefits involving preventative and primary care, emergency services, hospital stays, outpatient services, prescription drugs, and mental health services. Specifically, a plan must: (1) Cover prescription drugs. (2) Cover 3 regular doctor visits and check-ups for an individual or 6 for a family before any deductibles. (3) Cap the deductible at \$2,000 for an individual or \$4,000 for a family each year. (4) Cap out-of-pocket spending for non-Rx health services at \$5,000 for an individual or \$10,000 for a family each year if you have a deductible or co-insurance. (5) Not cap total benefits for a sickness or for each year. Additional Minimum Creditable Coverage standards went into effect on January 1, 2010.

Dep't. of Health and Human Serv., Minimum Creditable Coverage, [http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Healthcare+Reform&sid=Eeohhs2&b=terminalcontent&f=dhcfp\\_governme nt\\_mcc&csid=Eeohhs2](http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Healthcare+Reform&sid=Eeohhs2&b=terminalcontent&f=dhcfp_governme nt_mcc&csid=Eeohhs2) (last visited Mar. 29, 2011).

hospital benefits,” a health benefit plan does not comply with the minimum creditable coverage requirements unless it provides, at a minimum, the benefits established by the Connector.<sup>56</sup> Without further regulatory guidance, it is difficult to ascertain whether and how these concepts of minimum coverage might differ. It is possible that an individual’s coverage might meet the federal minimum essential coverage standard but not the state minimum creditable coverage requirements.<sup>57</sup> Until this tension is resolved, Massachusetts residents, employers, and insurers will have to comply with state law requirements and be prepared to adjust as needed as 2014 approaches.

### 3. Reporting Requirements

Beginning after 2013, PPACA will require employers to file information returns with the IRS and the Secretary of the Treasury. Each employer providing minimum essential coverage to an employee must file a return with the IRS describing the coverage and the portion of the premium paid by the employer.<sup>58</sup> Employers with fifty or more employees will likewise have to file a return with the Secretary of the Treasury certifying whether they provide minimum essential coverage and the number of full-time employees covered.<sup>59</sup> These employers will also have to provide information to their employees documenting whether each employee received minimum essential coverage and the employer’s contribution toward that coverage.<sup>60</sup> There are currently no details on how an employer will be required to provide this information. Beginning after December 31, 2011, the value of most of the employer-sponsored group health plan

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<sup>56</sup> MASS. GEN. LAWS ch. 111M, § 1; 956 MASS. CODE REGS. 5.01 (2008). *See supra* note 46 and accompanying text (discussing the Connector).

<sup>57</sup> *See* BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., P.L. 111-148, GRANDFATHERED HEALTH PLANS UNDER PPACA (2010). PPACA includes provisions grandfathering existing health care plans which are exempt from most of the new health insurance reforms, and thus, a plan grandfathered by PPACA will be deemed to meet the federal minimum essential coverage requirement but may not meet the Massachusetts minimum creditable coverage requirement. *See id.* For example, a grandfathered plan that meets the federal requirements might not grant coverage for mental health services, but this coverage is required under the Massachusetts minimum creditable coverage standard. *See id.*

<sup>58</sup> *See* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1514, 124 Stat. 119, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 26 U.S.C. § 6056) (pertaining to an employer’s reporting of health insurance coverage offered to employees); *see also* I.R.C. § 6056 (2010) (regarding requirements placed upon certain employers for reporting health insurance coverage offered to employees).

<sup>59</sup> Patient Protection and Affordable Care Act of 2010 § 1514 (to be codified as amended at 26 U.S.C. § 6056).

<sup>60</sup> *Id.*

coverage that employees receive will be reported on the employer's annual Form W-2.<sup>61</sup> Employer compliance with this requirement is optional for 2011, but compliance for employers filing more than 250 Forms W-2 for 2011 will be mandatory thereafter.<sup>62</sup>

Massachusetts employers must already provide their employees with a Form 1099-HC that discloses whether they have minimum creditable coverage.<sup>63</sup> Where the employer's group health plan is insured with a Massachusetts-licensed carrier, the obligation to furnish the Form 1099-HC shifts to the carrier.<sup>64</sup> Thus, individuals use the information on the Form 1099-HC to complete and file Schedule HC with their state income tax return. This filing enables the Massachusetts Department of Revenue to determine whether taxpayers have complied with the individual mandate and if not, the amount of the penalty due.<sup>65</sup>

Although the federal reporting requirements have yet to be specifically defined, it is likely that the federal government will request information similar to that needed by the Commonwealth of Massachusetts for determining whether individuals have the required coverage and whether penalties must be assessed. However, since the federal and state requirements and penalties are calculated differently, this likely means that there will be added administrative burdens on employers and possibly individuals to comply with these requirements.

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<sup>61</sup> *Id.*; I.R.C. § 6056(b).

<sup>62</sup> Patient Protection and Affordable Care Act of 2010 § 9002 (to be codified as amended at 26 U.S.C. § 6051); I.R.C. § 6051(a)(14); IRS Notice 2010-69, 2010-44 I.R.B. 576 (Nov. 1, 2010), available at [http://www.irs.gov/irb/2010-44\\_IRB/ar13.html](http://www.irs.gov/irb/2010-44_IRB/ar13.html); IRS Notice 2011-28, 2011-16 I.R.B. (Mar. 29, 2011), available at <http://www.irs.gov/pub/irs-drop/n-11-28.pdf> (explaining, among other things, that small employers that are required to file fewer than 250 Forms W-2 for the preceding calendar year will not be required to report the cost of health coverage for that year, until further guidance is issued).

<sup>63</sup> MASS. GEN. LAWS ch. 62C, § 8B (2008); 830 MASS. CODE REGS. 111M.2.1(8) (2007). See also Massachusetts Department of Revenue, Form MA 1099-HC Questions, [http://www.mass.gov/?pageID=dorterminal&L=4&L0=Home&L1=Tax+Professionals&L2=Current+Year+Tax+Information&L3=Health+Care%3A+Frequently+Asked+Questions+for+Insurance+Carriers&sid=Ador&b=terminalcontent&f=dor\\_healthcare\\_Form\\_MA\\_1099HC\\_Questions&csid=Ador#Q16paper](http://www.mass.gov/?pageID=dorterminal&L=4&L0=Home&L1=Tax+Professionals&L2=Current+Year+Tax+Information&L3=Health+Care%3A+Frequently+Asked+Questions+for+Insurance+Carriers&sid=Ador&b=terminalcontent&f=dor_healthcare_Form_MA_1099HC_Questions&csid=Ador#Q16paper) (last visited Mar. 29, 2011).

<sup>64</sup> See 830 MASS. CODE REGS. 111M.2.1(8) ("an employer or other sponsor of an employment-sponsored health plan is required to . . . provide, or arrange with service providers or insurance carriers to provide, a written statement . . . annually . . . to each subscriber"); see also MASS. GEN. LAWS ch. 62C, § 8B(b) (requiring an insurer to annually provide a written statement to the insured).

<sup>65</sup> MASS. GEN. LAWS ch. 62C, § 8B(b); 830 MASS. CODE REGS. 111M.2.1(5), (9). Employers may also be penalized for failure to provide proper health insurance documentation to employees. See 830 MASS. CODE REGS. 111M.2.1(5), (9).

#### 4. *Appeals*

PPACA requires group health plans and insurers to make certain claims and appeals procedures available to insured individuals whose benefits have been denied, as well as allow those individuals whose claims continue to be denied to seek further review through an external reviewer not associated with their health plan.<sup>66</sup> These requirements begin with and expand upon the current claims review standards established for group health plans under ERISA.<sup>67</sup> Under interim final rules issued on July 22, 2010, group health plans and insurers must comply with a series of steps intended to provide plan participants with information describing the basis on which their claim for benefits was denied, their right to appeal denial of their claim, and the process for doing so.<sup>68</sup> If these internal review procedures do not result in the claim being allowed, the interim final rules establish standards for external review to be conducted either in accordance with applicable state or federal external review processes.<sup>69</sup> A plan or issuer is subject to the federal external review process where the state external review process does not meet, at a minimum, the consumer protections in the National Association of Insurance Commissioners Uniform Model Act, or where there is no applicable state external review process.<sup>70</sup> The Secretary of HHS will determine whether a state external review process meets these requirements; if it does not, health insurance issuers in the state must implement the federal external review process.<sup>71</sup> The DOL has issued two technical releases setting forth a grace period that will delay enforcement of certain of the internal claims and appeals standards.<sup>72</sup>

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<sup>66</sup> See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2719, 124 Stat. 119, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 300gg-19) (outlining the appeals process for coverage determinations and claims).

<sup>67</sup> 29 C.F.R. § 2560.503-1 (2010).

<sup>68</sup> See 75 Fed. Reg. 43330 (July 23, 2010) (discussing the interim final rule on PPACA appeal process changes, which will be codified in 26 C.F.R. pts. 54 and 602, 29 C.F.R. pt. 2590, and 45 C.F.R. pt. 147). The interim final rule defines the requirements affecting health insurance issuers, group health plans and participants or enrollees, and beneficiaries concerning internal claims and appeals, and the external review process. *Id.*

<sup>69</sup> 29 C.F.R. § 2560.503-1. Prior to the enactment of PPACA, ERISA preempted the application of state external appeals requirements to self-insured group health plans. *Id.*

<sup>70</sup> *Id.* (setting state standards for external review processes).

<sup>71</sup> *Id.*

<sup>72</sup> DOL Technical Release 2010-02 (released Sept. 20, 2010 and *available at* <http://www.dol.gov/ebsa/newsroom/tr10-02.html>) established a grace period until July 1, 2011. Technical Release 2011-01 (released March 18, 2011 and *available at* <http://www.dol.gov/ebsa/newsroom/tr11-01.html>) modifies Technical Release 2010-02 and extends the enforcement grace period for certain provisions to either the first day of the plan year beginning on or after July 1, 2011 or the first day of the plan year beginning on or after January 1, 2012.

Massachusetts has external review mechanisms in place that comply with the necessary protections established under PPACA.<sup>73</sup> Accordingly, while employers and insurers in Massachusetts will have to adapt and, in certain instances adopt, internal claims and appeals procedures, the Massachusetts external review process is likely to remain undisturbed by this change in federal law.

### 5. *Dependent Coverage*

Under PPACA, group health plans and health insurance issuers who offer dependent coverage are required to continue coverage for children who have not attained age twenty-six.<sup>74</sup> The MA Act specifies that carriers with health insurance benefit plans that cover dependents must provide coverage up to age twenty-six or for two years after the child loses federal tax dependent status, whichever is earlier.<sup>75</sup> The interim final rules issued by the Departments specify that state laws that impose stricter requirements on health insurance issuers than those imposed by PPACA will not be superseded by PPACA.<sup>76</sup> However, since the MA Act provision governing dependents is less expansive than the federal law, which requires coverage until age twenty-six regardless of whether the child is a dependent for federal tax purposes, the Massachusetts dependent coverage requirements will be preempted by federal law.

### 6. *Exchanges*

PPACA requires each state to establish an exchange to facilitate the purchase and availability of qualified health plans to eligible individuals and small business by

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<sup>73</sup> See MASS. GEN. LAWS ch. 176, § 14 (2008) (allowing for review of a grievance by a panel established by the Office of Patient Protection pursuant to MASS. GEN. LAWS ch. 111M, § 217(a)).

<sup>74</sup> See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1001, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 300gg-14) (requiring that “[a] group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child (who is not married) until the child turns 26 years of age”).

<sup>75</sup> See 2006 MASS. LEGIS. SERV. ch. 53-58 (West) (detailing insurance coverage provisions for carriers with dependants).

<sup>76</sup> See Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37, 188 (June 28, 2010) (to be codified at 26 C.F.R. pts. 54 and 602; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 144, 146, 147) (noting that state laws that impose coverage requirements on health care insurers that are stricter than those imposed by PPACA will not be superseded).



January 1, 2014.<sup>77</sup> Beginning in 2017, states may allow health insurance issuers in the large group market to purchase qualified health plan coverage through such an exchange.<sup>78</sup> PPACA's exchanges are to be implemented on a state level,<sup>79</sup> but a federal exchange may be established in the event that some states decline to or are unable to implement them by 2014.<sup>80</sup>

As previously mentioned, Massachusetts has already established the Connector, which is an independent public entity that allows certain individuals and businesses to purchase health insurance products, in some cases through pre-tax payroll deductions.<sup>81</sup> Those eligible to purchase Commonwealth Choice coverage through the Connector include Massachusetts residents employed by companies with more than fifty employees that do not offer insurance and Massachusetts residents not eligible for employer sponsored and subsidized insurance.<sup>82</sup> Small businesses with fewer than fifty employees

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<sup>77</sup> Patient Protection and Affordable Care Act of 2010 § 1311(b)(1) (to be codified as amended at 42 U.S.C. § 18031).

<sup>78</sup> *Id.* at § 1312(f)(2)(B)(i) (to be codified as amended at 42 U.S.C. § 18032). A "large employer" for inclusion in the large group market is defined by PPACA as an employer with 101 or more employees. *Id.* at § 1304(b)(1) (to be codified as amended at 42 U.S.C. § 18024).

<sup>79</sup> *See* Patient Protection and Affordable Care Act of 2010 § 1311(b)(1), (d)(1) (to be codified as amended at 42 U.S.C. § 18031) (requiring that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange" and "[a]n exchange shall be a governmental agency or nonprofit entity that is established by a State," respectively).

<sup>80</sup> Julian Pecquet, HealthWatch, Two states turn down federal grants for insurance exchanges (Sept. 30, 2010), <http://thehill.com/blogs/healthwatch/health-reform-implementation/121931-two-states-turn-down-federal-grants-for-insurance-exchanges> (last visited Mar. 29, 2011).

<sup>81</sup> MASS. GEN. LAWS ch. 118H, § 2 (2008). The section reads:

The program shall provide subsidies to assist eligible individuals in purchasing health insurance, provided that subsidies shall only be paid on behalf of an eligible individual who is enrolled in a health plan that has been procured by the commonwealth health insurance connector under said chapter 176Q, and shall be made under a sliding-scale premium contribution payment schedule for enrollees, as determined by the board of the connector.

*Id.* § 2. *See also* Massachusetts Health Connector, <https://www.mahealthconnector.org/portal/site/connector/menuitem.dc4d8f38fdd4b4535734db47e6468a0c> (last visited Mar. 29, 2011).

<sup>82</sup> MASS. GEN. LAWS ch. 176Q, § 1 (2008) (defining eligible individual). This definition was amended by 2010, 288, Sec. 41, effective July 1, 2012, and will mean "an individual who is a resident of the Commonwealth and who is not seeking individual coverage to replace an employer-sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage." *See also* MASS. GEN. LAWS ch. 176Q, § 4(a) (explaining that the Connector may only offer coverage to eligible individuals and groups).

and self-employed individuals can also purchase coverage through the Connector.<sup>83</sup> In addition, the Connector administers the Commonwealth Care Health Insurance Program, which provides subsidized coverage to eligible individuals.<sup>84</sup>

Utah and California have also established health insurance exchanges.<sup>85</sup> Utah enacted legislation in 2008 that directed the Department of Health, the Insurance Department, and the Governor's Office of Economic Development to develop a health care reform strategy in cooperation with the Legislature.<sup>86</sup> In 2009, further legislation was enacted that amended the Insurance Code and the Governor's Office of Economic Development Code to expand access to health insurance and provide greater transparency in the health insurance marketplace through, among other things, the creation of an internet portal for health insurance information.<sup>87</sup> California established its exchange following the enactment of PPACA with the goal of offering more affordable coverage through competition in the health insurance marketplace that will make plans more affordable.<sup>88</sup>

Despite the efforts of Massachusetts, Utah, and California, it is unclear whether their exchanges will satisfy the requirements established by the Departments for state exchanges. It remains to be seen what adjustments, if any, they will have to make as exchange requirements become more clearly defined.

## B. Impact on Other State and Municipal Reforms

While Massachusetts has gone further than any other state in attempting to deal with the challenges of health insurance access and cost, other states and at least one municipality have embraced the challenges as well. As of June 2010, thirty-seven states have passed legislation expanding the age until which dependent children can remain on

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<sup>83</sup> MASS. GEN. LAWS ch. 176Q, § 101 (defining eligible small groups).

<sup>84</sup> MASS. GEN. LAWS ch. 118H, § 3 (defining eligibility of uninsured individuals who may participate in the Commonwealth Care Health Insurance Program).

<sup>85</sup> Utah HB 133 (2008), Utah HB 188 (2009); Cal. AB 1602 (2010), Cal. SB 900 (2010).

<sup>86</sup> Utah HB 133.

<sup>87</sup> Utah HB 188. See also Utah Health Exchange – About the Exchange, <http://www.exchange.utah.gov/about-the-exchange> (last visited Mar. 29, 2011).

<sup>88</sup> Cal. AB 1602, SB900; see also Robin Hindery, *California Health Insurance Exchange: Schwarzenegger Signs Major Health Care Bills*, THE HUFFINGTON POST, (Sept. 30, 2010, 9:20 PM), [http://www.huffingtonpost.com/2010/10/01/california-health-insuran\\_n\\_746884.html](http://www.huffingtonpost.com/2010/10/01/california-health-insuran_n_746884.html) (last visited Mar. 29, 2011) (quoting Assembly Speaker John Perez, D-Los Angeles, the author of Cal. AB 1602).

their parent's employer-sponsored health insurance.<sup>89</sup> In addition, San Francisco established the Health Care Security Ordinance ("HCSO") to help finance health care coverage for certain employees who work in the City and County of San Francisco.<sup>90</sup>

As discussed above, whether PPACA will preempt all or portions of the dependent eligibility requirements of any given state will depend on whether the state requirements prevent the application of the PPACA dependent eligibility standards.<sup>91</sup> How PPACA will affect the HCSO is less clear. The HCSO requires covered employers (i.e. for-profit businesses employing twenty or more persons or non-profit businesses employing fifty or more persons per week during a quarter)<sup>92</sup> to spend a minimum amount of money each quarter on their covered employees' health care. Covered employers who fail to make the required health care expenditure, as defined by the HCSO, whether because they do not offer coverage or they do not contribute enough to the cost of the coverage they offer, must pay funds to the City for its Healthy San Francisco program or for a Medical Reimbursement Account it maintains for eligible individuals.<sup>93</sup> As is the case with employers who are required to make Fair Share Contribution payments in Massachusetts, the imposition of the HCSO assessment could create confusion for employers with employees working in San Francisco and could result in these employers being penalized at both the federal and local levels. Again, further clarification prior to the effective date of the assessment of the employer penalties under PPACA would be welcome.

While beyond the scope of this article, it is worth briefly noting that state health care reform initiatives are themselves the subject of preemption challenges. For instance, the Golden Gate Restaurant Association unsuccessfully challenged the HCSO on the grounds that ERISA preempted it.<sup>94</sup> This followed the Retail Industry Leaders

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<sup>89</sup> See, e.g., N.Y. INS. LAW § 3216 (McKinney 2010) (allowing unmarried children to remain on their parents' health insurance until age thirty); N.Y. INS. LAW §§ 4321, 4322 (McKinney 2010); N.J. STAT. ANN. 17B:27-30.5 (West 2009) (allowing unmarried children without their own dependents to stay on their parents' health insurance until age thirty-one); National Conference of State Legislatures, Dependent Health Coverage (State Implementation), <http://www.ncsl.org/default.aspx?Tabid=14497> (last visited Mar. 29, 2011) (providing a complete list of states with expanded dependent coverage).

<sup>90</sup> S.F. ADMIN. CODE, §§ 14.1-14.8 (2008), available at <http://library.municode.com/HTML/14131/level1/CH14SAFRHECASEOR.html>.

<sup>91</sup> See *supra* notes 33-34 and accompanying text.

<sup>92</sup> CITY AND COUNTY OF SAN FRANCISCO, DEPARTMENT OF ADMINISTRATIVE SERVICES, OFFICE OF LABOR STANDARD ENFORCEMENT, HEALTH CARE SECURITY ORDINANCE, 2010 NOTICE, available at <http://sfgsa.org/Modules/ShowDocument.aspx?documentid=6778>.

<sup>93</sup> See *id.* (enumerating examples of payment options for employers).

<sup>94</sup> Golden Gate Rest. Ass'n v. City & County of San Francisco, 546 F.3d 639, 661 (9th Cir. 2008)

Association's successful challenge to a Maryland law that imposed a health care expenditure requirement on certain large employers, in particular Wal-Mart, operating in Maryland.<sup>95</sup> The Fourth Circuit found that a mandate on employers to make a specified level of health care expenditures was preempted by ERISA.<sup>96</sup> This conflict among the Circuits found its way to the U.S. Supreme Court, but it declined to hear the case.<sup>97</sup> To date, no part of the MA Act has been challenged on ERISA preemption grounds, and many have questioned whether such a challenge would succeed.<sup>98</sup> It is quite possible that the implementation of federal health care reform will reduce, if not eliminate, future ERISA challenges to state reform, but as is discussed below, should PPACA be scaled back or repealed, or should the courts find the individual mandate unconstitutional, arguments over preemption will continue to loom large over state health care reform efforts.

## V. What Happens Now?

If many predictions made in the wake of the mid-term elections of November 2010 are to be believed, PPACA could be scaled back, if not repealed outright,<sup>99</sup> thereby returning to the states the task of addressing health care reform. The United States House of Representatives passed the Repealing the Job-Killing Health Care Law Act by a 245-189 vote on January 19, 2011.<sup>100</sup> The vote, however, was widely viewed as only a

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*cert. denied*, 130 S. Ct. 3497 (2010).

<sup>95</sup> Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 183 (4th Cir. 2007). In *Fielder*, the Retail Industry Leaders Association challenged a Maryland statute that required employers who had 10,000 or more employees to spend at least eight percent of total wages for health insurance costs. *Id.* If the employer failed to pay eight percent, then the employer would have to pay the shortfall back to the state. *Id.* The court concluded that the Maryland Fair Share Health Care Fund Act conflicted with ERISA's goal of administering a standardized nationwide act. *Id.* The Act's conflict with ERISA resulted from the requirement that Maryland employers had to restructure employee health insurance plans. *Id.*

<sup>96</sup> *Id.* at 193-94 (holding that ERISA preempted the Maryland statute because it conflicted with ERISA's goal of a uniform administration of employer provided health benefits).

<sup>97</sup> *Golden Gate Rest. Ass'n*, 546 F.3d at 639.

<sup>98</sup> See, e.g., Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1205 (2007) (predicting that a challenge to the Massachusetts law would not succeed).

<sup>99</sup> See, e.g., Gail R. Chaddock, *Health Care Reform: After GOP Gains Will It Be Repealed?*, CHRISTIAN SCIENCE MONITOR, Nov. 3, 2010 (noting full repeal likely first floor vote); Peter Nicholas & James Oliphant, *Obama, Republicans Reposition for Shift in Power*, L.A. TIMES, Nov. 4, 2010, at LAT Extra 1 (describing Eric Cantor's intention to use every tool to achieve a full repeal); Robert Pear, *G.O.P. to Fight Health Law with Purse Strings*, N.Y. TIMES, Nov. 7, 2010, at A1 (discussing possible Republican strategies in challenging main elements of the law).

<sup>100</sup> H.R. 2, Repealing the Job-Killing Health Care Law Act (2011).

symbolic statement of opposition, and the Senate voted down the effort to repeal PPACA on February 2, 2011.<sup>101</sup> Given that the House efforts at total repeal have failed for the time-being,<sup>102</sup> they may still produce a narrower piece of legislation under a “repeal and replace” approach.<sup>103</sup> Under such a scenario, the patient protections and access to coverage provisions of PPACA could survive,<sup>104</sup> and states will still be confronted with how to reconcile their own innovative health care reforms, enacted through their insurance and patient protection statutes, with those under PPACA.<sup>105</sup> The law also has to survive rumored Congressional attempts to either eliminate funding for various provisions of PPACA or slow their implementation,<sup>106</sup> as well as numerous

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<sup>101</sup> The effort to repeal PPACA was presented in the Senate as an amendment to a bill reauthorizing the Federal Aviation Administration, and the Senate voted not to waive a budget point of order against the repeal measure, meaning the amendment failed. S. 223, FAA Air Transportation Modernization and Safety Improvement Act (2011). See also David Herzenhorn & Robert Pear, *House Votes for Repeal of Health Law in Symbolic Act*, N.Y. TIMES, Jan. 20, 2011, at A1, available at [http://www.nytimes.com/2011/01/20/health/policy/20cong.html?\\_r=1&hpA1](http://www.nytimes.com/2011/01/20/health/policy/20cong.html?_r=1&hpA1).

<sup>102</sup> Many believe repeal would be ill-advised. See, e.g., J. Gruber, *Be Careful What You Wish For: Repeal of the Affordable Care Act Would Be Harmful to Society and Costly for Our Country*, CENTER FOR AMERICAN PROGRESS (Jan. 19, 2011), available at [http://www.politico.com/static/PPM195\\_gruber\\_careful\\_what\\_you\\_wish\\_for.html](http://www.politico.com/static/PPM195_gruber_careful_what_you_wish_for.html).

<sup>103</sup> See, e.g., M. Viser & M. Arsenault, *Ultimate GOP Aim is a Slimmer Health Plan*, BOSTON GLOBE, Jan. 19, 2011, at A1 (discussing smaller attempts to change PPACA). See also Herzenhorn & Pear, *supra* note 99.

<sup>104</sup> See, e.g., *What can Republicans Actually do?*, PHILADELPHIA DAILY NEWS, Nov. 5, 2010, at 21 (hypothesizing that Republicans will be unable to repeal PPACA outright); *Now the Hard Part*, THE COURIER JOURNAL, Nov. 4, 2010, at A14 (predicting PPACA will remain intact despite Republican pledges to repeal it).

<sup>105</sup> On November 18, 2010, Senator Scott Brown from Massachusetts introduced the Empowering States to Innovate Act, S. 3958, which would allow states to opt out of certain provisions of PPACA, such as the individual mandate and the exchanges, if states applied for and obtained waivers demonstrating that the issue of how states will implement PPACA is a critical issue. See S.P. Sullivan, *Sen. Scott Brown Co-sponsors 'Empowering States to Innovate Act,' Proposal to Modify Health Care Overhaul*, MASSIVE.COM, Nov. 22, 2010, [http://blog.masslive.com/thefray/2010/11/sen\\_scott\\_brown\\_cosponsors\\_emp.html](http://blog.masslive.com/thefray/2010/11/sen_scott_brown_cosponsors_emp.html) (last visited Mar. 29, 2011). On January 18, 2011, Senator Bernie Sanders of Vermont introduced the State Leadership in Health Care Act, which would, among other things, allow states to apply for waivers from certain provisions of PPACA effective January 1, 2014, rather than January 1, 2017, as set forth in section 1332 of the Patient Protection and Affordable Care Act. See *Vermont Leaders Move Forward on Health Care*, COMMONDREAMS.ORG, Jan. 18, 2011, <http://www.commondreams.org/newswire/2011/01/18-0> (last visited Mar. 29, 2011).

<sup>106</sup> On April 5, 2010, the House Energy and Commerce Committee approved along party lines bills that would strip PPACA of billions of dollars in mandatory spending, including funding for states to develop insurance exchanges. H.R. 1213, To repeal mandatory funding provided to States in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges (2011); see also H.R. 1214, H.R. 1215, H.R. 1216, H.R. 1217 (2011). The 2011 budget

constitutional challenges.<sup>107</sup> Various plaintiffs have raised, among other things, the question of whether the individual mandate violates the Commerce Clause of the U.S. Constitution and whether PPACA's regulation of the health insurance market violates the Constitution's Supremacy Clause.<sup>108</sup> In *Commonwealth of Virginia v. Sebelius*,<sup>109</sup> Judge Henry Hudson stated that "no specifically articulated constitutional authority exists to mandate the purchase of health insurance,"<sup>110</sup> and, in granting the Commonwealth's Motion for Summary Judgment, he found that the Minimum Essential Coverage provision of PPACA<sup>111</sup> "exceeds the constitutional boundaries of congressional power."<sup>112</sup> In *Florida v. U.S. HHS*, Judge Roger Vinson also found that Congress exceeded its authority under the Commerce Clause in enacting the individual mandate,<sup>113</sup> but he went a step further. He ruled that since PPACA does not contain a severability clause, the individual mandate could not be severed from the remainder of PPACA, and

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agreement passed by Congress on April 14, 2011 contains provisions that repeal and defund certain provisions of PPACA. Specifically the "free choice voucher program," which required employers to provide vouchers for employees whose employer-provided health insurance premiums cost between eight percent and 9.8 percent of the employee's family income, was repealed, and \$2.2 billion of the \$6 billion in start-up funding provided for the Consumer Operated and Oriented Plan program created under PPACA section 1322 was rescinded.

<sup>107</sup> See, e.g., *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882, 895-96 (E.D. Mich. 2010) (denying plaintiff's motion for a preliminary injunction and finding the plaintiff's claim that PPACA is unconstitutional under the commerce clause has failed on the merits); *Commonwealth of Virginia v. Sebelius*, 702 F. Supp. 2d 598, 615 (E.D. Va. 2010) (denying a motion to dismiss on a claim alleging the unconstitutionality of the federal government's requirement that all citizens to maintain a minimum level of health insurance coverage or pay a fine under PPACA); *Florida v. U.S. HHS*, No. 3:10-cv-91-RV/EMT at 13, 121 (N.D. Fla. 2010). The court denied the defendant's motion to dismiss as to count I alleging that congressional enactment of PPACA exceeds their power under the commerce clause, and as to count IV alleging that PPACA is in violation of article I, Amendment IX and X as it commandeers the state with respect to Medicaid. See *Florida v. U.S. HHS*, 716 F. Supp. 2d 1120, 1156-60.

<sup>108</sup> See *Florida v. U.S. HHS*, No. 3:10-cv-91-RV/EMT (N.D. Fla. 2011) (finding that Congress exceeded its authority under the Commerce Clause in enacting the individual mandate and striking down PPACA since a lack of severability clause means that the individual mandate cannot be severed and therefore the entire act is unconstitutional). But see *Thomas More Law Ctr.*, 720 F. Supp. at 891-94 (dismissing the claim that PPACA exceeded Congressional authority under the Commerce Clause).

<sup>109</sup> *Commonwealth of Virginia v. Sebelius*, 2010 U.S. Dist. LEXIS 130814 (E.D. Va. Dec. 13, 2010).

<sup>110</sup> *Id.* at \*34.

<sup>111</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 18091); I.R.C. § 5000A (2010).

<sup>112</sup> *Commonwealth of Virginia*, 2010 U.S. Dist. LEXIS 130814 at 38.

<sup>113</sup> See *Florida v. U.S. HHS*, No. 3:10-cv-91-RV/EMT (N.D. Fla. 2011).

therefore, PPACA in its entirety is unconstitutional.<sup>114</sup> While the path and endpoint of this constitutional litigation are somewhat unclear,<sup>115</sup> states will likely have to consider their health care reform options long before any of this and any future legal challenges run their course.<sup>116</sup>

In Massachusetts, the Connector and other state regulators charged with monitoring, enforcing, and studying various part of the MA Act will have to consider how to open and maintain lines of communication with federal regulators such that all parties, at both the state and federal level, can move forward with care, mindful of the impact that the federal law will have on the reforms already in place in Massachusetts.<sup>117</sup> It is not beyond the realm of possibility that if PPACA remains largely intact by the time

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<sup>114</sup> *Id.*

<sup>115</sup> On January 14, 2011, the U.S. Attorney filed an appeal in Thomas More Law Center v. Obama that was granted by the U.S. Court of Appeals for the Sixth Circuit on February 6, 2011; hearings are tentatively schedule for mid-May 2011. See Thomas More Law Center v. Obama, 720 F.Supp.2d 882 (E.D. Mich. 2010) (Case: 10-2388 Doc.: 006110845078), available at [http://op.bna.com/hl.nsf/id/mapi-8d8pud/\\$File/thomas%20more%20govt%20brief.pdf](http://op.bna.com/hl.nsf/id/mapi-8d8pud/$File/thomas%20more%20govt%20brief.pdf). On March 8, HHS filed notices to appeal the decision in *Florida v. U.S. HHS*, and to expedite review, indicating that it will ask the U.S. Court of Appeals for the Eleventh Circuit to rule on the constitutionality of PPACA's individual mandate and whether it can be separated from the rest of the statute. *Florida v. U.S. HHS*, Nos. 11-11021-HH, 11-11067-HH, 3:10-cv-91-RV/EMT (N.D. Fla. 2011). *Commonwealth of Virginia v. Sebelius*, 210 U.S. Dist. LEXIS 130814, at \*40-41. Judge Hudson's decision would "sever only Section 1501 and directly-dependent provisions which made specific reference to Section 1501" from PPACA and leave the rest of PPACA intact. *Id.* Furthermore, Judge Hudson declined to grant the Commonwealth's request for injunctive relief enjoining implementation of Section 1501 stating that "[t]he outcome of this case has significant public policy implications. And the final word will undoubtedly reside with a higher court." *Id.* at \*63. In fact, Virginia took an unusual step on February 8, 2011, when it filed a petition for direct U.S. Supreme Court review of the District Court's decision that rendered the individual mandate provision invalid without invalidating the remainder of PPACA. *Virginia ex rel. Cuccinelli v. Sebelius*, U.S., No. 10-1014. On April 25, 2011, the Supreme Court rejected Virginia's petition to bypass intermediate appellate review with no recorded vote or public dissent, but still allowed implementation of the law. *Id.* The denial allows the cross-appeals pending in the Fourth Circuit to proceed, where oral argument has been scheduled for May 10, 2011.

<sup>116</sup> See, e.g., the Executive Order issued by Idaho Governor C.L. "Butch" Otter, directing that "no executive branch, department, agency, institution or employee of the State shall establish or amend any program or promulgate any rule to implement any provision of the PPACA." Executive Order No. 2011-03 (Apr. 20, 2011).

<sup>117</sup> For example, a recent study has concluded that the Massachusetts individual mandate had a causal role in improving insurance risk selection under the Commonwealth's Health Care Reform Act. See A. Chandra, J. Gruber & R. McKnight, *The Importance of the Individual Mandate – Evidence from Massachusetts*, 364 NEW ENG. J. MED. 293 (2011), available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1013067>.

its central features go into effect on January 1, 2014, state regulators, including the Connector and the Division of Health Care Finance and Policy, will seek to modify existing requirements. Additionally, the Massachusetts Legislature could amend or even repeal parts of the MA Act that are deemed either redundant or in conflict with provisions of PPACA intended to achieve similar goals.

As the political debates rage on in Washington, D.C., the work being done by the Departments to provide guidance to employers about PPACA is likely to continue unabated. Furthermore, work on other aspects of federal health care reform is on-going with equal vigor. For example, the Department of Health and Human Services is already working on the infrastructure needed to establish the state exchanges. Todd Park, Chief Technology Officer at DHHS noted:

[T]here's a lot of very energetic work happening at the state level and federal level. There's a huge amount of questions about how this is supposed to work, how data is supposed to go back and forth, how states and federal government interact. [We'll] really try to map out how this is supposed to work and how it is a part of that. We're in the middle of doing that.<sup>118</sup>

While much remains to be clarified, including how to resolve potential conflicts with already enacted state reforms, what is clear is that a dialogue about a vitally important public problem is on-going. This dialogue can be energizing for those charged with crafting solutions and frustrating for those, such as employers, who have to live with the uncertainty. Yet, the authors feel confident that the attention being paid to this issue will give all parties the opportunity to be heard and to be part of what continues to be a critical conversation taking place at a historic time in America.

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<sup>118</sup> Jennifer Haberkorn & Sarah Kliff, *Berwick Renominated – Sebelius to HELP Hearing – Fourth Circuit to Hear Reform Case in May – AHIP Pushes Anti-Fraud Work – Guardian Ends Health Ins Business*, POLITICO PULSE (Jan. 11, 2011), <http://www.politico.com/politicopulse> (last visited Mar. 29, 2011).



