An Employers' Guide to the 2006 Massachusetts Health Care Reform Act

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> "It is one of the happy accidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory, and try novel social and economic experiments without risk to the rest of the country." [1]
>
> —Justice Louis D. Brandeis

This oft-quoted statement penned by Justice Brandeis in 1932 aptly describes the sweeping health care reform bill—Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care* (the "Act")—which Massachusetts Governor Mitt Romney signed into law on April 12, 2006 during an elaborate and highly publicized ceremony at Boston's historic Faneuil Hall. In addition to Governor Romney, presenters at the signing ceremony included the President of the Massachusetts Senate, Robert Travaglini, the Speaker of the Massachusetts House of Representatives, Salvatore DiMasi, and the Commonwealth's Senior United States Senator, Edward Kennedy, each of whom in turn spoke glowingly of the role of the new law in expanding access to affordable health care. But in a display of candor not usually associated with such occasions, the speakers acknowledged that the Act's prescriptions (and proscriptions) were novel and untested and that they will in all likelihood need to be revisited.[2]

Chapter 324 of the Acts of 2006, *An Act Relative to Health Care Access* (the "Technical Corrections Act"), made certain technical corrections to the Act, including changes to a handful of effective dates. Chapter 450 of the Acts of 2006, *An Act Further Regulating Health Care Access* ("Chapter 450"), further tinkered with certain of the Act's provisions and also pushed back certain effective dates of particular interest to employers. Lastly, signed into law on November 29, 2007, Chapter 205 of the Acts of 2007, an *Act Further Regulating Health Care Access* ("Chapter 205") made further technical corrections and refinements.

Because health care in the United States is in large part employer-based, any efforts aimed at reform will inevitably impact employers. Following a brief overview of the Act and a description of the Act's individual mandate, this paper examines the Act's effects on Massachusetts employers and multi-state employers that operate in Massachusetts. In particular, it explains the following features of the Act and, in each case, what employers will need to do to comply:

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[1] New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932).

[2] *See* Act § 132 (requiring the secretary of the executive office of health and human services to issue and periodically update an implementation plan tracking progress on the Act's implementation, the purpose of which is to alert the legislature to instances where certain of the Act's provisions may need to amended).

	Requirement	Statutory Provision	M.G.L. Laws Chapter/Section
1.	Fair share contribution requirement	Act §§ 47 and 134	c. 149, §§ 187, 188
2.	The Free Rider Surcharge	Act §§ 32, 33, 35 through 40, 44 and 46 Technical Corrections Act § 22; c. 450 § 2	c. 118G, §§ 1, 2, 3, 5, 6, 6D½, 18B (c. 118G, §§ 18 and 18A repealed)
3.	The "health insurance responsibility disclosure" (or "HIRD") form	Act § 42 Technical Corrections Act § 25; c. 450 § 7; c. 205 § 22	c. 118G, §§ 6B, 6C
4.	The cafeteria plan requirement	Act § 48	c. 151F
5.	Reporting (Form 1099-HC, etc.)	Technical Corrections Act § 11	c. 62C, § 8B
6.	The insured plan non-discrimination requirement	Act §§ 50, 52, 55 and 59	c. 175, § 110(O) c. 176A, § 8½ c. 176B, § 3B c. 176G, §6A
7.	Expanded coverage of dependents	Act §§ 53, 56 and 58 Technical Corrections Act §§ 33, 34 c. 205 §§ 5, 31, 33-38	c. 175, § 108(2)(a) c. 175, § 110(P) c. 176A, § 8Z/8AA c. 176B, § 4Z/4AA c. 176G, § 4R/4S
8.	Small group insurance requirements regarding waiting periods, creditable coverage, and pre-ex conditions	Act §§ 77, 82, 83, 84 Technical Corrections Act §§ 43 through 50	c.176J, §§ 1, 3, 4, 5
9.	Health Insurance Portability	Act § 96 through 100 Technical Corrections Act §52	c. 176N, §§ 1, 2

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Of these requirements, only the first five are properly referred to as "employer mandates," i.e., as imposing obligations directly on employers. The last four, the group health plan non-discrimination requirement, the expanded definition of "dependent" under group health plans, small-group insurance reform, and health insurance portability requirements, are imposed on insurance companies, but they will result in changes in the underlying design of employer-sponsored group health plans and impose additional administrative burdens on employers than sponsor insured (as opposed to self-funded) group health plans.

I. OVERVIEW OF THE ACT

Escalating uncompensated health care costs combined with rapidly rising Medicaid expenditures have put enormous stress on state budgets. Lacking health insurance coverage, uninsured individuals routinely forgo preventative care, and, when absolutely necessary, they obtain treatment at emergency rooms. Massachusetts hospitals are generally required to provide care even if a patient cannot pay for it irrespective of residency status, thus leaving hospitals with mounting unpaid bills.

Dissatisfied with the status quo, constituencies from both ends of the Massachusetts political spectrum had been advocating for some time for comprehensive health care reform. But in 2006 the state also faced pressure from the federal government. Specifically, the Centers for Medicare & Medicaid Services ("CMS") demanded fundamental changes to the state's Medicaid program, which had previously operated under a federal waiver that permitted the state to allocate $385 million to assist health plans operated for the uninsured by two large public hospital systems. The federal authorities directed the state to shift those funds to insurance coverage. Faced with an uninsured population of over 500,000 residents[3] and the potential loss of some $385 million in federal Medicaid revenues unless the number of uninsured individuals was reduced,[4] the Commonwealth of Massachusetts needed to do something.

Prior to the Act, Massachusetts paid about $600 million annually into a fund known as the "uncompensated care pool."[5] Established in 1985, the uncompensated care pool (a/k/a the "free care pool") reimburses hospitals and community health centers for care provided to uninsured and underinsured individuals with incomes below 200 percent of the Federal Poverty Level (or "FPL") ($20,420 for an individual in 2007). The free care pool is funded through an annual assessment on insurance providers and hospitals, with the balance being paid out of general state and federal tax revenue. Responding to CMS requirements, the Act shifts dollars away from uncompensated care and toward premium subsidies for low income individuals.

Drawing on the approach taken toward the regulation of auto insurance, the Act requires every Massachusetts resident to purchase health insurance by July 1, 2007. Employers too must play their part by offering or facilitating access to health insurance. Many of those currently uninsured will receive some form of direct or indirect state assistance to help them obtain coverage. Of these, approximately 100,000 are eligible for Medicaid; another 200,000 with

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[3] Commonwealth of Massachusetts Executive Department, *Press Release: Romney Signs Landmark Health Insurance Reform Bill* (Apr. 12, 2006).
[4] Commonwealth of Massachusetts Executive Department, *Press Release: Implementation of Health Care Law Proceeds* (May 1, 2006).
[5] Conference Committee Report, Apr. 3, 2006

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incomes below 300% of the FPL will receive sliding-scale premium assistance and will be eligible for no-deductible policies; and the remaining 200,000 (those with higher incomes) will be eligible for special private market policies.[6]

In Fiscal Year 2007, a variety of sources provides funding for the Act's reforms. The 2005 Medicaid waiver allows the state to redirect funds from the uncompensated care pool toward expanded coverage, bringing in $605 million. The Commonwealth will receive about $154 million in federal matching funds for expanding its Medicaid and State Child Health Insurance Program (or "SCHIP"). The existing assessment on hospitals and third-party payers will generate a total of $320 million. The Act provided the newly-established Massachusetts Health Insurance Connector Authority with $25 million in funding to start, with the goal that it be financially self-sustaining by 2009. The Connector will generate revenue by charging the insurers in two new programs created under the Act, "Commonwealth Care" and "Commonwealth Choice" an administrative fee for each person the agency enrolls in the insurers' plans. "Fair share contributions" by employers that do not make a "fair and reasonable" contribution to employee health coverage are estimated to generate an additional $24 million. In addition to these sources, the commonwealth will use $300 million in general funds.[7]

The Act includes other major provisions that include the following:

- $20 million is allocated for public health initiatives aimed at reducing diabetes, cancer, infections, smoking, and other health problems.

- A Quality and Cost Council sets benchmarks for quality improvement and cost containment, collects data on health outcomes and health system spending from providers throughout the state's health care system, and publishes its findings on its Web site.

- A statewide Racial and Ethnic Health Disparities Council tracks disparities data and creates Pay for Performance benchmarks.

- $3 million is appropriated for grants to community-based organizations to identify people who are eligible for subsidized coverage and enroll them in MassHealth or Commonwealth Care.

A. The Commonwealth Health Insurance Connector

Act § 101, which adds to the General Laws chapter 176Q, establishes the "Commonwealth Health Insurance Connector" (or simply, the "Connector") for the purpose of implementing certain of the Act's key features.

(1) *Overview*

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[6] *See* note 4, *supra*.
[7] *See* note 5, *supra*.

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The Connector is “a body politic and corporate and a public instrumentality”[8] of the Commonwealth of Massachusetts. Its purpose is to furnish access to eligible individuals and eligible small groups to affordable health insurance products. An eligible small group is defined as individuals and businesses or other organizations or associations that on at least 50% of their working days during the previous year employed between 1 and 50 employees.[9] A board of ten members[10] from government and the private sector governs the Connector. Insurance products offered through the Connector will carry with them the Connector’s “seal of approval,” which is given by “the board of the connector to indicate that a health benefit plan meets certain standards regarding quality and value.”[11]

The Connector serves the following six main functions:

(a) Facilitating Health Insurance Access under “Commonwealth Choice”

The Connector collects premium payments from eligible individuals and small groups and remits premiums to insurers under its “Commonwealth Choice” health insurance program. Coverage under Commonwealth Choice is made available through private health insurance plans. Once enrolled, an individual will become a member of the particular health plan option he or she selects.[12] The Connector has the power to appoint an agent or agents, which are referred to as “sub-connectors,” for this purpose.[13]

(b) Defining “minimum creditable coverage”

Under the Act’s individual mandate, Massachusetts residents must obtain and maintain health care plan coverage that constitutes “minimum creditable coverage.” The Connector is charged with the task of setting “minimum creditable coverage” standards. (See Section II.B below for a discussion of the Connector’s “minimum creditable coverage” guidance.)

(c) Administering Commonwealth Care

The Connector is charged with the task of overseeing and administering a health insurance program called the “Commonwealth Care Health Insurance Program” (or, simply,

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[8] Act § 101, adding M.G.L. c. 176Q. *See* M.G.L. c. 176Q, § 2(a).
[9] M.G.L. c. 176Q, § 1.
[10] *Id*. § 2(b); Technical Corrections Act § 53 (providing that the Connector board will consist of the secretary for administration and finance, chair, the director of Medicaid, the commissioner of insurance, the executive director of the group insurance commission; 3 members appointed by the governor (an actuary, a health economist and a representative of small business), 3 members appointed by the attorney general (a health benefits plan specialist, a representative of a health consumer organization, and a representative of organized labor)).
[11] Act § 67 amending M.G.L. c. 176J.
[12] *See* Section I.E (discussing Commonwealth Choice).
[13] *See* M.G.L. c. 176Q, § 3(r) (empowering the Connector board “to establish criteria, accept applications, and approve or reject licenses for certain sub-connectors which shall be authorized to offer health benefit plans offered by the connector”). While more than one sub-connector is authorized, the Connector board, following an open bidding process, selected a single vendor for this purpose.

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"Commonwealth Care),"[14] which subsidizes health insurance coverage for low-income individuals through the Connector.[15]

(d) Establishing "Affordability" standards

The requirement to obtain and maintain "creditable coverage" under the individual mandate may be waived where an individual can demonstrate that "affordable" coverage is unavailable.[16] It is the Connector that establishes standards what constitutes "affordable" coverage (see Section II.C below).

(e) Promulgating Cafeteria Plan Regulations

The Connector is directed to promulgate rules and regulations implementing the Act's "cafeteria plan" mandate, under which employees may pay premiums with pre-tax dollars. (See Section III.D below for a discussion of the Act's cafeteria plan requirements.)

(f) Administering Waivers and Appeals

The Connector will handle requests for individual waivers of the individual mandate based on an individual's inability to obtain affordable coverage.

Essentially, the Connector is a pooling mechanism, or "aggregator," through which individuals and small groups are combined together under a state-run purchasing cooperative in order to procure insurance. This pooling approach should put downward pressure on premiums, since policies offered through the Connector cover a large number of insureds. Connector advocates point to two further advantages: It should stimulate competition among health insurance, and it should encourage health insurance portability.

Employers can contribute to an employee's health insurance through the Connector, and it is intended that employees (e.g., part-time, seasonal and temporary employees) who work in more than one job will be able to have employer and employee contributions from more than one job aggregated for the purpose of funding their Connector-provided coverage. Coverage, in effect, can be "carried" from job to job thereby fostering health insurance portability. The employee will, as a result, experience no break in his or her medical coverage. The new employer can continue payments to the Connector for the same coverage.

Insurance products offered through the Connector are generally required to satisfy all applicable state licensing requirements and to include all health insurance coverage mandates.[17] Under a narrow exception, however, carriers may offer coverage for "young adults" (i.e., ages 19 and 26 "who do not otherwise have access to health insurance coverage subsidized by an employer") with alternative coverage. Young adult coverage must, at a minimum, provide:

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[14] Act § 45, adding M.G.L. c. 118H.
[15] *See* Section I.B, *infra*.
[16] M.G.L. c. 176Q, § 3(a)(5).
[17] *See generally* M.G.L. c. 175, 175A, 176B and 176G.

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> "reasonably comprehensive coverage of inpatient and outpatient hospital services and physician services for physical and mental illness and shall provide *all services which a carrier is required to include under applicable division of insurance statutes and regulations*, including, but not limited to, mental health services, emergency services, and any health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plans."[18] (Emphasis added.)

On or about April 17, 2007, the Massachusetts Division of Insurance issued emergency regulations[19] establishing standards governing young adult health benefit plans. The emergency regulations require that young adult health benefit products (i) must be offered only through the Connector (and have the Connector's seal of approval), and (ii) subject to certain transitional rules, the only carriers that may offer such plans are those that have an aggregate enrollment (individuals, employees and dependents, but not enrollees in young adult health benefit plans) of 5,000 in health benefit plans sold, issued, or delivered through the Connector.[20]

Young adult health benefit plans must, under the Division of Insurance proposal, generally include an annual out-of-pocket maximum for in-network covered services not to exceed $5,000 in total (with exceptions for plans with coinsurance for only a limited number of non-core benefits that are not required to be part of a young adult health benefit plan, e.g., outpatient prescription drug coverage or durable medical equipment).[21] Such plans may, however, include a limitation on covered medical services that is no less than either $50,000 per illness, injury, or condition in a contract year, or $50,000 per calendar year for in-network and out-of network services combined.[22] The annual deductible for all covered medical services must not exceed $2,000 for in-network benefits. Such plans must provide coverage of inpatient and outpatient hospital services, physician services for physical and mental illness, emergency services, and all other services mandated to be covered under Massachusetts law, and they may include reasonable co-payment, coinsurance and deductible levels (as approved by the Connector).[23] In addition, cost control techniques commonly used in the health insurance industry, including tiered provider networks and selective provider contracting, are also permitted by the Connector. Lastly, any carrier offering young adult health benefit plans must offer at least one young adult health benefit plan that includes coverage for outpatient prescription drugs.

Carriers are not required to issue a young adult health benefit plan to an eligible young adult if the young adult has made (i) at least three or more late payments, (ii) committed fraud, misrepresented the eligibility of a person as an eligible young adult or misrepresented information necessary to determine the health benefit plan premium rate, (iii) failed to comply

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[18] Act § 90 adding M.G.L. c. 176J, § 10.
[19] 211 CMR 63.00.
[20] 211 CMR 63.05(1) (proposed).
[21] *Id*.
[22] *Id*. at 63.05(1)(b).
[23] *Id*. at 63.05(2).

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with a material health benefit plan provision, or (iv) voluntarily ceased coverage under the carrier's health benefit plan before the contract renewal date.[24]

The emergency regulations also provide standards governing renewability,[25] which generally track the renewability standards of state[26] and federal law.[27] Similarly, the standards relating the treatment of pre-existing condition limitations and waiting periods largely mirror the Commonwealth's small group rules.[28] Rating standards are also prescribed.[29]

Chapter 205, § 41 establishes a special commission to "investigate and study the role of the connector in providing access to health insurance products." The commission is instructed to focus on the Connector's utilization of private sector entities, including insurance brokers, and to look for ways to promote enrollment and prevent unnecessary duplications in coverage. Chapter 205 specifies the commission's membership, and it directs the periodic reporting of findings.

(2) *Access to the Connector*

Under M.G.L. c. 176Q, § 4, the Connector may only offer health benefit plans to "eligible individuals," and "eligible small groups." [30] The statute[31] defines the terms "eligible individual" to mean "an individual who is a resident of the commonwealth [and who] is not offered subsidized health insurance by an employer with more than 50 employees," and "eligible small group" to mean an employer with 50 or fewer employees in the Commonwealth. The net effect of these provisions is that the Connector may offer coverage to Massachusetts residents who are—

(a) Non-working individuals;

(b) Individuals who work for a company of any size that does not offer health coverage;

(c) Individuals who work at a company of any size who are not eligible for health coverage (e.g., part-time employees, independent contractors, and newly-hired employees); and

(d) Employees of large groups who are ineligible for subsidized employer-sponsored coverage.

Under these provisions, an employee with access to employer-subsidized coverage under a plan sponsored by an employer with more than 50 employees is not eligible to purchase health insurance through the Connector. This rule has important implications that the Connector will

[24] *Id*.
[25] 211 CMR 63.06.
[26] *See* Section IV.C, *infra* (relating to the Act's small group insurance reform requirements).
[27] *Id.* (relating to the HIPAA Title I portability rules).
[28] *Id*. at 63.08.
[29] *Id*. at 63.07.
[30] Act § 101, adding M.G.L. c. 176Q. *See also* M.G.L. c. 176Q, § 1 (defining the term "eligible individuals" and "eligible small groups").
[31] M.G.L. c. 176Q, § 1.

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ultimately need to address and clarify. For example, what level of coverage must an employer offer before an employee is barred from Connector access? Is a stand-alone dental or vision arrangement sufficient? Whatever the Connector finally decides, there is a limited exception for employees with income below 300% of the Federal Poverty Limit ("FPL") (and who are therefore eligible for subsidized coverage under Commonwealth Care) and who are also eligible for employer-provided coverage. Under M.G.L. c. 118H,[32] an uninsured individual shall be eligible to participate in the program if—

> (i) His or her or his or her family's household income does not exceed 300% of the FPL;
>
> (ii) The individual has been a resident of the Commonwealth for the previous six months;
>
> (iii) The individual is not eligible for any MassHealth program, for Medicare, or for the State Child Health Insurance Program ("SCHIP");[33]
>
> (iv) The individual's or family member's employer has not provided health insurance coverage in the last six months for which the individual is eligible and for which the employer covers at least 20% of the annual premium cost of a family health insurance plan or at least 33% of an individual health insurance plan; and
>
> (v) The individual has not accepted a financial incentive from his employer to decline his employer's subsidized health insurance plan. (While individuals that have access to employer-subsidized coverage may be ineligible for subsidized coverage through the Connector, i.e., Commonwealth Choice, these individuals will likely be eligible for a waiver of their obligations under the individual mandate by reasons of their inability to access affordable coverage. Accordingly, they will not be subject to a tax penalty for violating the individual mandate.)

The Act confers on the Connector the power to waive the requirement in item (iv) (relating to coverage under an employer-sponsored plan in the prior six months) where the employer coverage is provided under a plan that complies with the insurance non-discrimination requirements (see Section IV.A below), and the employer pays to the Connector the cash equivalent of its premium contribution.[34] Where the employer offers more than one plan, the cash equivalent of its premium is based on its most popular plan.[35]

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[32] Act § 45, as amended by the Technical Corrections Act § 27.
[33] Balanced Budget Act of 1997, Pub. L. 103-35 (amending Title XXI of the Security Act). SCHIP's are established under and are jointly financed by the Federal and state governments but are administered by the states. Within Federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides a capped amount of funds to states on a matching basis, and payments are based on State expenditures under approved plans.
[34] M.G.L. c. 118H, § 4(b).
[35] *Id*.

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In an internal policy adopted May 18, 2007, the Connector further refined and clarified the requirements under which an individual can elect coverage under Commonwealth Choice. Specifically, an individual is eligible for Commonwealth Choice if he or she:

(1) Is a resident of the Commonwealth of Massachusetts;

(2) Is 18 years old or older (or is less than 18 years of age with the permission of a parent/legal guardian);

(3) Is at any income level (although, if he or she has income of less than 300% of the FPL, he or she may qualify for Commonwealth Care);

(4) Is either employed or unemployed, but, if employed, he or she either must:

  (i) Work for an employer with 50 or more employees, but is:

    (A) Not be eligible for employer-sponsored insurance;

    (B) On a waiting period for employer-sponsored insurance;

    (C) Eligible for employer-sponsored insurance, but does not receive an employer contribution of at least 33% toward the cost of the employee health insurance (individual policy); or

    (D) Eligible for employer-sponsored insurance, but the health insurance offered by the employer does not meet minimal creditable coverage standards; or

  (ii) Works for an employer with fewer than 50 employees regardless of whether or not the employer contributes to the employee insurance premium; and

(5) Lives in the selected Commonwealth Choice plan's service area.

B. The Commonwealth Care Health Insurance Program

The Commonwealth Care Insurance Program (or, simply, "Commonwealth Care") provides eligible Massachusetts residents access to medical care through subsidized health insurance.[36] Commonwealth Care is operated by and under the auspices of the Connector, which has currently developed four plan types that differ based on income and payment structure. The plan types are as follows:[37]

[36] Act § 45, adding M.G.L. c. 118H.
[37] *See* http://www.mahealthconnector.org/portal/site/connector/ for a description of the Commonwealth Care plan types.

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(1) *Plan Type 1*

Since October 1, 2006, Massachusetts residents with earnings less than or equal to 100% of the federal poverty limit (FPL) are eligible for coverage under "Plan Type I," which covers inpatient and outpatient services including X-rays, lab work, mental health, and substance abuse. It also covers preventive care, prescription drugs, emergency care, rehabilitation services, wellness, ambulance, hospice, dental care including preventive, diagnostic and restorative services such as oral surgery, and vision care (eyeglasses and exams every 24 months). There is no monthly charge (premium) to be enrolled in Plan Type 1, but there are modest co-payments (e.g., $1 for generic prescription drugs and $3 for other drugs with a calendar out-of-pocket maximum of $200).

(2) *Plan Type 2*

Commencing January 1, 2007, Massachusetts residents earning between 100.1%-200% of the FPL can enroll in "Plan Type 2," which provides comprehensive coverage similar to Plan Type1, with the exception of dental services. Premiums are subsidized based on a sliding scale.

(3) *Plan Types 3 and 4*

Also commencing January 1, 2007, Massachusetts residents earning between 200.1% and 300% FPL can enroll in Plan Type 3 or 4, which have coverage identical to Plan Type 2 but differ as to premiums and co-payments. Plan Type 3 is a low premium option that requires higher co-payments; Plan Type 4 is a low co-payment/higher premium option.

To be eligible for subsidies, an individual (i) must have been a resident of Massachusetts for the previous six months, (ii) must not be eligible for MassHealth, Medicare, or a state child health insurance program, (iii) must not, through their own or a family member's employer, have been provided health insurance coverage in the last six months for which the individual is eligible, and where the employer covers at least 20 percent of the annual premium cost of a family health insurance plan or at least 33 percent of an individual health insurance plan (this requirement may be waived in certain circumstances), and (iv) must not have accepted a financial incentive from an employer to decline the employer's subsidized health insurance plan.[38]

Plans offered through the premium assistance program will not include a deductible, and they will be offered exclusively by Medicaid managed care organizations that currently contract to provide Medicaid managed care insurance for MassHealth enrollees (i.e., Neighborhood Health Plan, Boston Medical Center Health Net, Network Health, and Fallon Community Health Plan) through July 2009, but only so long as these plans meet designated enrollment targets. After 2009, enrollment for the premium assistance program beneficiaries will be opened to other plans.

[38] M.G.L. c. 118H, § 3.

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On June 5, 2007, the Connector adopted a final rule governing eligibly for Commonwealth Care and establishing an appeals process through which individuals denied access are entitled to an administrative hearing to contest the denial.[39]

C. Medicaid/MassHealth

In 1995, the Commonwealth of Massachusetts obtained a Medicaid waiver that provided Federal funding for the free care pool. At the same time, the legislature established MassHealth, an expanded Medicaid program, that covers children, parents, and childless adults. MassHealth combined the state's Medicaid and SCHIP programs. The legislation also established MassHealth Essential, which covers non-disabled, unemployed, childless adults with incomes below the Federal poverty level. The MassHealth Essential benefit package is somewhat more limited than the benefits that are offered to other Medicaid enrollees. Implemented in 1997, MassHealth Essential was halted when it hit an enrollment cap. The 1995 Medicaid waiver also permitted the state to implement MassHealth Family Assistance, which provides coverage for children with family incomes of up to 200 percent of FPL. The program also provides premium assistance for some low-income, working parents.[40]

The Act expands MassHealth by increasing the enrollment cap on MassHealth Essential, allowing more eligible childless adults to enroll. To be eligible for MassHealth Essential, childless adults must meet the following criteria: (1) they must have been unemployed or underemployed for more than one year; (2) their income must be below the FPL; (3) they cannot be eligible for unemployment compensation; (4) if they have a spouse, the spouse cannot work more than 100 hours per month; and (5) they must be citizens or qualified immigrants. (The rules for qualified immigrants are the same as those that apply to federal Medicaid programs.)[41]

Under the Act, children with family incomes of up to 300 percent of the FPL are now eligible for MassHealth Family Assistance. The benefit package for children in MassHealth Family Assistance includes: emergency care, inpatient hospital care, outpatient physician services, preventive care, well-child visits and immunizations, diagnostic services and laboratory work, early intervention for developmental disabilities, prescription drug coverage, mental health services, hearing and vision care, dental services, rehabilitative services, home health care, and medical equipment and supplies.

The Act expanded coverage for childless adults in the MassHealth Essential program. Adults in this program receive a more limited benefit package than other MassHealth enrollees. MassHealth Essential benefits include: inpatient hospital care, outpatient physician services, preventive care, diagnostic services and laboratory work, prescription drug coverage, mental health and substance abuse treatment, hearing and vision care, dental services, family planning, rehabilitative services, and medical equipment and supplies. The Act also restored MassHealth's coverage of dental services, dentures, and eyeglasses for adults. These are all services that state

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[39] 956 CMR 3.00 (Eligibility and Hearing Process for Commonwealth Care).

[40] *See* "Mental Health and Substance Abuse Services in Medicaid and SCHIP in Massachusetts," Jul. 2003 (reporting information under the state's Medicaid and SCHIP agencies).

[41] Act § 15.

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Medicaid programs can cover under federal law, but they are not required to cover these services. Massachusetts had eliminated coverage of these services in previous years.[42]

Children and adults enrolled in MassHealth receive care based on their income level, age, and family status. They will either have their medical services paid for directly by the Office of Medicaid, receive care through a Medicaid managed care plan, or have their services managed by a primary care provider who may refer them to specialists who are directly paid by the Office of Medicaid. When it is cost-effective, MassHealth may provide premium assistance for eligible people enrolled in employer-sponsored plans rather than enrolling these individuals directly in MassHealth.

Families pay monthly premiums for children enrolled in MassHealth Family Assistance based on family income. Currently, the premiums are as follows:

- Caretakers of children with family incomes between 150 and 200 percent of the FPL pay a monthly premium of $12 for each child, with a family maximum of $84.
- Caretakers of children with family incomes between 200 and 300 percent of the FPL pay $20-$28 per child, with a family maximum of $84.
- Premiums are waived for children if the adults in the family are enrolled in Commonwealth Care.

There are no co-payments for children enrolled in MassHealth Family Assistance.

Act § 122 preserves FY 2006 funding levels for the Boston Medical Center Corporation and the Cambridge Health Alliance, which operate safety net hospitals that have historically provided a significant amount of the uncompensated care in the Commonwealth. For FY 2008 and 2009, however, funding will depend on their ability to transition individuals from the free care pool into insurance plans.[43] Under the Act, MassHealth will now cover children in families earning up to 300% of the FPL,[44] which is an increase over the prior eligibility level of 200% of the FPL.

The Act also aims to reduce racial and ethnic health disparities by requiring hospitals to collect and report on health care data related to race, ethnicity and language.[45] Medicaid rate increases are made contingent upon providers meeting performance benchmarks, including in the area of reducing racial and ethnic disparities. The Act creates a study of a sustainable "community health outreach worker program"[46] to target vulnerable populations in an effort to eliminate health disparities and remove linguistic barriers to health access.

MassHealth also manages programs aimed at furnishing coverage to children. These include (i) the "Children's Medical Security Plan (CMSP)," which provides uninsured children

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[42] *Id*.
[43] Act §§ 122 and 123.
[44] Act § 132.
[45] Act § 3.
[46] Act § 110.

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and adolescents access to primary and preventive services, regardless of family income, (ii) the Healthy Start Program (HSP), which promotes prenatal care for low-income, uninsured pregnant women, and (iii) the "Special Kids/Special Care Pilot Program," which provides medical care to children in foster care with special health-care needs.

D. The Insurance Partnership

Established in 1999, the Insurance Partnership is a state-sponsored program administered by the Executive Office of Health and Human Services that provides subsidies to small businesses (those with 50 or fewer employees) and to their low-income employees to afford them access to health insurance coverage. To qualify for the employer subsidy, an employer must contribute at least 50% of the premium. Employer subsidies depend on the number of qualified employees and the type of coverage provided. Eligible employees are full- or part-time employees who (i) are between the ages of 19 and 64 (inclusive), (ii) are residents of Massachusetts, (iii) have not have been offered health insurance by his or her current employer in the past six months, (iv) have not been eligible for health insurance through his or her spouse's employer in the past six months, and (v) have a gross (pre-tax) annual family income that is less than a specified percentage of FPL.[47]

The Act also expanded the income limit to 300% from 200% of the FPL. But after October 1, 2006, an employee can only participate if he or she has not been offered health insurance by his or her current employer or his or her spouse's employer in the past six months. Also, beginning July 1, 2007, the Act imposes certain limits on Insurance Partnership subsidies to self-employed individuals and couples.

E. Commonwealth Choice

M.G.L. c. 176Q, § 5 established rules under which the Connector may approve and facilitate the sale of health insurance policies that carry with them the Connector's seal of approval. These plans "must contain a detailed description of benefits offered, including maximums, limitations, exclusions and other benefit limits," and no such plan can exclude an individual from coverage "because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age." The Connector markets plans that are offered pursuant to this provision of the Act as "Commonwealth Choice." When fully phased in, Commonwealth Choice will have four levels of coverage: premier, value, basic, and young adult. In contrast to Commonwealth Care, coverage purchased through Commonwealth Choice is not subsidized. Premiums depend on the particular health plan and benefit package, which the individual enrollee purchases. Premiums are due monthly, and co-payments are the norm. Deductibles will be required under some but not all Commonwealth Choice products. Commonwealth Choice enrollments began on May 1, 2007, and coverage commenced on July 1, 2007.

Commonwealth Choice products are offered through Massachusetts-licensed commercial insurance carriers. Each insurance carrier offers four levels of plans: Bronze, Silver, Gold and Young Adult Plans. All the plans cover the same services, but have different costs.

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[47] 72 Fed. Reg. No. 15 (Jan. 24, 2007) pp. 3147, 8.

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(1) Bronze level plans have the lowest monthly premiums, and most require a deductible. While some doctor visits are covered before the deductible, Bronze level plans usually have the highest costs of all plans for medical services. These costs include co-payments and may include co-insurance. Before 2009, Bronze level plans can be purchased with or without prescription drug coverage, but beginning in 2009, all Bronze level plans will have drug coverage.

(2) Silver level plans have higher monthly premiums than Bronze level plans. Most Silver level plans do not have a deductible, and co-payments are generally lower than in a Bronze level plan. Silver level plans also are likely to have a larger provider network when compared to Bronze level plans.

(3) Gold level plans have the highest monthly premiums, but they have no deductibles and the lowest co-payments of the three. Gold level plans are also likely to have larger provider networks than some Silver or Bronze level plans.

(4) Young Adult plans are only for people between 19 and 26 years old. They are not available as family plans. In many ways, these plans are like Bronze level plans. Sometimes there is a cap (limit) on how much money individuals pay for healthcare services each year. If an individual needs more services, then he or she will have to pay the full cost by himself or herself.

F. Insurance Reform

One of the Act's more ambitious reforms is the merger of the non- and small-group health insurance markets, which became effective on July 1, 2007. Of the two markets, the non-group market is by far the more adversely selected. The Act mandates an actuarial study of the consequences of merging of the two insurance markets before the merger is completed. The study, which was issued in December 2006,[48] estimates that the effect of the merger of the small group and non-group markets will result in a decrease in non-group rates of approximately 15% and an increase in small group rates of approximately 1 to 1.5%. The Act modifies the factors health insurance issuers may use to adjust premiums and places limits on waiting periods and exclusions on coverage for pre-existing conditions.

Separately, Act § 60 enables HMOs to offer High Deductible Health Plans ("HDHP"), within the meaning of § 223 of the Internal Revenue Code (the "Code"), which will support contributions to Health Savings Accounts ("HSAs"). (Previously, only licensed insurers could offer HDHPs that could be paired with HSAs.)

NOTE: Massachusetts gross income generally includes all items included in federal gross income as defined in the Code as of a specific date. As federal provisions are added, deleted or changed, federal and Massachusetts tax provisions can diverge. Periodically, the Massachusetts Legislature adopts a more recent version of the Code. In Chapter 163 of the Acts of 2005 ("An Act Relative to Tax Laws"), Massachusetts personal income tax law was updated to include,

[48] "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets Prepared for the Massachusetts Division of Insurance and Market Merger Special Commission," Dec. 26, 2006.

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among other things, favorable tax treatment of HSAs.[49] The recently enacted Tax Relief and Health Care Act of 2006[50] includes provisions designed to enhance HSAs. It removes the annual plan limitation on deductible HSA contributions, and permits, among other things, flexible spending accounts, and health reimbursement account terminations to fund HSAs. In TIR 07-4, the Massachusetts Department of Revenue ruled that HSA-related changes under the Tax Relief and Health Care Act apply as well for Massachusetts tax purposes.

Although the Act does not tamper with the insurance mandates under current law, health insurance issuers are permitted under Act § 90[51] to provide lower-cost, specially designed products through the Connector to 19-26 year-olds who do not have access to subsidized employer-sponsored health insurance coverage. Coverage for young adults must be "reasonably comprehensive," and must include "inpatient and outpatient hospital services and physician services for physical and mental illness and . . . all services which a carrier is required to include under applicable division of insurance statutes and regulations."[52] Any carrier offering young adult health plans must offer at least one product with outpatient prescription drug coverage. It also may impose reasonable co-payments, coinsurance and deductibles and other common cost control techniques (e.g., tiered provider networks and selective provider contracting).[53] Act § 127 imposes a moratorium on the creation of new health insurance mandated benefits through 2008.

Lastly, effective January 1, 2007, Act § 82 amends M.G.L. c. 176J to impose new small group premium setting and rate requirements. Among other things, the Act establishes a maximum rate band range for age, industry, participation-rate, wellness program rate, and a special tobacco use rate. Carriers are limited to applying the following factors outside of the rating band in establishing premiums: benefit level, geographic region, adjustment for eligible individual rather than small group, and group size adjustment.

G. Free Care

Act § 8 eliminates the current uncompensated care trust fund under M.G.L. 118G, § 18 as of October 1, 2007, and establishes in its place the "Health Safety Net Trust Fund." Act § 117 directs the Commonwealth's comptroller to transfer any balance remaining in the uncompensated care trust fund to the Health Safety Net Trust Fund.[54] Like the uncompensated care trust fund, the purpose of the Health Safety Net Trust Fund is to reimburse hospitals and community health centers for the cost of certain reimbursable services provided to low-income, uninsured or underinsured individuals. Funding and administration of the Health Safety Net Trust Fund are similar to the uncompensated care trust fund. Amounts also are allocated annually for demonstration projects that use case management and other methods to reduce the liability of the fund for acute hospitals. A newly created Health Safety Net Office located within the Office of Medicaid administers the Health Safety Net Trust Fund. The Health Safety Net

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[49] *See* Massachusetts Department of Revenue Technical Information Release ("TIR") 05-16 (outlining the affect of M.G.L. c. 163 and confirming the treatment of HSAs for Massachusetts tax purposes).
[50] H.R. 6111 (Dec. 20, 2006).
[51] Adding M.G.L. ch 176J, § 10.
[52] *Id*.
[53] *Id*.
[54] M.G.L. ch 118E, § 57.

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Office will develop a new standard fee schedule for hospital reimbursements, including a fee-for-service reimbursement system for acute care hospitals, based on Medicare-like reimbursement procedures, replacing the current charges-based payment system.

H. Quality Programs and Transparency

Act § 3 establishes a Health Care Quality and Cost Council, the purpose of which is to promote high-quality, safe, effective, equitable health care. The Council is charged with the responsibility of developing and implementing health care quality improvement goals intended to lower or contain growth in health care costs and to improve quality of care, including reductions in racial and ethnic health disparities in care. The statute authorizes the Council to contract with an independent health care organization for technical assistance in developing health care quality goals; cost containment goals; performance measurement benchmarks; design and implementation of health quality interventions; and a consumer health information website and reports to provide consumers comparative quality data on select services.

II. THE INDIVIDUAL MANDATE

Perhaps the Act's most novel and controversial provision is the "individual mandate"[55] under which, beginning July 1, 2007, all residents of the Commonwealth must obtain and maintain a minimum level of health insurance coverage—referred to as "creditable coverage"—based on a premium schedule published each December 1 that will allow for variations for age and geographic location.

A. Premium Schedule and Rates

M.G.L. c. 176J, § 3 contemplates the use of a "base premium rate," which carriers may adjust in certain respects to arrive at a "modified community rate" for their health insurance products (including those products offered through the Connector). The term "modified community rate" is defined in M.G.L. c. 176J, § 1 to mean:

> "a rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a health benefit plan is the same without regard to health status, *but premiums may vary due to factors such as age, group size, industry, participation rate, geographic area, wellness program usage, tobacco usage, or benefit level for each rate basis type as permitted by this chapter*."[56]

Premiums will vary based on age and geographic area, subject to the limits on rate bands established by M.G.L. c. 176J, § 3(a). When collecting premiums for the various health insurance policies and products offered through the Connector under M.G.L. c. 176Q, § 6 (i.e., where an employer elects to purchase coverage through the Connector), the Connector will issue a list bill, that itemizes the premium cost participant-by-participant. Under a "list bill" (or "individual list bill") arrangement, employees with different premiums can apply and be charged for coverage individually.

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[55] Act § 12 adding M.G.L. c. 111M; Technical Corrections Act § 16.

[56] *But see* Treas. Reg. § 54.9802-1(f) (limiting the extent to which premiums may vary based on tobacco usage).

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Under HIPAA, group health plans are barred from requiring an individual, as a condition of enrollment or continued enrollment, to pay a premium contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health factor that relates to the individual or a dependant of the individual.[57] In addition, Treas. Reg. § 54.9802-1(c) (1)(ii) provides, in pertinent part, that "[a] group health plan may not quote or charge an employer (or an individual) a different premium for an individual in a group of "similarly situated individual[s] . . . *based on a health factor*." (Emphasis added.) Neither age nor geographic location is included in the enumerated list of health factors.

B. "Creditable Coverage" and "Minimum Creditable Coverage"

The Act's individual mandate is set out in M.G.L. c. 111M, § 2(a), which provides, in pertinent part:

> "[T]he following individuals age 18 and over shall obtain and maintain *creditable coverage* so long as it is deemed affordable under the schedule set by the board of the connector, established by chapter 176Q: (1) residents of the commonwealth; or (2) individuals who become residents of the commonwealth within 63 days . . ." (Emphasis added.)

The Act defines the term "resident" broadly to include the following persons:

> (1) Obtained a property tax exemption in real property located in Massachusetts;[58]
>
> (2) Filed a Massachusetts resident income tax return;
>
> (3) Obtained a Massachusetts rental deduction;[59] under subparagraph (9) of paragraph (a) of Part B of section 3 of chapter 62;
>
> (4) Declared Massachusetts as his or her principal residence;
>
> (5) Obtained homeowner's liability insurance coverage on a Massachusetts principal residence;
>
> (6) Filed a certificate of residency and identified his place of residence in a city or town in the Commonwealth (in order to comply with a Massachusetts residency ordinance for governmental employment);
>
> (7) Paid in-state tuition rates to attend (or to have a child attend) a state-sponsored college, community college or university;
>
> (8) Applied for and received public assistance from the Commonwealth;

[57] Treas. Reg. § 54.9802-1(c)(1)(i).
[58] M.G.L. c. 59, §§ 5, 5C.
[59] M.G.L. c. 62, § 3(a)(9).

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(9) Has a child or dependent enrolled in a public school in Massachusetts (unless the cost is paid for by the individual, or his or her child or dependent, or by another education jurisdiction;

(10) Is registered to vote in the Commonwealth;

(11) Obtained any benefit, exemption, deduction, entitlement, license, permit or privilege by claiming principal residence in the commonwealth; or

(12) Is a resident under any other written criteria under which the Commissioner of Revenue may determine residency in the Commonwealth.

M.G.L. c. 111M, § 1 defines the term "creditable coverage" to mean and include any of the following health plans:

(a) An individual or group health plan which meets the definition of "minimum creditable coverage" as established by the board of the connector;

(b) A health plan including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program (under M.G.L. c. 15A, § 18) or a qualifying student health program of another state;

(c) Medicare Part A or Medicare Part B;

(d) Medicaid;

(e) TRICARE;

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) The Federal employees' health plan;

(i) Certain public health plans;

(j) A health benefit plan under the Peace Corps Act;

(k) Coverage for "young adults" under the Act; and

(l) "Any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as amended, or by regulations promulgated under that act."

Specifically excluded from the definition of creditable coverage is a laundry list of limited scope and disease-specific plans as well as plans that provide no health coverage or do so only

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tangentially (e.g., a motor vehicle accident policy that may also cover some medical costs). Workers' compensation, long-term care, and disability policies and plans are similarly excluded.

On July 5, 2007, the Connector issued a final[60] regulation pursuant to its mandate under M.G.L. c. 111M, § 1(a) that establishes criteria for "minimum creditable coverage" for purposes of the Act's individual mandate. The rule is nearly identical to a proposed regulation issued March 20, 2007.

(1) *July 1, 2007 to December 31, 2008*

Beginning July 1, 2007, coverage under any "Health Benefit Plan" will be treated as "minimum creditable coverage" for purposes of complying with the Act's individual mandate.[61] The term "Health Benefit Plan" is defined in the proposed regulation as follows:

> Any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under MGL c. 175; a group hospital service plan issued by a non-profit hospital service corporation under MGL c. 176A; a group medical service plan issued by a non-profit medical service corporation under MGL c. 176B; a group health maintenance contract issued by a health maintenance organization under MGL c. 176G; coverage for young adults health insurance plan under section 10 of MGL c. 176J; and any self-funded health plan, including a self-funded health plan which is an ERISA "employee welfare benefit plan" providing medical, surgical or hospital benefits, as that term is defined in 29 U.S.C. section 1002.[62]

Thus, fully-insured plans issued by Massachusetts-licensed insurance companies are automatically deemed to be Health Benefit Plans, as are self-funded plans that provide "medical, surgical or hospital benefits" (e.g., a self-funded mini-med plan).

As written, there is a gap in the rule, since a policy issued by an out-of-state carrier to an employer domiciled outside Massachusetts with employees at Massachusetts locations would not be deemed to provide minimum creditable coverage, even where the coverage includes the features required of self-funded plans in order to be considered minimum creditable coverage. The Connector addressed the issue in an Administrative Information Bulletin (No. 04-07) dated November 15, 2007. Prior to December 31, 2008, any health coverage issued "by a company that is licensed or otherwise statutorily authorized to transact business in the Commonwealth of Massachusetts or any other state within the United States of America" is deemed to provide minimum credible coverage.

(2) From and After January 1, 2009

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[60] 956 CMR 5.00 (Minimum Creditable Coverage).
[61] *Id*. at 5.03(1).
[62] *Id*. at 5.02 (definition of "Health Benefit Plan").

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Beginning January 1, 2009, only those "Health Benefit Plans" that meet certain requirements will constitute "minimum creditable coverage." These requirements include:[63]

- A "broad range of medical benefits, including but not limited to, preventive and primary care, emergency services, hospitalization, ambulatory patient services, prescription drugs, and mental health services" (but the plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers).

- Varied levels of co-payments, deductibles and co-insurance are permitted within limits, *i.e.*, (i) the plan must disclose to covered persons the deductible, co-payment and co-insurance amounts applicable to in-network and out-of-network covered services, (ii) any deductible for in-network covered services must not exceed $2,000 for an individual and $4,000 for a family; and (iii) any separate deductible imposed for prescription drug coverage must not exceed $250 for an individual and $500 for a family.

- If the plan includes deductibles or co-insurance, the plan must set out-of-pocket maximums for in-network covered services that do not exceed $5,000 for an individual and $10,000 for a family (this requirement does not apply to a plan that includes co-insurance only for a limited number of select covered services).

- A plan's calculation of any out-of-pocket maximum must include all the following payments for covered services made by the individual or family: co-payments over $100, coinsurance and deductibles, provided, however, that amounts paid for prescription drugs, whether through deductibles, co-insurance or co-payments, need not be considered in calculating the out-of pocket maximum.

- A plan may not impose an annual maximum benefit or a per illness annual maximum benefit for covered services, nor may it impose a fee schedule of indemnity benefits for covered services.

- A plan that imposes a deductible must cover the following on an annual basis before imposing a deductible: (i) for an individual, at least three preventive care visits to a physician or other health care provider; and (ii) for a family, at least a total of six preventive care visits to a physician or other health care provider.

- Any preventive care visits covered before the imposition of a deductible may be subject to co-payments or co-insurance, but co-payments or co-insurance may not exceed the co-payment or co-insurance applied by the plan to primary care or routine physician office visits.

- A plan must either (i) include prescription drugs as a covered medical benefit, after a deductible ranging from $0 to $250 for individual coverage and ranging from $0 to $500 for family coverage; or (ii) (as approved by the Connector)

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[63] *Id*. at 5.03(2).

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> provide alternative plan designs that would allow for coverage of preventive prescription drugs without any deductible, in addition to coverage of other prescription drugs with a deductible, co-payment or co-insurance, for a projected average increase of no more than five percent in the price of premiums.

The regulation also sets out a list of items that do not rise to the level of minimum creditable coverage. This list includes, among others: accident only, credit only, or limited scope vision or dental benefits; hospital indemnity insurance policies if offered as independent, non-coordinated benefits (*e.g.*, policies which provide an in-patient hospitalization benefit not to exceed $500 per day); disability income insurance; supplemental liability insurance; specified disease insurance; insurance arising out of a workers' compensation law or similar law; and automobile medical payment insurance.

In addition to the above, any plan that meets the Act's other creditable coverage requirements (see the definition set out above) is deemed to constitute "minimum creditable coverage." Thus, for example, Medicare Parts A and B (but not, apparently, a Medicare HMO), and Medicaid, are deemed to provide creditable coverage, as are plans covering young persons under the Act's provisions for "Young Adult Plans."[64]

> **NOTE:** The Act defines "creditable coverage" to include "minimum creditable coverage," while the proposed regulation defines "minimum creditable coverage" to include creditable coverage.

(3) *The Self-Funded Plan Conundrum*

Prior to the issuance of the Connector's proposed minimum creditable coverage rule, there was some debate over whether minimum creditable coverage should include prescription drug coverage (the Connector ultimately decided that it did from and after January 1, 2009). This debate raised another potentially more daunting issue: does the Connector's definition of minimum creditable coverage have the effect of imposing a mandate—albeit indirectly—on self-funded plans in violation of the Employee Retirement Income Security Act of 1974[65] ("ERISA")? Since the mandate is on individuals and not plans, ERISA would not appear to be implicated. But plan sponsors will be under a great deal of pressure to change plan design to ensure that their employees satisfy the Act's individual mandate. At issue is whether the individual mandate constitutes an indirect requirement that "relates to" an ERISA plan.

One argument that has been advanced on behalf of self-funded plans is that they can satisfy the minimum creditable coverage requirements under M.G.L. c. 111M, § 1(l) ("any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996") rather than under M.G.L. c. 111M, § 1(a) ("individual or group health plan which meets the definition of 'minimum creditable coverage' as established by the board of the connector"). It is also possible, however, that § 1(l) is merely a placeholder meant to accommodate future expansions of creditable coverage under HIPAA. What the Legislature intended is not clear because HIPAA does not technically *require* anything. Rather, under HIPAA "creditable coverage" can be applied to reduce pre-existing condition exclusions.

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[64] M.G.L. c. 176J, § 10.
[65] Pub. L. 93-406.

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C. Affordability

On April 11, 2007, the Connector issued a release entitled "Affordability Standards Recommended to the Connector Board," which proposes baseline "affordability" requirements. Residents may be exempted from the individual mandate if they can demonstrate that, according to the Connector's affordability standards, they cannot afford insurance. If an individual cannot obtain coverage in his or her region for a price that is at or below the premium indicated by the affordability schedule, he or she will not be penalized for noncompliance with the individual mandate. Exemptions from the individual mandate will be granted to people in the following earning categories:

For individuals earning:

- $30,631-$35,000 if the lowest available monthly premium exceeds $150;
- $35,001-$40,000 if the lowest premium exceeds $200; and
- $40,001-$50,000 if the lowest premium exceeds $300.

For couples earning:

- $41,071-$50,000 if the lowest available monthly premium exceeds $270;
- $50,001-$60,000 if the lowest monthly premium exceeds $360; and
- $60,001-$80,000 if the lowest monthly premium exceeds $500.

For a family with one or more children:

- $51,511-$70,000 if the lowest available monthly premium exceeds $320;
- $70,001-$90,000 if the lowest monthly premium exceeds $500; and
- $90,001-$110,000 if the lowest monthly premium exceeds $720.

Even if individuals should be able to find and buy insurance (according to the affordability standards), they are permitted to file a waiver for an exemption or appeal a penalty.

Under the Connector's affordability notice, an individual is deemed to have coverage in 2007 for purposes of satisfying the individual mandate if he or she has coverage on December 31, 2007. The notice hastens to add, however, that "individuals will also have the opportunity to seek a waiver from the mandate, based on their particular circumstances."

On June 5, 2007, the Connector issued a final rule governing affordability determinations,[66] which, among other things, establishes a formal process for determining affordability. Under the final rule, the Connector board must vote annually, no later than June 1st

[66] 956 CMR 6.00 (Determining Affordability for the Individual Mandate).

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of each year, to adopt an affordability schedule prescribing the percentage of an individual's adjusted gross income that the individual can be expected to contribute toward the cost of health insurance. Public comment is permitted as a part of the process, and a formal appeals process also is included. Individuals who demonstrate that no Connector health plans are affordable for them may seek a certificate that the penalty should not be assessed.

D. Enforcement

The Massachusetts Department of Revenue enforces the Act's individual mandate. Residents will be required to confirm that they have health insurance coverage on their 2007 state income tax forms filed in 2008, and coverage will be verified through a database of insurance coverage for all individuals. Individuals who fail to comply with the individual mandate in 2007 (and do not otherwise qualify under a waiver or exemption) are faced with the loss of their personal exemption. For 2008 and beyond, failure to comply results in the imposition of a penalty of up to 50% of the monthly "minimum insurance premium for creditable coverage" for each month without coverage. The penalty is first satisfied by forfeiture of any available tax refunds (subject to higher statutory priority claims on use of refunds), and, if that is insufficient, a direct assessment on the affected individual for the balance.

An individual need not obtain coverage in accordance with the individual mandate where his or her refusal to obtain coverage is based on (i) his or her religious beliefs, (ii) a hardship (based on criteria established by regulation), or (iii) a determination that no affordable coverage is available. Individuals for whom there are not affordable products available will not be penalized for not having insurance coverage. In addition, individuals will have appeal rights to dispute a determination that the mandate applies or that he or she can access affordable coverage.

On December 30, 2007, the Massachusetts Department of Revenue issued draft guidelines relating to penalties for violations of the individual coverage requirement for 2008. According to the Department, penalties will apply only to adults who can afford health insurance, based on Connector-established standards. Individuals up to the age of 26 with incomes too high to qualify for subsidized health insurance will face a penalty of $672 for an entire year without coverage. People with similar incomes age 27 and over will face a potential annual penalty of $912. Subsidized insurance is available to individuals earning up to $30,636 per year. For a family of four, the threshold is $61,956. Individuals who meet the income guidelines for subsidized insurance through either the Commonwealth Care program offered by the Health Connector or MassHealth will be penalized based on four income ranges.

- Up to $15,324, no penalty (since Commonwealth Care is free for people at this income level).
- Between $15,325 and $20,424, the annual penalty is $210.
- Between $20,425 and $25,536, the 2008 annual penalty is $420.
- Between $25,537 and $30,636, the annual penalty is $630.

Where a violation does not cover the full year, the annual penalty amount is pro-rated.

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On December 29, 2007, the Department of Revenue issued an emergency regulation[67] mandating that each Massachusetts resident who files (or is required to file) a Massachusetts personal income tax return indicate on the return whether he or she had "creditable coverage" during the taxable year. For this purpose, coverage may be individual coverage or coverage as a named beneficiary under the policy of another. "Self-insurance," however, is not creditable coverage. For 2007, filers must indicate on their returns whether they have coverage "as of December 31, 2007." For 2008 and later years, filers must indicate whether they had creditable coverage in force for each of the 12 months of the taxable year for which the return is filed (other than a 63-break in coverage). This form must accompany the individual's Massachusetts personal income tax return.

The Department of Revenue's emergency regulation also fleshes out the penalties for failure to obtain coverage. For 2007, where a taxpayer either fails to indicate on his or her return whether he or she had creditable coverage for the year, or indicates that he or she did not have creditable coverage in force on December 31, 2007, the penalty is the loss of the personal exemption for the year. For 2008 and later years, where a taxpayer fails to indicate whether he or she had creditable coverage or reports that he or she does not have creditable coverage, the penalty is an amount "up to fifty per cent of the cost of the lowest cost premium available to the individual through the Connector." The penalty is assessed month-by-month.

The Department's emergency regulation confirms that taxpayers may claim exemptions from the tax penalties in the case of affordability (see Section II.C), religious belief, and hardship:

- *Affordability*. The taxpayer must demonstrate that no affordable coverage is available to him or her based on rules established by the Connector.

- *Religious Belief*. A taxpayer may claim exemption based on his or her "sincerely held religious beliefs." This requires, among other things, the filing of a sworn affidavit stating that "he or she did not have creditable coverage and that his or her sincerely held religious beliefs are the basis of the refusal to obtain and maintain creditable coverage during the 12 months of the taxable year for which the return was filed."

- *Hardship*. A taxpayer who does not qualify for the affordability exemption nevertheless may appeal the imposition of the penalty by claiming hardship. The determination of whether to allow a hardship appeal is made by the Connector, not the Department of Revenue. The emergency regulation sets out a detailed appeals procedures for this and other purposes.

III. EMPLOYER MANDATES

The Act imposes the following employer mandates:

A. The Fair Share Premium Contribution

[67] 830 CMR 111M.2.1.

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Because of constraints imposed by Federal law,[68] no state can adopt a law requiring employers to offer health insurance to employees. States are free, however, to impose a tax on employers and their group health plans for purposes of funding uncompensated care.[69] What is not entirely clear is whether a state can impose a fee, levy or tax on group health plans, but provide employers with a deduction or offset for amounts contributed for health coverage on employees' behalf[70]—so-called "pay-or-play" arrangements.

The Act's fair share premium contribution requirement is a variation on the "pay-or-play" theme. Effective October 1, 2006, Act §§ 47 and 134 established a "fair share" premium contribution requirement under which employers with 11 or more full-time equivalent employees in the Commonwealth must either:

(i) Make a "Fair and Reasonable Premium Contribution" to the health insurance costs of its employees; or

(ii) Pay into the newly established Commonwealth Care Trust Fund[71] an "Annual Fair Share Employer Contribution" not to exceed $295 per "Full-Time Equivalent" ("FTE") employee.[72]

A final regulation issued September 8, 2006[73] provides guidance on what constitutes a Fair and Reasonable Premium Contribution on the part of an employer, and how the Annual Fair Share Employer Contribution is determined. In assessing whether an employer makes a Fair and Reasonable Premium Contribution, the final regulation establishes two tests—a primary test and a secondary test. If an employer passes either test for a year, then it has no obligations to make any payments to the Commonwealth Care Trust Fund. But if an employer employs 11 or more full time employees in the Commonwealth and is unable to pass either test, it must make a per employee fair share contribution not to exceed $295.00, pro-rated for FTE status based on a 2,000 hour year.[74]

For purposes of testing compliance with the fair share contribution rules, the final regulation defines the term "Employer" to mean an "Employing Unit subject to M.G.L. c. 151A, and the commonwealth, its instrumentalities, political subdivisions, ..."[75] An "Employing Unit" for this purpose is defined broadly to mean and include individuals, partnerships, firms, associations, trusts, trustees, estates, joint stock companies, insurance companies, domestic or

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[68] *See* ERISA §§ 502(b) and 514(b) (establishing rules under which state laws that prescribe alternative remedies or otherwise "relate to" employee benefit plans are preempted, and setting out important exceptions for state laws regulating insurance, banking, and securities).
[69] New York Conference of Blue Cross Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).
[70] *Cf.*, Retail Indus. Leaders Ass'n v. James D. Fielder, Jr., Maryland Sec'y of Labor, Licensing, and Regulation, No. 06-316 (D. Md. July 19, 2006), *aff'd.* 2007 U.S. App. LEXIS 920 (4th cir. 2007) (holding that the pay-or-play mandate adopted by the State of Maryland was preempted by ERISA).
[71] Act § 30. The Commonwealth Care Trust Fund is funded by fair share contributions from employers, free rider surcharges, transfers from the Health Safety Net Trust Fund, "§ 1115" waiver funds from CMS, and penalties for violations of the individual mandate.
[72] Act § 47.
[73] 114.5 CMR 16.00 (Determination of Employer Fair Share Contribution) (Sept. 8, 2006).
[74] Act § 47 (adding new M.G.L. c. 188).
[75] 114.5 CMR § 16.02 (definition of "Employer").

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foreign corporations, among others, which have or had "one or more individuals performing services for him or it within the Commonwealth of Massachusetts."[76] Nothing in this definition requires that corporations and other entities be combined for testing purposes in a manner similar to that prescribed by the "controlled group" rules of Code §§ 414(b), (c) and (m). An employer could, as a consequence, break itself up into multiple entities for purposes of limiting its exposure under this rule. (The regulators have made it clear that they are aware of this issue, and they will be on the lookout for abuses.)

(1) *The Primary Test*

(i) Primary Test Under the Final DHCFP Regulation

Under the primary test,[77] an employer is deemed to make a Fair and Reasonable Premium Contribution if 25% or more of its Full-Time employees at Massachusetts locations are enrolled in the employer's group health plan. (These employees are referred to as "Enrolled Employees.") This test measures the "take-up" rate, i.e., the rate at which employees have agreed to accept the coverage and terms that the employer is offering. For purposes of this rule, a "group health plan" is defined with reference to Code § 5000(b)(1),[78] which provides medical care,[79] whether insured or self-funded, that is "sponsored and paid for, *in whole or in part*, by an employer . . . ." (Emphasis added.) Thus, the primary test does not require the employer to make any particular level of contribution (but it must contribute something), nor does it require any particular level or type of coverage.

For purposes of applying the primary test, the term "Full-Time" employee is defined to mean those employees who work at least 35 hours per week.[80] Part-time employees are excluded. There is no adjustment to take account of other coverage that a Full-Time employee might have, such as through a spouse. An employer may, however, exclude a Full-Time employee if the employee claims exemption from the individual mandate because of sincerely held religious beliefs and has filed the necessary affidavit.[81] To take advantage of this exclusion, the employer must maintain documentation to verify that the employee has claimed such an exemption. Also excluded from the definition of Full-Time employees are independent contractors, and seasonal and temporary employees, which have the following meanings:

> *Independent Contractors*. Independent contractors are defined with reference to M.G.L. c. 151A, § 2. Under this provision, a worker is classified as an "independent contractor," only if:

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[76] *Id*. (definition of "Employing Unit").
[77] 114.5 CMR § 16.03(1)(a).
[78] *See* 114.5 CMR § 16.02(1) ("A group health plan, as defined in 26 U.S.C. § 5000(b), to provide Medical Care, whether insured or self-funded, that is (1) sponsored and paid for, in whole or in part, by an employer, or (2) sponsored by a self-employed person or an employee organization, for the purpose of providing health care (directly or otherwise) to the employees, former employees, self-employed individuals, or others associated or formerly associated with an employer or self-employed individual in a business relationship, or their families").
[79] Code §§ 213(d)(1)(A) and (B).
[80] 114.5 CMR § 16.03(1)(a), 1.b.
[81] Act § 12 adding M.G.L. c. 111M, § 3.

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(i) He or she has been and will continue to be free from control and direction in connection with the performance of such services, both under his contract for the performance of service and in fact,

(ii) The services are performed either outside the usual course of the business for which the services are performed or are performed outside of all the places of business of the enterprise for which the services are performed, and

(iii) He or she is customarily engaged in an independently established trade, occupation, profession or business of the same nature as that involved in the service performed.

NOTE: This definition is more stringent than the standard applied for Federal tax purposes,[82] and it differs slightly from the test set out in M.G.L. c. 149, § 148 relating to determinations of independent contactor status for workers compensation purposes.[83]

Seasonal Employees. The term "seasonal employee" is defined with reference to M.G.L. c. 151A, § 1(bb) as an employee that is (i) hired as a "seasonal employee" during an employer's seasonal period in its seasonal operations for a specific, temporary seasonal period, (ii) notified by the Massachusetts Division of Unemployment Assistance that he or she is performing seasonal services for a seasonal employer, (iii) employed no earlier than the beginning of the seasonal period and no later than the end of the seasonal period, and (iv) works no more than 16 weeks.

Temporary Employees. Temporary employees are those whose employment, whether part-time or full-time, is explicitly temporary in nature and does not exceed 12 consecutive weeks during the period from October 1 through September 30.[84]

Under the primary test as established by the final DHCFP regulation, the percentage of Enrolled Employees is calculated by dividing (i) the total payroll hours of FTE Employees by (ii) the total payroll hours of all Full-Time employees. Calculations under the primary test are based on the period from October 1 to September 30 each year. For this purpose, the total payroll hours of Enrolled Employees means the total payroll hours for which both wages were paid and the employee was enrolled in the health plan. Also, if an employee works in both part-time and

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[82] *See, e.g.*, Rev. Rul. 87-41, 1987-1 C.B. 296 (prescribing a 20-factor test for purposes of assessing employee status for employment tax purposes); Comm'r of the Div. of Unemployment Assistance v. Town Taxi of Cape Cod, 68 Mass. App. Ct. 426 (2007) (holding that taxi drivers are independent contractors because they performed services "outside the of all of the places of business if the enterprise").

[83] Massachusetts Attorney General Adv. 2004-2 (relating to amendments to Massachusetts independent contractor law).

[84] 114.5 CMR § 16.02 (definition of Seasonal Employee).

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full-time capacities during the year, only the payroll hours of the period in which the employee worked full-time are counted.

> **EXAMPLE:** Employer A's headcount from October 1 to September 30 in a year is (i) 50 employees who work 40 hours each week for the entire period, (ii) 20 employees who work 30 hours per week for the entire period, and (iii) 20 employees who work 40 hours per week for 26 weeks during the period and 30 hours per week remaining 26 weeks. Employer A's total payroll hours of full-time employees is the sum of (i) 50 (i.e., the 50 employees who work 40 hours each week for the entire period) x 40 hours x 52 weeks (or 104,000 hours) plus (ii) 20 (i.e., the 20 employees who work 40 hours per week for 26 weeks during the period and 30 hours per week remaining 26 weeks) x 40 hours x 26 weeks (or 20,800), for a total of 124,800 hours. For purposes of this calculation, employees who work 35 or fewer hours are not counted. For Employer A to satisfy the primary test, the total payroll hours of Enrolled Employees must be at least 31,200 (or 25% x 124,800).

(ii) Primary test under subsequent DHCFP and DUA Guidance

On September 14, 2007, DHCFP issued an administrative bulletin that substantially modified the particulars of the primary test's application. Based on a pilot program with some 25 Massachusetts employers, the regulators determined that "it was virtually impossible [for employers] to compile data" necessary to perform the primary test in the manner contemplated by the DHCFP's final regulation because employers "generally do not maintain data relating to employees enrolled in health plans" in a manner that conforms to the DHCFP's approach. The bulletin instead establishes a rule under which an employee's full-time status for primary test purposes is based on group health plan enrollment as of the last day of December, March, June and September of each year. In a subsequent DUA document entitled "Filing Instructions" (discussed below in Section III.A(6)), the DHCFP's quarterly testing approach was modified such that, for purposes of the primary test only, "full-time employees" are employees who worked "full-time" *a majority of their time* during the calendar quarter ending on the date indicated. "Full-time" for this purpose is the lower of (i) the number of weekly payroll hours to be eligible for "full-time health plan benefits" or (ii) 35 payroll hours per week. "[F]ull-time health plan benefits" means the equivalent level of employer contribution to the employer's health plan that is offered to full-time employees.

The DHCFP's September 14, 2007 administrative bulleting also for the first time addressed "Multiemployer Health Benefit Plans," i.e., plans "to which more than one employer is required to contribute and which are maintained pursuant to one or more collective bargaining agreements," and certain government contract (e.g., Davis-Bacon) benefits mandates. Specifically, for purposes of the primary test:

> (i) An employer making multiemployer plan contributions on behalf of a full-time employee may include that full-time employee in the number of employees enrolled in the health plan—i.e., the employee is treated as being enrolled in the employer's group health plan; and

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(ii) An employer operating under a contract to provide services to the federal government that requires the payment of employee benefits in accordance with federal requirements may similarly include that employee in the number of employees enrolled in the health plan. (This rule is limited to "federal" requirements and does not by its terms apply to, say, state prevailing wage laws.)

Because the primary test does not establish a minimum level or type of medical coverage, plans that place limits on coverage, either as to the types of procedures covered or the amounts paid can nevertheless qualify as group health plans. For example, a mini-med program with a minimal employer contribution would qualify as a group health plan for purposes of this rule. Such a plan may be insufficient to attract 25% of full-time employees, however, since it is unlikely to provide "creditable coverage" for purposes of satisfying the individual mandate under Act § 12.[85] This means that employees will still need to obtain other coverage that satisfies the individual mandate or pay the tax penalties for failing to obtain coverage. As a result, employers that want to take advantage of the primary test will likely need to offer coverage that qualifies as creditable coverage for purposes of the individual mandate.

NOTE: An oft-heard response from employers and others when first exposed to the fair share premium contribution rules is, "why not just skip coverage altogether and pay the $295?" Currently, employers can "skip" coverage entirely and pay nothing. For employers with insured plans (that are subject to the health insurance non-discrimination rules discussed below in Section IV.A), this would require that <u>all</u> insurance coverage be dropped for all full-time employees. Such an employer would need to pay the $295 annual fee based on the hours of all of its employees (full-time, part-time, seasonal and temporary) pro-rated based on a 2,000 hour year. Also, each employee who is a Massachusetts resident would have to obtain other creditable coverage in order to satisfy the individual mandate. If the employer has 50 or fewer employees, it has the option of designating the Connector as its plan and furnishing pre-tax premiums under a cafeteria plan. Employers with self-funded plans are at a significant advantage in this regard, inasmuch as they are free to cover some but not all their full-time employees.

(iii) Partnerships and LLCs

No FSC guidance to date expressly addresses the FSC primary test (and secondary test, discussed below) as applied to partnerships, LLCs, and professional corporations. In some partnerships (e.g., certain law firms), partners elect and pay for 100% of their own health care coverage (i.e., their coverage is not employer subsidized). If these partners are treated as "employees" for purposes of the FSC rules, then it makes it marginally more difficult for the partnership to pass the primary test, and impossible to pass the secondary test. If, in the other hand, these individuals are not counted as employees for FSC purposes, the primary test will be marginally easier to pass, and it will still be possible to pass the secondary test.

Similar issues arise in connection with LLCs, which may be classified for federal income tax purposes as a sole proprietorship (if it has only a single member), a partnership or a

[85] Adding new M.G.L. c. 111M, § 12.

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corporation. Single member LLCs are automatically treated as sole proprietorships, unless an election is made to be treated as a corporation. If the LLC has two or more owners, it will automatically be considered to be a partnership unless an election is made to be treated as a corporation. So the question arises as to how to treat LLC members for FSC purposes.

The final DHCFP FSC regulation does not separately define the term "Employee," but it does refer to M.G.L. c. 151A (relating to unemployment insurance) for purposes of certain exclusions,[86] leaving the impression that an "Employee" for FSC purposes is an employee for which an employer is required to make an unemployment contribution. While subsequent DHCFP and DUA guidance is similarly silent on this subject, DUA representatives, in their informal remarks on the subject, have expressed the following views on the matter:

- Partners and sole proprietors, who are not employees for unemployment insurance purposes, also are not employees FSC purposes;

- Members of an LLC that have elected to be taxed as a partnership are not employees of that LLC for unemployment insurance and FSC purposes;

- Members of an LLC that have elected to be taxed as a corporation are employees of the LLC for unemployment insurance and FSC purposes;

- All individuals who are performing services for a professional corporation are employees of that corporation for unemployment insurance and FSC purposes; and

- A single member of an LLC is treated as a sole proprietor and is not an employee for unemployment insurance and FSC purposes.

(iv) Definition of "Employer"

As originally adopted, Act § 47 (adding M.G.L. c. 149, § 188) defined the term "Employer" to mean "an employing unit that is subject to M.G.L. c. 151 [relating to unemployment insurance] as defined in section 1 of chapter 151A. M.G.L. § 1. But § 6(r) of this chapter excludes:

> "Service performed in the employ of a church or convention or association of churches, or an organization which is operated primarily for religious purposes and which is operated, supervised, controlled, or principally supported by a church or convention or association of churches . . . ."

But the final DHCFP regulation, 114.5 CMR 16.02 adopts a broader rule under the term "Employee," which is defined as follows:

> "An Employing Unit subject to M.G.L. c. 151A, and the commonwealth, its instrumentalities, political subdivisions, an instrumentality of a political subdivision, including municipal hospitals, municipal electric companies, municipal water companies, regional school districts and any other

[86] 114.5 CMR 16.02 (definition of "Independent Contractor").

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> instrumentalities as are financially independent and are created by statute. *An entity is an Employing Unit whether or not the services performed are deemed employment under c. 151A*." (Emphasis added.)

Under this definition, churches would be subject to the Fair Share Contribution rules, but it appears that the DHCFP definition exceeds that reach of the statute. Chapter 205 resolves this issue in favor of the broader reading by expanding the definition of "employer" to mean, "an employing unit as defined in section 1 of chapter 151A or *in section 1 of chapter 152*." M.G.L. c. 152 governs workers compensation insurance, and its definition of "employer" is sufficiently broad to include churches. Thus, churches are now included among the class of employers subject to the FSC rules. Chapter 205 did not make similar changes to the definition or "employer" under the HIRD form rules. The applicable definition of "employer"[87] differs slightly from that under the FSC rules, so it is not clear whether the HIRD form requirement applies to churches.

(2) *The Secondary Test*

If an employer cannot pass the primary test, it can still be deemed to make a Fair and Reasonable Premium Contribution if it can pass the "secondary test," which requires that the employer offer to pay "at least 33% of the premium cost of any Group Health Plan offered by the Employer to its Full-Time Employees that were employed at least 90 days during the period from October 1 [through] September 30, 2007." [88] Unlike the primary test, the secondary test is not based on "take-up" but is rather based on the amount the employer offers to contribute to the plan. As is the case with the primary test, there is no requirement that the underlying group health plan provide creditable coverage. If coverage is not creditable, however, employees will need to arrange to obtain creditable coverage elsewhere in order to comply with the Act's individual mandate. Since the secondary test is based entirely on the quality of the offering, whether an employee has other coverage is irrelevant.

Because the definition of Full-Time Employee is set out under the primary test, it was not clear from the final regulation whether the definition of Full-Time employee carries over into the secondary test. Representatives of the Commonwealth's Executive Office of Health and Human Services, in their informal remarks on the subject, early on expressed the view that the definition is intended to be the same, both with respect to the basic definition of what constitutes a Full-Time Employee (i.e., 35 hours) and the available exceptions (independent contractors, temporary employees, and seasonal employees). So, for example, employers should be able to exclude from the secondary test employees who have not worked 90 days in the year and employees who do not perform services for 12 consecutive weeks. (Although not stated in the text of the rule, the 90-day period should be applied only to an employee's initial eligibility and not in each successive year.)

In its FSC Filing Instructions, the DUA purported to make some important changes to the definition of "Full-Time Employee" for purposes of the secondary test. Under the DUA approach, the employer must offer to pay at least a portion of the cost of a health insurance

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[87] *See* M.G.L. c. 118G, § 1 (defining "employer" to mean, "an employer as defined in section one of chapter one hundred and fifty-one A").

[88] 114.5 CMR § 16.03(1)(b).

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premium under its group health plan for all full-time employees employed at least 90 days during the applicable 12-month base period. This offer must have been in effect by July 1, 2007 rather than October 1, 2006. But in a marked departure from the DHCFP final regulation on the matter, "Full-Time Employee" is defined to mean "*those employee positions* that met the requirement to be considered full-time by the employer and its health insurer when contracting for employer-sponsored health insurance." (Emphasis added.) While clearly not intended by the DUA, this definition can be read to mean that no plan could ever fail the secondary test, since it is based on designated employee positions rather than hours.

> **NOTE:** For the reasons described in Section III.A(5) below, it's not clear that the DUA has the statutory authority to prescribe rules relating to the conduct of the primary or secondary tests, since these tests go to the question of whether an employer is a "non-contributing" employer—a determination that the Act delegates to the DHCFP. But the DUA's refinements generally favor employees, so the DUA's apparent usurpation of the DHCFP's role, at least with respect to the primary and secondary tests, is not likely to attract a challenge.

The DHCFP's September 14, 2007 administrative bulleting was silent with respect to the treatment of multi-employer plans under the secondary test, but DHCFP returned to this issue an Administrative Bulletin issued in early November 2007, which established the following rules:

- If an employer that contributes to its own group health plan also contributes to a multiemployer health plan pursuant to a collective bargaining agreement, or if an employer makes contributions pursuant to federal contract requirements, the employer must apply the secondary test based on the employer's percentage contribution to the employer-sponsored health plan.

- If an employer contributes to a multiemployer plan unrelated to a collective bargaining agreement or a federal contract, and if the employer makes different percentage contributions for different employee groups, the employer must apply the lowest premium percentage contribution for purposes of the secondary test.

- If an employer contributes to its own group health plan and also contributes to a multiemployer plan unrelated to a collective bargaining agreement or a federal contract, the employer must use the lowest premium percentage contribution for purposes of the secondary test.

A special rule applies to municipalities that have adopted the provisions of M.G.L. c. 32B, under which the municipality must (i) offer health insurance to anyone working at least 20 hours per week and (ii) pay at least 50% of the health insurance premium cost. These municipalities are not required to complete the FSC testing portion of the annual DUA filing for the reporting period ending October 1, 2007. These municipalities are instead deemed to pass the secondary test by virtue of their compliance with M.G.L. c. 32B. The DUA will allow municipalities to file either on-line or through a certification to DUA that the municipality has conformed with M.G.L. c. 32B. (DUA has created a special form for municipalities to make this certification.)

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(3) *Special Rules for Leasing Companies*

Applying the primary and secondary tests is relatively straightforward in a traditional, two-party employment setting, where there is only an employer and its employees. But where there are three parties to the relationship, i.e., employer, staffing company or PEO, and a client company, the analysis gets more complex. When testing for compliance with the FSA primary two questions arise:

> (1) For FSC testing purposes (i.e., when applying the primary and secondary tests, is the worker allocated to, and counted with other employees of, the staffing firm or with the client company?
>
> (2) Who bears the legal responsibility for the payment of any FSC contribution, the staffing firm or the client?

The rules promulgated by the DHCFP and the DUA in connection with the treatment of third-party employment arrangements—i.e., arrangements involving "Employee Leasing Companies" and "Client Companies" in the parlance of the applicable rules—further complicate matters.

The final DHCFP regulations contain special rules for "Employee Leasing Companies,"[89] which are defined as:

> "A sole proprietorship, partnership, corporation or other form of business entity whose business consists largely of leasing employees to one or more Client Companies under contractual arrangements that retain for such employee leasing companies a substantial portion of personnel management functions, such as payroll, direction and control of workers, and the right to hire and fire workers provided by the employee leasing company; provided, however, that the leasing arrangement is long term and not an arrangement to provide the client company temporary help services during seasonal or unusual conditions."[90]

The term "Client Company" is defined as a "person, association, partnership, corporation or other entity *that is a co-employer of workers provided by a Employee Leasing Company* pursuant to a contract." (Emphasis added.)

The DHCFP regulation then establishes a special rule that provides: "If there is a co-employment arrangement between a Client Company and an Employee Leasing Company, the Employee Leasing Company shall be responsible for *calculating and remitting* the Fair Share Contribution on behalf of the Client Company."[91] (Emphasis added.)

In a bulletin issued on or about January 19, 2007 addressing the status of the guidance on certain of the Act's employer mandates, the DHCFP said that Employee Leasing Companies will be required to perform the fair share contribution tests separately for each client company, but

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[89] 114.5 CMR § 16.03(2)(a).
[90] 114.5 CMR § 16.02.
[91] 114.5 CMR § 16.03(2).

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the client company is responsible for any fair share contribution liability. DHCFP's September 14, 2007 bulletin further clarified that "[n]otwithstanding any arrangement between a Client Company and an Employee Leasing Company, the Client Company is the employer for [fair share contribution] purposes."

The DUA definition of "Employee Leasing Company" is similar to but not exactly the same as the DHCFP definition. The DUA definition reads:

> "Employee Leasing Company", an employing unit that contracts with a client company to supply workers to perform services for the client company; provided, that the term "employee leasing company" does not include private employment agencies that provide workers to employers on a temporary basis or entities such as driver-leasing companies which lease employees to an employing unit to perform a specific service."[92]

Also, importantly, DUA defines "Client Company" as follows:

> "Client Company", an individual, association, partnership, corporation or other business entity that agrees to lease or is leasing its employees through an employee leasing company on a long term basis."[93]

The DUA's regulation then sets out it own special rule for Employee Leasing Companies, which provides: "Notwithstanding any arrangement between a Client Company and an Employee Leasing Company, the Client Company is the employer for purposes of M.G.L. c. 149, §188 and 430 CMR 15.00."

The DHCFP definition appears to contemplate the role that is most often associated with PEOs, which aggressively market their role in taking control of all of an employer's personnel management functions. Confirming this view, the DHCFP's definition of Client Company specifically refers to "co-employment." Mainstream staffing firms generally treat the workers placed with client companies as their (i.e., the staffing company's) employees. They do not claim to be "co-employers," and for good reason: among other things, any group health plan maintained by the staffing company would run the risk of being treated as a multiple employer welfare arrangement or MEWA subject to regulation under state law irrespective of whether fully insured or self-funded.

For staffing firms, the center of gravity of the employment relationship (or, more accurately the nexus of control) is with, or at least deemed to be with, the staffing company. While the identity of the common law employer is not always clear in any three-party employment arrangement, mainstream staffing companies have traditionally treated their field employees as their employees, and not those of the client or as co-employees. PEOs, on the other hand, generally treat the workers' place with clients as "co-employees'. (While this claim might be accurate for purposes of many Federal and state employment laws, among others, it almost certainly fails for most tax and benefits purposes, with respect to which the doctrine of co-employment is generally not recognized.)

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[92] 430 CMR 15.03.
[93] *Id*.

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The narrower definition of Employee Leasing Company in the DHCFP's regulation, together with the reference to "co-employment" in the definition of Client Company, indicate that the DHCFP employee leasing company rules are intended to apply only to PEOs. As a consequence, mainstream staffing companies would appear to be required to treat employees placed with client companies as staffing company employees for FSC purposes. PEO's on the other hand would be required to test compliance with the FSC rules at the client level. While it might have been intended to do so, the recent DHCFP bulletin does not seem to change this result, since it does not change any of the underlying definitions.

The DUA's regulation reaches the opposite result. Under the DUA rule, *any* staffing company or PEO (i.e., an "employing unit"), that contracts with a Client Company is an "Employee Leasing Company" unless it is a private employment agency that "provides workers to employers on a temporary basis or entities such as driver-leasing companies which lease employees to an employing unit to perform a specific service." The definition of "Client Company" for this purpose is not limited to co-employment arrangements. This result flows from the provision in the DUA regulation that flatly states: "Notwithstanding any arrangement between a Client Company and an Employee Leasing Company, the *Client Company* is the employer . . . ." (Emphasis added.)

Critical to the application of both definitions of "Employee Leasing Company" is what it means for employment to be "temporary." Is it a month, six months or a year? And does it matter if the employee is hired for a limited period but continues well past the date on which his or her engagement was scheduled to end? Anecdotal evidence indicates that staffing firms and their clients are following the pre-existing DUA rules relating to unemployment compensation.

(4) *Amount of the Fair Share Premium Contribution*

114.5 CMR 16.04 sets out rules for determining the amount of the fair share premium contribution, which DHCFP and the Director of Workforce Development are directed to determine annually.[94] Specifically, under 114.5 CMR 16.04, the annual contribution is the <u>lower</u> of (i) $295 per full-time equivalent employee or (ii) the sum of the fair share employer contribution and "the Per Employee Cost of Unreimbursed Physician Care." The regulation goes on to prescribe methodology for determining the annual fair share premium contribution based on factors prescribed by the Act,[95] which include the total number of users of the uncompensated care pool, the percentage of employers that are non-contributing employers, and overall "private sector" liability for uncompensated care.

(5) *Enforcement*

Oversight and enforcement of the Act's fair share premium contribution requirement is split between two state agencies. Act § 47[96] assigns to DHCFP the power to determine what constitutes a "fair and reasonable premium contribution." (Later technical corrections did not change this delegation of authority.) The Legislature originally delegated the power to prescribe rules enforcing the fair share premium contribution requirement to the Massachusetts

[94] Act § 47, and amended by Technical Corrections Act § 30.
[95] Act § 47 adding M.G.L. c. 149, § 188(c).
[96] Adding M.G.L. c. 149, § 188.

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Department of Labor, but that delegation was revoked in Technical Corrections Act § 29 and placed the authority instead in the hands the Director of Workforce Development, in consultation with the Director of Unemployment Assistance.

The Division of Unemployment Assistance ("DUA") issued a final rule, 430 CMR 15.00, establishing rules relating to the enforcement of the fair share contribution requirement on or about August, 2007. According to 430 CMR 15.01, "the provisions of 114.5 CMR 16.00 [i.e., the final DHCFP regulations discussed above] govern the determination of whether an employer makes a fair and reasonable premium contribution." The regulation generally (though not in all cases) tracks the definitions under the DHCFP's final fair share premium regulations.

The scope of the DUA' rule is expansive, perhaps to the point of exceeding the DUA's statutory mandate. According to 430 CMR 15.04:

> "[A]ny "employer subject to the provisions of M.G.L. c. 151A [relating to employment and training] is subject to the provisions of 430 CMR 15.00 *whether or not the employer is required to pay the fair share employer contribution*." (Emphasis added.)

This requirement appears to be at odds with express provisions of the statute, M.G.L. c. 149, § 188(b), which imposes a monetary penalty on employers who are not "contributing employers." The term "contributing employer" (i.e., an employer required to pay the fair share premium) is, in turn, determined by the DHCFP, and not DUA.[97] This expansive reading of its own authority is of particular concern in 430 CMR 15.05, which makes the following parties liable for the fair share premium contribution:

> "(1) Any employer that: (a) employs 11 or more full-time equivalent employees in the commonwealth; and (b) 1. is not a contributing employer or 2. *is a contributing employer solely because it meets the provisions of 114.5 CMR 16.03(1)(b) [this is the secondary test under the final Division of Health Care Policy and Finance Fair Share Premium regulation] but does not meet the provisions of 430 CMR 15.05 (5)*." (Emphasis added.)
>
> 430 CMR 15.05 (5), in turn, reads as follows:
>
> "For purposes of determining the employer's liability for payment of the annual fair share employer contribution, the following provisions apply:
>
>> (a) During the Initial Base Period, the employer must offer to pay at least 33% of the cost of any Group Health Plan as defined in 114.5 CMR 16.02 offered by the employer to its full time employees specified in 114.5 CMR 16.03(1)(b). Said health care plan must be in effect and available to those full time employees no later than July 1, 2007.
>>
>> (b) During any Subsequent Base Period, the employer must offer to pay at least 33% of the cost of any Group Health Plan as defined in 114.5

[97] M.G.L. c. 149, § 188(a).

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> CMR 16.02 offered by the employer to its full time employees specified in 114.5 CMR 16.03(1)(b). Said health care plan must be in effect and available to those full time employees for all 12 months of any subsequent base period." (Emphasis added.)

The terms "initial base period" and "subsequent base period" are defined in 430 CMR 15.05 (3) as follows:

> (a) Initial Base Period. The initial base period shall be the 12 consecutive month period beginning October 1, 2006 and ending September 30, 2007.
>
> (b) Subsequent Base Period. The subsequent base period shall be the 12 consecutive month period beginning each October 1 and ending September 30th of the following year.

The DHCFP's secondary test provides as follows:

> "If the percentage calculated in accordance with 114.5 CMR 16.03 (1) (a) is less than 25%, but the Employer offered to pay at least 33% of the premium cost of any Group Health Plan offered by the Employer to its Full Time Employees that were employed at least 90 days during the period from October 1, 2006 to September 30, 2007, said Employer shall be exempt from the Fair Share Contribution."

This regulation is ambiguous on the issue of when coverage must commence—if, for example, an employer provides coverage commencing on September 1, 2007, does it pass for the 2006/2007 testing year? The DUA rule at 430 CMR 15.05(5) appears intended to plug this "loophole." Thus, under the DUA regulation, coverage must begin as of July 1, 2007 in order to pass the secondary test for the 2006/2007 testing year. While well-intentioned, it appears that this expansion of the rule ought to fall to DHCFP and not DUA.

The DUA regulation also establishes a framework for annual reporting and payment requirements. Annual reports are required by November 15, and they will be in a form determined by DUA in future guidance. 430 CMR 15.07(4) further establishes payment dates based on annual (November 15), semi-annual (November 15 and May 15) and quarterly (November 15, February 15, May 15, and August 15) payment schedules.

430 CMR 15.08 imposes penalties on employers that fail to pay any portion of the fair share employer contributions, which essentially require payment of the delinquent contribution with interest as 12% per annum from the date due until the date paid. Referral may also be made to the Attorney General where there has been any evidence of an attempt to evade or defeat any applicable contribution or penalty, or where an employer has made any false statements or misrepresentations to avoid or reduce any contribution or penalty. An appeals process also is established.

The DUA's final fair share contribution regulation includes special rules for "employee leasing companies," which do not appear to match the DHCFP's final rule. Specifically, the regulation's definition of "client company" does not contain a reference to "co-employment," as

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a result of which the special leasing company rule under the DUA's proposed regulation would likely apply to all staffing companies, and not just PEOs. Under the rule, it is the client company, and not the leasing company or PEO that is liable for fair share premium contribution.

(6) *The DUA Filing Instructions*

In an October 3, 2007 document entitled "Filing Instructions" (the "Filing Instructions"), the DUA fleshed out the particulars of the FSC compliance steps and the information that needs to be filed in connection with the employer HIRD form (discussed below in Section III.C). The DUA also cautioned employers not to confuse the FSC contribution with the DUA's signature program relating to unemployment health insurance contributions (UHI). Since 1990, DUA has been administering the state's UHI program, which requires a contribution from employers with an average of at least six employees in a quarter. (The UHI contribution is based on one of three tax rates, depending upon the length of time an employer has been in business. The assigned UHI tax rate is applied to the first $14,000 in wages paid to each employee during the calendar year. All employers in business for two or more years are subject to the DUI filing requirement.)

According to the Filing Instructions, FSC and HIRD filing is accomplished on-line via the DUA website. The DUA sent notice to some employers advising of the filing requirements, but it also made clear that an employer's obligation to file did not depend on whether it received such a notice. Employers who receive a notice to file for FSC from DUA must file, even if they do not have 11 FTE's, in order to avoid non-filer notices and potential tax assessments. These employees, however, will find the filing process relatively easy, since only one data element will be required, i.e., the number of payroll hours of employees who worked at least one calendar month during the base year.

Whether an employer owes an FSC contribution is based on the period from October 1 through September 30, with the filing for that base period due by November 15. Liability is based on employment levels, payroll hours, and health insurance coverage available to employees. Although the filing is completed only once annually, payment may be made in a single payment at the time of filing, or spread out to either two semi-annual payments, or four quarterly payments, at the employer's option. Employers also must be registered as a UI-subject employer with DUA, and must have already received their 8-digit DUA number. Employers must use their unique DUA number each time they access this FSC filing system. Special rules apply to new employers and to employers involved in corporate reorganizations.

The Filing Instructions require electronic payment of the FSC contribution using an ACH debit method that automatically debits the employer's account. To ensure that employers are prepared for this debit activity, DUA will send the employer a reminder of the upcoming debit date and amount about two weeks before DUA debits the employer's account on each pre-scheduled due date. Employers will need to provide DUA with their banking information for ACH debit purposes. This includes the bank routing number and their bank account number. When an employer fails to file in a timely manner, DUA may first send a reminder notice. If payment is not forthcoming, DUA will estimate the FSC contribution and issue a bill to the employer.

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B. The Free Rider Surcharge

Act § 44, as amended by Technical Corrections Act §§ 22 and 57, imposes on "Non-Providing Employers"[98] a charge equal to a portion of the Commonwealth's cost of providing health benefits to the employers' uninsured employees if (i) any one employee (or dependent of an employee) receives free care services four or more times in a single year or (ii) the employer has five or more total instances in a single year among all its employees (or their dependents) receiving free care. Codified in M.G.L. c. 118G, § 18B, this requirement is referred to formally as the "Employer Surcharge for State-Funded Health Costs" and colloquially as the "free rider surcharge." The requirement's effective date was July 1, 2007.

On December 22, 2006, the DHCFP issued a final regulation implementing the free rider surcharge.[99] The final regulation was later withdrawn, however, following the adoption of a technical correction.[100] On June 20, 2007, DHCFP issued an emergency rule re-implementing the Employer Surcharge for State-Funded Health Costs.

(1) *Background*

Early on in the legislative process leading to the Act's adoption, the Employer Surcharge for State-Funded Health Costs was conceived as a separate, substantive requirement under which an employer that failed to offer coverage could be liable for medical costs incurred by its uninsured employees. This represented a substantial change from pre-Act law and practice, however, and it predictably encountered stiff resistance from employers. As a compromise, the administration and the legislature agreed that the surcharge would instead apply only to an employer that neither offered nor "arranged for" coverage. An employer was deemed to have "arranged for" coverage if it offered access to other coverage (e.g., through the Connector) with pre-tax dollars under a section 125 cafeteria plan.[101] (Technical Corrections Act § 22 further clarified this result.) Thus, the free rider surcharge is the penalty for failing to comply with the Act's section 125 cafeteria plan requirement (*see* Section III.D below).

(2) *The June 20, 2007 Emergency Regulation*

The June 20 emergency regulation, 114.5 CMR 17.00, took effect on July 1, 2007, and it imposes a surcharge on:

> "an Employer of a State-Funded Employee . . . that employs eleven or more full time equivalent Employees and is not in compliance with the requirement to adopt and maintain a Section 125 Cafeteria Plan for such State-Funded Employee."[102]

These employers are referred to as "Non-Providing Employers." The surcharge imposed on Non-Providing Employers is for State-Funded Health Costs of more than $50,000[103] incurred in a designated measuring period by its employees (whether or not they are Massachusetts residents)

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[98] M.G.L. c. 118G, § 1; *see also* 114.5 CMR 17.03(2) and 17.04.
[99] 114.5 C.M.R. 17.00 et seq. (Dec. 22, 2006).
[100] DHCFP Bulletin, January 19, 2007.
[101] M.G.L. c. 151F § 2.
[102] 114.5 CMR 17.03(2).
[103] 114.5 CMR 17.03(1)(c).

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employed at Massachusetts locations for at least one month, or their dependents, who are not offered participation in the employer's section 125 cafeteria plan. The measuring period is generally the fiscal year beginning October 1 and ending September 30, but for 2007, the measuring period is July 1, 2007 to December 31, 2007.[104]

> **NOTE:** Curiously, under the emergency regulation, an employer is a Non-Providing Employer if, among other things, it is not "in compliance with the requirement to adopt and maintain a Section 125 Cafeteria Plan" for its state-funded employees. There is no cross-reference in this definition to the Connector rules implementing the Act's section 125 cafeteria plan requirement, which suggests that an employer that adopts a section 125 plan that complies with the requirements of the Code but fails to comply with the requirements of 956 CMR 4.00 (i.e., the Connector section 125 cafeteria plan rules) would nevertheless escape the free rider surcharge—a result which is contrary to the express requirements of M.G.L. c.151F § 2, which requires each employer with more than 10 employees in the commonwealth to "adopt and maintain a cafeteria plan that satisfies 26 U.S.C. 125 *and the rules and regulations promulgated by the connector*." (Emphasis added.)

(a) State-Funded Health Costs

As the name suggests, "State-Funded Health Costs" are amounts that are paid by the Commonwealth for uncompensated health care. Under the Act, these amounts are paid from the Health Safety Net Trust Fund,[105] which is the successor to the state's Uncompensated Care Pool Trust Fund.[106] In assessing the amount of the State-Funded Health Costs, the DHCFP will look to claims for services submitted for payment by hospitals and community health centers, and it will match claims to employers using, among other things, employee application forms, the provider claim or emergency room debt forms, HIRD forms, Medicaid data, and data from the Department of Revenue and Division of Unemployment Assistance.[107]

(b) State-Funded Employees

A "State-Funded Employee" is defined in 114.5 CMR 17.03(3) as an employee or dependent of an employee (i) with more than three State-Funded admissions or visits during a fiscal year, or (ii) of an Employer whose employees or dependents make five or more "state-funded admissions" or visits during a fiscal year beginning each October 1 and ending the following September 30.

(c) Employers Subject to the Rule

The free rider surcharge requirement applies to Massachusetts employers with eleven or more full time equivalent employees.[108] The period for measuring full time equivalent status is

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[104] 114.5 CMR 17.03(4).
[105] M.G.L. c. 118E, § 57.
[106] M.G.L. c. 118G, § 18.
[107] 114.5 CMR 17.03(4).
[108] 114.5 CMR 17.03(2).

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the fiscal period beginning October 1 and ending September 30 (the "determination period"),[109] and "full time" means up to 2,000 hours—i.e., hours in excess of 2,000 worked by an particular employee are not counted.[110] The mechanics of the calculation work as follows: if "the sum of total payroll hours for all employees" during the determination period divided by divided by 2,000 is equal to or greater than eleven, then the employer is potentially subject to the requirement. Payroll hours include all hours for which an employer paid wages including, regular, vacation, sick, FMLA, short term disability, long term disability, overtime and holiday hours. Payroll hours of independent contractors are not counted.

These general rules have some important exceptions: Employers who (i) are signatories to or obligated under a "negotiated, bona fide collective bargaining agreement that governs the employment conditions of the State-Funded Employee"[111] or (ii) participates in the Massachusetts Insurance Partnership[112] (see Section I.D above). There is also a special rule that applies to "Employee Leasing Company" arrangements, under which the "Client Company" is the employer for purposes of the surcharge with respect to itself and its employees covered by the arrangement.[113] For this purpose, an "Employee Leasing Company" is defined as:

> "A sole proprietorship, partnership, corporation or other form of business entity whose business consists largely of leasing Employees to one or more Client Companies under contractual arrangements that retain for such Employee leasing companies a substantial portion of personnel management functions, such as payroll, direction and control of workers, and the right to hire and fire workers provided by the Employee Leasing Company; provided, however, that the leasing arrangement is long term and not an arrangement to provide the Client Company temporary help services during seasonal or unusual conditions."[114]

114.5 CMR 17.02 defined the term "Client Company" as a "person, association, partnership, corporation or other entity that uses workers provided by an Employee Leasing Company pursuant to a contract."[115] This definition is not the same as the definition of "Client Company" under the fair share premium regulations at 114.5 CMR 16.03(2)(a), which requires a co-employment relationship. Since (as described above in Section III.A.3 above) "co-employment" is a feature of PEOs but is not usually associated with traditional staffing arrangements, these Employee Leasing Company provisions appear to apply to both PEOs and staffing firms.

(d) Determination of Surcharge Amount

The DHCFP determines the amount of the surcharge by taking into account the following information:[116]

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[109] *See* 114.5 CMR 17.02.
[110] 114.5 CMR 17.03(2)(a)(1).
[111] 114.5 CMR 17.03(2)(c).
[112] M.G.L. c. 118E, § 9C.
[113] 114.5 CMR 17.03(2)(d).
[114] 114.5 CMR 17.02.
[115] *Id*.
[116] 114.5 CMR 17.04.

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- The number of Employees of the Employer;
- The number of admissions and visits for each State-Funded Employee;
- The total State-Funded Health Services attributed to the Employer's employees; and
- The percentage of Employees for whom the Employer provides health insurance.

Under the emergency regulation, the percentage of State-Funded Costs assessed based on the following categories[117] that vary by the number of the employer's FTEs:

Category 1	11 to 25 Employees
Category 2	26 to 50 Employees
Category 3	more than 50 Employees

Based on the criteria set out above and the Employer's category, an assessment percentage is determined based on the following table:[118]

State-Funded Costs	Category 1	Category 2	Category 3
$50,000 to $75,000	20%	50%	80%
$75,001 to $150,000	30%	60%	90%
Over $150,000	40%	70%	100%

The product of the State-Funded Health Costs and the applicable percentage is then reduced, but not by more than 75%, by the percentage of the employees covered by employer-provided health insurance. To determine the percentage of the employees covered by employer-provided health insurance, the emergency regulation refers to the definition of "Enrolled Employee" under the fair share premium contribution final regulation, which defines the term "Enrolled Employee" as "an employee who has accepted and is enrolled in the employer's sponsored Group Health Plan."[119]

> **Example:** A Category 2 employer would be assessed 50% of its state-funded costs between $75,001 and $150,000, but the assessment percentage of 50% would be reduced to 25% if it provided group health insurance to half of its

[117] 114.5 17.02.
[118] 114.5 CMR 17.04(4).
[119] 114.5 CMR 16.02.

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employees. In establishing the percentage of employees to whom it provides coverage, only employees who have actually accepted and enrolled in the employer's group health plan are counted.

(e) Collection of Surcharge

The DHCFP will notify employers subject to surcharge at the end of each fiscal year.[120] Where a state-funded employee is employed by more than one non-providing employer at the time services are rendered, the amount of the surcharge is prorated based on "the best available data."[121] An employer may challenge the determination only if it can establish either that (i) an individual identified as a state-funded employee was not its employee or the dependent of one of its employees, or (ii) the employer is not a non-providing employer. Penalties for nonpayment or late payment include an assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 percent and late fees or penalties at a rate not to exceed 5 percent per month. Where there is a transfer of ownership, the non-providing employer's surcharge liability is assumed by its successor. If an employer fails to file (or files false or misleading) information required by the DHCFP in connection with its enforcement of the free rider surcharge, it is subject to a civil penalty of up to $5,000 for each week during which the failure occurs or continues.[122]

C. The Health Insurance Responsibility Disclosure Form

Act § 42 directs DHCFP to promulgate a "Health Insurance Responsibility Disclosure" (or "HIRD") form that provides information necessary to administer and enforce the Act's individual insurance mandate, the fair share contribution requirement, and the free rider surcharge. As originally enacted, M.G.L. c. 118G, § 6C called for a single HIRD form, but a later technical correction expanded the requirement to include both an employer HIRD form and an employee HIRD form.[123] The HIRD requirements become effective July 1, 2007.[124] While the purpose of the original HIRD form requirement was to ascertain whether an employer satisfied the section 125 cafeteria plan requirement, the final HIRD form requirement instead focuses on identifying employees who declined coverage under an employer-sponsored group health plan. It reads, in pertinent part, as follows:

> "The division shall prepare a form, to be called the employee health insurance responsibility disclosure, on which an employee of employers with 11 or more full-time employees[125] *who declines an employer-sponsored health plan* shall report whether he has an alternative source of health insurance coverage." (Emphasis added.)

On December 29, 2006, DHCPF issued an emergency regulation providing guidance on the implementation of the HIRD form requirements, but, in a bulletin issued on or about January

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[120] 114.5 CMR 17.05.
[121] 114.5 CMR 17.05(2).
[122] 114.5 CMR 17.05.
[123] Technical Corrections Act, § 25.
[124] M.G.L. c. 450, § 7 (the HIRD requirement effective date prior to amendment was January 1, 2007).
[125] M.G.L. c. 207, § 23 (substituting "11 or more" for "more than 10").

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19, 2007, DHCFP withdrew the emergency regulation following the enactment of Chapter 450 (which postponed the provision's effective date). On June 20, 2007, DHCFP re-issued an emergency HIRD form rule, 114.5 CMR 18.00, which retains the basic form of the December 29, 2006 emergency rule with some welcome refinements.

(1) *Applicability of the HIRD Form Rules*

The HIRD Form requirement applies to Massachusetts employers with eleven or more full time equivalent employees.[126] The period for measuring full time equivalent status is the fiscal period beginning October 1 and ending September 30 (the "determination period"), and "full time" means up to 2,000 hours—i.e., hours in excess of 2,000 worked by any particular employee are not counted.[127] The emergency regulation refers to the employers subject to the HIRD from rule as "Reporting Employers." The mechanics of the calculation work as follows: if "the sum of total payroll hours for all Employees" during the determination period divided by divided by 2,000 is equal to or greater than eleven, then an employer is a Reporting Employer. Payroll hours include all hours for which an employer paid wages including, regular, vacation, sick, FMLA, short term disability, long term disability, overtime and holiday hours. Payroll hours of independent contractors are not counted. The term "independent contactor" is defined (narrowly) with reference to M.G.L. c. 151A, § 2 (see the discussion above in Section III.A).

(2) *The Employer HIRD Form*

Reporting Employers must submit an "Employer HIRD Form" based on information as of July 1 of each year. The method of submitting the form and the due date for submission will be established at a later time pursuant to an administrative bulletin. Newly established employers must register with the DHCFP at the same time that they register with the Division of Unemployment Assistance. [128]

The Employer HIRD Form is required to include the following information:

1. Employer Legal Name;

2. Employer DBA Name;

3. Employer Federal employer identification number;

4. Division of Unemployment Assistance account number;

5. Whether the employer adopts and/or maintains a section 125 cafeteria plan in accordance with the requirements of the Connector;

6. Whether the employer contributes to the premium cost of a group health plan for its Employees;

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[126] 114.5 CMR 18.03(1).
[127] *Id*.
[128] 114.5 CMR 18.03(1)(b).

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7. If the employer contributes to the premium cost of a group health plan for its Employees, the employer contribution percentage for each employee category if the percentage varies by category;

8. If the employer contributes to the premium cost of a group health plan for its employees, the total monthly premium cost for the lowest priced health insurance offered for an individual plan and a family plan;

9. If the employer contributes to the premium cost of a group health plan for its employees, the total monthly premium cost for the highest priced health insurance offered for an individual plan and a family plan; and

10. If the employer offers an employer-sponsored group health plan, the open enrollment period of the employer-sponsored plan.

The Division of Unemployment Assistance has incorporated the employer HIRD form reporting requirement into its filing rules under the fair share premium requirements (see Section III.A above), and it will share the employers' responses with DHCFP. According to an announcement on the DUA website, this will relieve "the employer of the requirement to submit a separate report to [DHCFP]." [129] The particulars of this requirement were spelled out in the DUA Filing Instructions issued October 3, which require the disclosure of the following items relating to the October 1, 2006 to September 30, 2007 filing cycle:

- Whether the employer adopted and/or maintains a Section 125 Cafeteria Plan as of July 1, 2007 in accordance with the Connector's section 125 plan regulations.
- The percentage of the contribution of the employer's business to the premium cost as of July 1, 2007 for each of the following categories:
  - The definition of "full-time employee" (as defined for purposes of the secondary test above).
  - Full-time employees, individual plan.
  - Full-time employees, family plan.
  - Part-time employees, individual plan.
  - Part-time employees, family plan.
  - The total monthly premium for the lowest-cost individual and family health insurance plans as of July 1, 2007.
  - The total monthly premium for the highest-cost individual and family health

[129] Labor and Workforce Development Employer HIRD Reporting, http://www.mass.gov/?pageID=dlwdterminal&L=3&L0=Home&L1=Employers&L2=Understanding+Fair+Share+Contribution+(FSC)&sid=Edwd&b=terminalcontent&f=employers_revenueService_fscEmployerHirdRpt&csid=Edwd (last visited July 3, 2007).

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insurance plans offered as of July 1, 2007.

- The month in which the employer's next group health insurance plan open enrollment period begins.

(3) *Special Leasing Company Rule*

The emergency HIRD form rule contains special provisions that apply to "Employee Leasing Company" arrangements.[130] An "Employee Leasing Company" is defined in 114.5 CMR 18.02 to mean:

> "A sole proprietorship, partnership, corporation or other form of business entity whose business consists largely of leasing Employees to one or more Client Companies under contractual arrangements that retain for such Employee leasing companies a substantial portion of personnel management functions, such as payroll, direction and control of workers, and the right to hire and fire workers provided by the Employee Leasing Company; provided, however, that the leasing arrangement is long term and not an arrangement to provide the Client Company temporary help services during seasonal or unusual conditions."

114.5 CMR 18.02 defines the term "Client Company" to mean a "person, association, partnership, corporation or other entity that uses workers provided by an Employee Leasing Company pursuant to a contract." This definition is not the same as the definition of "Client Company" under the fair share premium regulations at 114.5 CMR 16.03(2)(a), which requires a co-employment relationship. Since (as described in Section III.A.3 above) "co-employment" is a feature of PEO arrangements but is not usually associated with traditional staffing arrangements, these Employee Leasing Company provisions appear to apply to both PEOs and staffing firms.

Under the HIRD form Employee Leasing Company rules, the Client Company is the employer with respect to itself and employees covered by the leasing arrangement, but the parties are free to change this result by written agreement. The Employee Leasing Company's failure to adhere to such an agreement, however, does not relieve the Client Company from liability. Where the Employee Leasing Company undertakes to file HIRD Form on behalf of its Client Companies, separate forms are required for each Client Company.[131]

(4) *Employee HIRD Form*

Reporting Employers are required to furnish an "Employee HIRD Form" to each employee who either declines to enroll in an employer-sponsored group health plan or (in the case of an employee who is not eligible for employer-subsidized coverage) who declines access to other coverage (e.g., through the Connector) through the employer's section 125 cafeteria plan.[132] But employees are ineligible for employer-provided coverage and who are not subject to the cafeteria plan requirement are not subject to the HIRD form requirement. These employees must sign an Employee HIRD Form and return it to the employer. If an employee fails to comply

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[130] 114.5 CMR 18.03(1)(d).
[131] *Id.*
[132] 114.5 CMR 18.04.

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with the employer's request to return the signed form, the employer must document its "diligent" efforts to obtain the form, and it must retain the documentation for three years.

The Employee HIRD Form must contain the following information:[133]

1. Employee Name;

2. Employer Name;

3. Whether the Employee was informed about the Employer's Section 125 Cafeteria Plan;

4. Whether the Employee declined to use the Employer's Section 125 Cafeteria Plan to pay for health insurance;

5. Whether the Employee was offered Employer subsidized health insurance;

6. Whether the Employee declined to enroll in Employer subsidized health insurance;

7. If the Employee declined Employer subsidized health insurance, the dollar amount of employee's portion of the monthly premium cost of the least expensive individual health plan offered by the Employer to the Employee;

8. Whether the Employee has alternative insurance coverage; and

9. The date the Employee completes and signs the HIRD form.

As a part of the Employee HIRD Form, the employee must also acknowledge that:[134]

- He or she has declined to enroll in employer-sponsored insurance and/or has declined to use the employer's section 125 cafeteria plan to pay for health insurance;

- If he or she declines an Employer's offer of subsidized health insurance, he or she may be liable for his or her health care costs;

- He or she is aware of the individual mandate and the penalties for failure to comply with the individual mandate;

- He or she is required to maintain a copy of the signed HIRD Form and that the HIRD Form contains information that must be reported on the Employee's Massachusetts tax return; and

- The truthfulness of his or her answers.

[133] 114.5 CMR 18.04(1)(a).
[134] 114.5 CMR 18.04(1)(b).

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> **NOTE:** In its current form, the provisions of the emergency rule implementing the employee HIRD form requirement appear to go beyond the Act's mandate. As indicated above, M.G.L. c. 118G, § 6C refers only to employees who decline coverage under an employer-sponsored group health plan. Moreover, the final section 125 cafeteria plan regulation makes clear that "[a] Section 125 Cafeteria Plan is not an employee benefit plan under ERISA."[135] Thus, there appears to be no basis for the employee HIRD form to request information about cafeteria plan coverage.

Employers must retain, and make available to the DHCFP on request, signed HIRD Forms for a period of three years.[136] The Employer must also retain documentation that an individual employee was not required to sign the HIRD Form for a period of three years—i.e., that the employee either enrolled in the employer's plan or he or she accessed other coverage under the employer's section 125 cafeteria plan. Lastly, the employer must provide a copy of signed Employee HIRD Form to each employee for use in filing his or her Massachusetts tax return.[137] The Connector has issued a model HIRD form which is available on its website.[138]

Employers must obtain signed Employee HIRD Forms upon the earliest of:

- 30 days after the close of each open enrollment period for the Employer's health insurance,
- 30 days after the close of each open enrollment period for the Employer's section 125 cafeteria plan, or
- September 30 of the reporting year.[139]

Where an employee terminates participation in the employer's group health plan, the employee must sign a HIRD Form within 30 days of the date of his or her termination or participation.

> **NOTE:** It is unclear whether an employee HIRD form is required in the case of a terminating employee, and whether it makes any difference whether the terminating employee elects COBRA. Where an employee fails to elect COBRA, he or she terminates participation, which would appear to trigger the employee HIRD form requirement. On the other hand, an employee who terminates employment is no longer an "employee," so the HIRD from requirement would not apply by its terms. The provision in the emergency HIRD form rule relating to termination of plan participation appears to be directed to an employee who terminates coverage during open enrollment but continues his or her employment.

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135 956 CMR 4.08(3). *See also* DOL Adv. Op. 96-12A (July 17, 1996) (holding that a premium-only cafeteria plan is not a group health plan for purposes of ERISA).
136 114.5 CMR 18.04(3).
137 114.5 CMR 18.04(3).
138 Commonwealth Connector, http://www.mahealthconnector.org/portal/site/connector/menuitem.26c01aac2120f4ce505da95c0ce08041 (last visited July 3, 2007).
139 114.5 CMR 18.04(5).

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In the case of newly hired employees, the employer must obtain the signed Employee HIRD Form from each new employee who either declines Employer-sponsored health insurance coverage or declines to access other coverage through the employer's section 125 cafeteria plan within 30 days after the close of the "applicable open enrollment period." It is not clear whether the "applicable open enrollment period" for this purposes is the end of the initial waiting period or the plans' next open enrollment period. Pending clarification, the safer approach is former.

The emergency rule imposes on each employer that knowingly falsifies or fails to file any information required by the DHCFP a fine of not less than $1,000 or more than $5,000.[140]

D. The Cafeteria Plan Requirement

Code § 125 permits employees to make pre-tax contributions under employer-sponsored group health plans. These plans are referred to as "cafeteria" plans. While often misunderstood and underappreciated, cafeteria plans allow employees to make contributions toward the costs of employer-provided coverage with pre-tax dollars. The advantages accrue to both employers and the employees: Where an employee pays for health insurance on a pre-tax basis, the employer saves FICA taxes of 7.65%, and the employee saves FICA, state and federal income taxes (about 40% on average).

(1) *The Act's Cafeteria Plan Mandates*

The Act contains not one, but two cafeteria plan requirements. The first, general requirement is set out in Act § 48, which adds M.G.L. c. 151F (Employer-Sponsored Health Insurance Access). M.G.L. c.151F § 2 requires each employer with 11 or more full-time equivalent employees[141] in the Commonwealth to "adopt and maintain a cafeteria plan that satisfies 26 U.S.C. 125 and the rules and regulations promulgated by the connector." This provision also requires a copy of the plan to be filed with the Connector. The second, more limited cafeteria plan requirement appears in Act § 101, adding M.G.L. c. 176Q (Commonwealth Health Insurance Connector), as amended by Technical Corrections Act § 57. Section 6(c) of M.G.L. c. 176Q requires small groups that choose to designate the Connector as their group health plan to "participate in a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from exclusions from gross income under 26 U.S.C. 104, 105, 106 and 125."

The Technical Corrections Act made clear that that cafeteria plan requirement is limited to so-called "premium-only" arrangements.[142] Nothing in the Act would require an employer to adopt a medical or dependent care flexible spending account. The purpose of the requirement is to permit employees to purchase health care with pre-tax dollars. Separately, Chapter 205, § 29 makes clear the section 125 plan rules do not apply to sole proprietors or tax exempt organizations staffed exclusively by volunteers.

(2) *Selected Cafeteria Plan Tax Issues*

[140] 114.5 CMR 18.05(2).
[141] *See* M.G.L. c. 205, § 30 (substituting "11 or more" for "more than 10").
[142] Technical Corrections Act § 57.

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Cafeteria plans are subject to the following non-discrimination testing requirements, the failure of which results in the loss of favorable Federal and state income tax treatment[143] to highly paid employees:

(a) Eligibility

Under Code §125(b)(1), a cafeteria plan may not discriminate in favor of highly compensated individuals as to eligibility. The term "highly compensated" individual includes officers, more-than-5% shareholders, and spouses and dependents of highly compensated individuals.

(b) Contributions and Benefits

Code §125(b)(1)(B) provides that the tax advantages afforded under a cafeteria plan are not available to highly compensated participants if the plan discriminates in favor of highly compensated participants "as to contributions and benefits." Section 125(c) clarifies (and provided a functional safe harbor) by providing that, for purposes of §125(b)(1)(B)—

> "a cafeteria plan does not discriminate where qualified benefits and total benefits (or employer contributions allocable to statutory nontaxable benefits and employer contributions for total benefits) do not discriminate in favor of highly compensated participants."

(c) Concentration Test

Under Code § 125(b)(2), "key employees" may not exclude from income any benefit received under a cafeteria plan if the nontaxable benefits provided to them exceed 25% of the aggregate nontaxable benefits provided for all employees under the plan. The term, "key employee" is defined in Code § 416 to mean, generally, certain officers, owners and highly paid employees. For most companies, and particularly for mid-sized and larger employers, this is usually a very small group.

Despite the intent of the Massachusetts Legislature, it is possible that certain individuals might not get the tax advantages envisioned under the Act. Consider, for example, a Massachusetts restaurant with 12 full-time employees that is organized as a C corporation (with a single class of voting, common stock) and offers no health insurance coverage, but instead designates the Connector as its group health plan and adopts a cafeteria plan as of July 1, 2007. Assume further that only the two owners (each of whom owns 50% of the common stock) choose to purchase coverage through the Connector. Under these circumstances, it is unlikely that the owners will get the benefits of pre-tax coverage, even though they have complied with the requirements of Massachusetts law. Also, for employers that have previously gone without cafeteria plans, the cafeteria plan testing rules will add new administrative burdens.

(3) *The June 5, 2007 Final Section 125 Cafeteria Plan Regulation*

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[143] *See* discussion of interaction of the Federal and Massachusetts income rules in Section I.D above.

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On June 5, 2007, the Connector Board approved a final Section 125 Cafeteria Plan regulation implementing the Act's general cafeteria plan requirement. The final regulation tracked closely the emergency rule issued March 20, 2007. The final regulation, 956 CMR 4.00 ("Employer-Sponsored Health Insurance Access"), applies to employers in the Commonwealth (referred to as "151F Employers") with 11 or more full-time equivalent employees. [144] In an administrative bulletin issued June 29, 2007, the Connector modified the definition of "employee" such that, "[f]or purposes of counting the number of employees to determine whether an employer has 11 or more employees," individuals who have been employed for less than one month are not included.[145] Full-time equivalency is based on 2000 payroll hours per year, which include regular, vacation, sick, FMLA absence, short term disability, long term disability, overtime and holiday payroll hours.[146] Multi-state employers need only count Massachusetts payroll hours.[147] The cafeteria plan rule applies regardless of whether medical care coverage is offered on an insured or self-insured basis, purchased on an individual or group basis, or provided through the Connector or through any other distribution channel.

The cafeteria plan requirement does not apply to multiemployer health benefit plans.[148] For this purpose, the term "Multiemployer Health Benefit Plan" is defined to mean:

> "A health benefit plan to which more than one Employer is required to contribute, which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one Employer, and there is evidence that such Employer contributions to the Multiemployer Health Benefit Plan were the subject of good faith bargaining between such employee representatives and such Employers."[149]

Thus, an employer that provides health benefits under a multiemployer arrangement pursuant to a collective bargaining agreement is not obligated by law to make a section 125 cafeteria plan available to covered bargaining unit employees, but, if the employer arranges for its own coverage, even if pursuant to a collective bargaining agreement, a cafeteria plan appears to be required. But because the free rider surcharge does not apply to employees covered by a collective bargaining agreement,[150] it appears that an employer that fails to provide cafeteria plan access to any employee covered by a bona fide collective bargaining agreement would not be subject to any penalty or sanction as a consequence.

Under a special rule, an employer that maintains a fully-contributory plan is not subject to the cafeteria plan requirement. To fit within this exception, the employer must provide medical coverage to all its non-excludable employees. The determination as to whether the employer covers all employees is made on a monthly basis.[151] The requirement that the employer

[144] 956 CMR 4.00, § 4.06(2).
[145] Administrative Information Bulletin 02-07: Guidance Regarding M.G.L. c. 151F, as implemented by 956 CMR 4.00, at 1 (June 29, 2007).
[146] *Id.* at § 4.06(2)(a).
[147] *Id.* at 4.06(2)(c).
[148] 956 CMR 4.07(3)(b)(4)(f)
[149] *Id*. at 4.02.
[150] 114.5 CMR 17.03(2)(c).
[151] *Id*. at 4.06(2)(e).

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pay the "full monthly cost" of a plan does not preclude coverage under arrangements that include deductibles, coinsurance, co-payments or other cost-sharing amounts for which the employee is responsible.[152]

Whether an employer has 11 or more full-time employees is tested on the basis of a "determination period." The initial determination period is the 12 consecutive month period beginning on April 1, 2006 and ending on March 31, 2007. Employers with 11 or more full-time employees in the initial determination period are subject to the section 125 cafeteria plan requirements as of July 1, 2007. For those Employers who do not have 11 or more Employees during the initial determination period (or a subsequent determination period, as applicable), the subsequent determination period the 12 consecutive month period beginning on October 1 and ending on September 30. An Employer with 11 or more employees during a subsequent determination period, becomes subject to the section 125 cafeteria plan requirements as of the following January 1.

As originally adopted, the definition of "Employee" in 956 CMR 4.00 did not include "Independent Contractors" within the meaning of M.G.L. c. 151A, § 2 (see Section III.A(1) above for a discussion of the Massachusetts rule). As a result, Internal Revenue Code and the Massachusetts section 125 cafeteria plan final regulation did not define the term "Independent Contractor" in the same way. (Actually, the Internal Revenue Code nowhere defines the term, but it distinguishes employees from self-employed individuals to the same effect.) It was therefore possible for a worker to be an independent contactor for Federal tax purposes and an employee for Massachusetts purposes.[153]

> **Example:** Company X manufactures widgets. During peak season, it requires additional assistance and reaches out to contactor A, who comes to work at X's principle place of business. For Federal tax purposes, whether A is an employee or an independent contractor depends on the application of a multi-factor test. A might, for example, hold himself out the "go to" person on the widget industry who can with a special expertise alleviating back logs. He might even have an advertisement in various widget trade journals to that effect and have a reputation as a much sought after free-lancer. But whatever the outcome for Federal tax purposes, X will be an employee for Massachusetts purposes.

For Federal tax purposes, cafeteria plans must cover employees and *only* employees. Recently issued proposed cafeteria plan regulations make clear that, if a cafeteria plan covers an independent contractor, the tax benefits of the plan are lost to *all* plan participants. Thus, an employer would run the risk of complying with the Massachusetts rules only to find that it has violated the Federal rules. Connector Administrative Bulletin 03-07 recognized and addressed this conundrum by revising the definition of "Independent Contractor" to include:

> "[A]n individual who provides services not deemed to be employment for federal employment tax and wage withholding purposes in accordance with Internal Revenue Code sections 3121 and 3401 [dealing with employment taxes and wage

[152] *Id*.
[153] *See* Mass. DOR, TIR-05-11 (Sept. 13, 2005) (adopting the Federal, rather than the Massachusetts, rule for Massachusetts income tax purposes).

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withholding at the source, respectively] and with the 20-factor test established by Internal Revenue Service Rev. Rul. 87-41 [i.e., the multi-factor test]."

By mirroring the Federal standard, the Massachusetts section 125 cafeteria plan rules can now operate consistently with the Federal rules.

(a) Cafeteria Plan Adoption and Maintenance

The regulation requires each 151F Employer to adopt and maintain and cafeteria plan in accordance with the rules and regulations promulgated by the Connector. The plan must be in writing, and it must include the following provisions:[154]

1. A specific description of each of the benefits available under the plan, including the periods during which the benefits are provided. (The benefit description need not be self-contained. Benefits described in other separate written plans may be incorporated by reference into the plan document.)

2. The plan's eligibility rules regarding participation.

3. The procedures governing participant elections under the plan, including the period during which elections may be made, the extent to which elections are irrevocable, and the periods with respect to which the elections are effective.

4. The manner in which Employer contributions may be made to the plan, such as by salary reduction agreement between the participant and Employer or by non-elective Employer contributions to the plan.

5. The maximum amount of elective Employer contributions available to any participant under the plan either by stating the maximum dollar amount or maximum percentage of compensation that a participant may contribute, or by stating the method for determining the maximum amount or percentage.

6. The plan year on which the cafeteria plan operates.

The cafeteria Plan document may be a separate, stand-alone document or combined/consolidated with other employer-provided plans. Employers are free to adopt more than one cafeteria Plan document, including a "Connector-only plan" document. A single plan may cover employees of two or more related employers (in which case the plan document must clearly identify all participating employers). Employers must take such actions as they deem "necessary or appropriate" to adopt its cafeteria Plan(s) in accordance with its own internal governance procedures and with applicable law.

[154] *Id*. at § 4.07(2).

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The cafeteria plan regulation makes clear that the plan need only contain a premium-only feature. An employer is free to add other features, such as flexible spending accounts and adoption assistance, but these are not required.

To satisfy the cafeteria plan regulation, the plan must, at a minimum, provide access to one or more "medical care coverage options" in lieu of regular cash compensation. The term "medical care coverage option" is not defined. The simplest way to apply this requirement is employee-by-employee, i.e., does each employee have access to pre-tax coverage under at least one medical care coverage option? Where the employer does not offer coverage, or in the case of an employee who is ineligible for employer-subsidized coverage, the most likely medical care coverage option would be the Connector. On the other hand, where an employer offers a single subsidized group health insurance plan, the medical care coverage option for eligible employees would be that plan. But if an employer offered multiple medical coverage options, only one would need to be made available through the cafeteria plan.

> **NOTE:** This rule raises concerns for any employer with high rates of employee turnover, since cafeteria plan elections would be required to conform to both the tax rules relating to mid-year election changes[155] and the Massachusetts requirements. While cafeteria plans are not required to allow mid-year election changes, those cafeteria plans subject to the Connector emergency regulation would, at a minimum, need to ensure that employees who leave and then return to work have the necessary access to pre-tax premiums. For employees who return to work within 30 days of termination, the Federal rules allow the employee's previous election to be reinstated.[156] In an effort to reduce administrative burdens, an employer could require the that an employee's election is fixed for the entire year, irrespective of when he or she returns during the year.

Certain employees can be excluded from cafeteria plan participation. These include:[157]

- Employees who are less than 18 years of age;
- Temporary Employees;
- Part-time Employees working, on average, fewer than 64 hours per month for an Employer;

> **NOTE:** In a June 29, 2007 administrative bulletin, the Connector clarified the manner in which the "fewer than 64 hours per month" exception applies. Generally, the employer must make "a reasonable, good faith effort to identify, determine, and document those employees excluded by this classification" using a procedure prescribed in the bulletin. With respect to existing employees, an employer is deemed to have made a reasonable, good faith effort "if the employer reasonably determines that, as of the employee's date of hire, the employee will be scheduled or will

[155] Treas. Reg. § 1.125-4.
[156] Treas. Reg. § 1.125-4(c)(4) (Example 8).
[157] *Id.* at § 4.07(3)(b)(4).

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be expected to work an average of 63 or fewer hours per calendar month during the first 180 days following commencement of employment." The term "new hire" for this purpose means an employee is hired on or after (i) July 1, 2007 and (ii) the effective date of the employer's section 125 cafeteria plan for which the employee is eligible (including eligibility subject to a waiting period). The bulletin also made clear that employers are free to establish some lesser amount of hours, e.g., 32 hours, below which cafeteria plan access would not be permitted.

- Employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, § 152A) and who earn, on average, less than $400 in monthly payroll wages (in the June 29, 2007 administrative bulletin, the Connector clarified that employers should not include tips when calculating whether an individual's wages exceed $400 monthly for purposes of determining whether employees fall within this exclusion);

- Student Employees who are employed as interns or as cooperative education student workers;

- Seasonal Employees who are international workers with either a U.S. J-1 student visa, or a U.S. H2B visa and who are also enrolled in travel health insurance; and

- Students who are employed part-time as Employees of the educational institution they attend and who, as a condition of attending that educational institution, "participate in a qualifying student health insurance program . . . or a qualifying student health insurance program of another state[] or in a health plan with comparable coverage, as required by state law." (This last requirement was added as a part of the Connector Administrative Bulletin 03-07 issued on September 6, 2007.)

(b) The Filing Requirement

151F Employers are originally required to file a copy of their cafeteria plans with the Connector. But a cafeteria plan maintained by a 151F Employer that is not available to any Employees employed at a Massachusetts location was not subject to the filing requirement. The manner of submission will be in "the form and manner specified by the Connector and shall include such other documentation . . . as the Connector may from time to time require."[158] In its June 29, 2007 administrative bulletin, the Connector postponed the filing requirement to October 1, 2007, and it also announced that it would not accept any filings until September 1, 2007. The Connector modified the filing rules in Administrative Bulletin 03-07, under which employers were merely required to furnish a copy of their section 125 plan upon the Connector's request. It is this position that Chapter 205, § 30[159] formally codified.

(c) Waiting Periods

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[158] *Id.* at § 4.08.
[159] Amending M.G.L. c. 151F, § 1.

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Before the Act's cafeteria plan requirements, cafeteria plan waiting periods were virtually always tied to the applicable waiting of the underlying medical plan. An employee became eligible to participate in the employer's cafeteria plan at the same time he or she became eligible for the employer's medical plan. Under the final rule, a cafeteria plan can impose a waiting period that matches that of the employer-sponsored plan in a manner that corresponds to prior practice. But after the Act, there are instances (such as when an employee with access to employer-provided or subsidized coverage purchases Commonwealth Choice coverage) where there is no underlying employer-sponsored plan. In these instances, a waiting period of no more than 60 days may be imposed.

(d) Special Leasing Company Rule

The cafeteria plan regulation establishes a special rule that applies to "Employee Leasing Companies." The term "Employee Leasing Company" refers to entities that provide workers to a "Client Company" but "retain . . . a substantial portion of personnel management functions, such as payroll, direction and control of workers, and the right to hire and fire workers."[160] Leasing companies that provide "temporary help services during seasonal or unusual conditions" are not Employee Leasing Companies for purposes of this rule.

The term "Client Company" is defined as an entity "that is a co-Employer of workers provided by an Employee Leasing Company pursuant to a contract."[161] This definition would appear to limit the special leasing company rule to "Professional Employer Organizations" or PEOs, which claim co-employment status for their workers, despite that the concept of "co-employment" is not recognized for benefits and income tax purposes. Traditional staffing firms, in contrast, usually treat workers placed with client companies as employees of the staffing firm.

Under the special rule, where there is a "co-employment" arrangement between a Client Company and an Employee Leasing Company, the *Client Company* is the 151F Employer as to the co-employees covered under the arrangement. The Client Company may contractually allocate to the Employee Leasing Company its cafeteria plan obligations, but the Employee Leasing Company remains contingently liable. So if the Employee Leasing Company agrees to comply with the cafeteria plan but fails to do so, the Client Company remains subject to the free rider surcharge.[162]

(e) Treatment of Partners and 2% Shareholders of S Corporations

956 CMR 4.05 defines the term "Employee" to mean "[a]ny individual employed by any Employer at a Massachusetts location . . ." and "Employer" to include "[a]n individual, partnership, association, corporation or other legal entity . . . ." Thus, partners and more than 2% shareholders of S corporations who provide services to the partnership/S corporation are subject to the cafeteria plan mandate. But partners and 2% S corporation shareholders are subject to different tax rules than other employees where health insurance is concerned. Unlike common law employees, partners are unable to exclude the premium cost of health insurance. Rather, they

[160] *Id.* at § 4.05 (definition of "Employee Leasing Company").
[161] *Id.* at § 4.05 (definition of "Client Company").
[162] *Id.* at § 4.06(2)(d).

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must take the cost of coverage into income and claim a deduction under Code § 162(l).[163] An S corporation's payment of health premiums for more than 2% shareholder-employees is subject to the same rules as apply for partnerships. Both are barred from a variety of fringe benefits, such as eligibility to participate in cafeteria plans. The emergency regulation is silent as to the coordination of the cafeteria plan mandate and the Federal tax rules in this instance.

(4) *Coordination of Federal and State Section 125 Cafeteria Plan Requirements*

In connection with the adoption of the Act's section 125 cafeteria plan mandate, some commentators objected that it was not possible for the requirement to work as advertised. In their view, Code § 125 was not sufficiently broad to permit employee contributions to be directed to individual market group insurance products on a pre-tax basis. But the Romney Administration and the Legislature were undeterred, principally because Code § 125 nowhere mentions the term "plan" or "employer-sponsored plan" or the like. It refers instead only to "insurance." Moreover, in a ruling that predated Code § 125, the IRS approved a similar approach.[164] Any doubt of the IRS's endorsement of this approach (or at least an approach that if its functional equivalent) under Code § 125 was removed in a recently proposed regulation under Code § 125, which expressly sanctions payment of reimbursement of employees' individual accident and health insurance premiums.[165]

E. Reporting on Form 1099-HC

Technical Corrections Act § 11 added to M.G.L. c. 62C a new § 8B, which requires employers and other plan sponsor of group health plans to either provide, or contract with their third-party administrators or insurance carriers to provide or before January 31 of each year a separate report verifying certain information relating to the coverage of Massachusetts employees and residents to both covered individuals and the Department of Revenue. The Department of Revenue (in consultation with the Division of Insurance), is given the authority to issue regulations implementing these requirements. Though no regulations have yet been issued, the Department of Revenue has issued a draft form 1099-HC in response to the latter mandate.

The Act imposes the 1099-HC reporting obligation on employers. But where the employer's group health plan is insured with a Massachusetts-licensed carrier, Technical Corrections Act §§ 35 (with respect to commercial carriers),[166] 37 (with respect to Blue Cross),[167] 39 (with respect to Blue Shield)[168] and 42 (with respect to HMOs),[169] shifts the obligation to furnish the form 1099-HC to the carrier. Where self-funded plans are concerned, employers will either shoulder the burden internally or contract with a third-party administrator.

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[163] Rev. Rul 91-26, 1991-1 C.B. 184.
[164] Rev. Rul. 61-146, 1961-2 C.B. 2 (holding that payments made directly to employees can be excludible under Code § 106 if paid to reimburse them for accident or health insurance premiums, provided that (i) employees have no right to use such amounts in a way that would result in current taxation, and (ii) the employer requires, as a condition of reimbursement, proof of payment of premiums).
[165] REG 142695-05, 72 Fed. Reg. 150, p. 43, 953-4 (Aug. 6, 2007).
[166] M.G.L c. 175, § 11.
[167] M.G.L c. 176A, § 34.
[168] M.G.L c. 176B, § 22.
[169] M.G.L c. 176G, § 61.

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In its December 29, 2007 emergency regulation,[170] the Department of Revenue furnished guidance on the particulars of the 1099-HC requirement. Effective as of January 1, 2008, an "employer or other sponsor (e.g. a multiemployer plan) of an employment-based health plan" must (i) provide (or arrange with service providers or insurance carriers to provide) a Form MA 1099-HC, annually on or before January 31 of each year, to each plan participant who is a Massachusetts resident, and (ii) file a separate report electronically verifying the statement to the Commissioner.

> **NOTE:** The Emergency Regulation appears to follow the original version of the Act, which imposes the Form 1099-HC reporting obligation of the plan sponsor. But in the case of fully insured plans underwritten by certain Massachusetts-licensed carriers (i.e., commercial carriers, Blue Cross & Blue Shield programs and HMOs), the primary reporting obligation was shifted to the carrier by a technical amendment.

In the case of individual market coverage, the MA Form 1099-HC reporting and filing obligations are imposed only on carriers that are Massachusetts-licensed commercial carriers, Blue Cross & Blue Shield programs and HMOs.

The Emergency Regulation prescribes the content of the Form 1099-HC, which must:

(i) Identify the carrier or employer;

(ii) Identify the covered individual and covered dependents;

(iii) Identify the insurance policy (or similar) numbers and dates of coverage; and

(iv) Provide "other information as required by the Commissioner of Revenue."

Where a plan sponsor or carrier fails to provide Form 1099-HCs or fails to furnish the appropriate reports to the Department of Revenue, a penalty is imposed in the amount of $50 per individual to which the failure relates up to a maximum of $50,000 per year per violator. While the Department retains the power to abate penalties for "reasonable cause," mere oversight or inadvertence will not suffice for this purpose.

IV. INSURANCE MANDATES AFFECTING EMPLOYERS

The Act changes the way that group health insurance is regulated in the Commonwealth of Massachusetts in a handful of important respects. While these changes affect health insurance carriers, there are at least four provisions that will result in changes to the underlying plan designs of insured group health plans of Massachusetts employers/policyholders. The changes consist of (i) the insured plan non-discrimination requirement, (ii) an expanded definition of who is a dependent, (iii) rules regulating waiting periods, creditable coverage, and pre-existing conditions in the small group insurance market, and (iv) health insurance portability rules that apply to small and large groups (and that largely parallel the small group rules regulating waiting

[170] 830 CMR 111M.2.1.

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periods, creditable coverage, and pre-existing conditions). These requirements are discussed below.

A. The Insured Plan Non-Discrimination Requirement

In crafting the various provisions of the Act relating to employers, the Massachusetts legislature did not want to create an incentive for employers to drop coverage in favor of coverage under the Connector—a phenomenon that it referred to as "crowd out." The legislature's solution was to impose nondiscrimination requirements on group health plans, using as its model the nondiscrimination rules in Code § 105(h) that apply to self-funded medical reimbursement plans.

(1) *Relationship to Federal Law*

Federal law (*i.e.*, the preemption provisions of ERISA) bars states from imposing group health plan nondiscrimination requirements, among others, directly on employers. Under ERISA's "insurance saving clause," however, states remain free to regulate insurance. Therefore, for the legislature to impose a nondiscrimination requirement on fully insured group health plans in Massachusetts meant amending the state's insurance code.

For reasons that are largely historical, no federal benefits-related nondiscrimination rules apply to insured group health plans. When it originally enacted the nondiscrimination provisions of Code § 105(h), Congress was of the view that insurance underwriting considerations could be relied upon to limit abuses in insured plans. But, as insurance underwriting practices became more sophisticated, Congress had a change of heart. In the Tax Reform Act of 1986, Congress added Code § 89, which established a comprehensive set of nondiscrimination rules that applied to a broad range of welfare and fringe benefit plans including insured group health plans. Code § 89 was the subject of intense criticism, however, and lobbying pressure ultimately doomed the measure. It was repealed in 1992 in the Debt Limit Extension Act[171] retroactive to 1989, and the prior law rules were resurrected.

(2) *The Insurance Non-discrimination Requirement*

Act §§ 50 (relating to any "general or blanket policy of insurance"),[172] 52 (relating to non-profit hospital service corporations, i.e., Blue Cross),[173] 55 (relating to medical service corporations, i.e., Blue Shield),[174] and 59 (health maintenance organizations)[175] require that insurance contracts or policies delivered in the Commonwealth:

- Be offered by the employer to all full-time employees who live in the Commonwealth, and

[171] P.L. 101-140, §202(a).
[172] Act § 50, adding M.G.L. c. 175, § 110(O).
[173] Act § 52, adding § 8 ½ to M.G.L. c. 176A.
[174] Act § 55, adding § 3B to M.G.L. c. 176B.
[175] Act § 59, adding § 6A to M.G.L. c. 176G.

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- Prohibit the employer from making "a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary" for its group health insurance or HMO offerings.

On April 6, 2006, the Massachusetts Division on Insurance issued Notice 2007-04, entitled, "Non-discriminatory Offer and Equal Contribution by Employers of Insured Group Health Benefit Plan Contracts Pursuant to Chapter 58 of the Acts of 2006, as amended," which fleshes out the particulars of the non-discrimination rule and its enforcement. The notice clarifies that a "full-time" employee means an employee who is "scheduled or expected to work at least the equivalent of an average of 35 hours per week." Excluded from the application of the rule are retirees, temporary employees (i.e., those expected to work 12 consecutive weeks or fewer), and seasonal employees (determined under rules established by the Massachusetts Department of Unemployment Assistance). Nor does the rule apply to an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.

Under the notice employers may (without running afoul of the insurance non-discrimination rule) establish:

(i) A fixed dollar amount contribution to the premium regardless of salary for all full-time employees;

(ii) Different percentage contributions or fixed dollar contributions for different plan choices as long as the contributions made with respect to each plan on behalf of full-time employees do not differ based on the salary level;

(iii) Greater contribution levels for increasing lengths of service, as long as "the schedule of contribution levels is part of a formal employee benefit plan and is designed as a reward for longevity rather than as a pretext for providing better health insurance contributions to more highly paid employees;"

> **NOTE:** This is exception might be used to grandfather certain (i.e., non-abusive) existing arrangements. For example, an employee with an hour of service prior to July 1, 2007 (or, if later, the post July 1, 2007 renewal) would be governed by the pre-July 1, 2007 rules. Employees hired on or after July 1, 2007 (or, if later, the post July 1, 2007 renewal) would be subject to the new rules. Whether the Division of Insurance—or the carriers—would agree with this approach remains to be seen. (We understand the regulators have been skeptical in their informal views if the matter.)

(iv) Greater contributions levels for employees who participate in company-sponsored health and wellness programs; and

(v) Contribution levels for dependents of covered full-time employees that differ from the contribution levels for full-time employees, as long as the

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contribution level is the same for all dependents and does not differ based on the salary level of the full-time employee.

The carrier's obligations under the non-discrimination rule apply at the time the insured health benefit contract is entered into or renewed. Carriers are not responsible for "actively monitoring whether employers' practices change during a contract period." The notice further clarifies that the insurance non-discrimination rule applies to insured group health plan contracts entered into with employers "on or after July 1, 2007." Thus, contracts entered into prior to July 1, 2007 that go into effect on or after that date are not subject to these provisions until their next renewal date.

The insurance non-discrimination requirement will all but eliminate disparate treatment of different classes of employees, such as hourly versus salaried employees, as to contribution levels. It will also prevent small business owners from paying, say, 100% of group health care premiums for themselves, while paying some lesser amount for the rest of their full-time employees. But, because they apply to circumstances prior to coverage under a health insurance policy, waiting periods are not subject to the non-discrimination requirement. Thus, an employer could offer immediate health insurance coverage as a recruiting incentive even if the employer's plan otherwise imposes, say, a 30 day waiting period.

Also in jeopardy are executive-premium or excess plans, at least those subject to regulation in Massachusetts (see discussion below regarding extraterritorial application of state insurance laws) that are marketed as "insured," even though they are usually minimum-deposit or cost-plus arrangements. These latter plans are classified by their issuers as insured in order to avoid the application of the Code § 105(h) nondiscrimination rules described above. (Whether this treatment is warranted is another matter entirely.)

(3) *Extraterritorial Effect*

These insurance non-discrimination provisions of the Act require only that insurance policies and HMO contracts issued or delivered within the Commonwealth by carriers licensed under specified provisions of the Massachusetts General laws containing certain provisions. The Act provides no penalties for failing to comply with the new group health plan nondiscrimination rules; it appropriates no separate funds for enforcement by the Commonwealth's Division of Insurance; and it says nothing about what happens if those provisions are waived or ignored. Of course the regulators have available to them their traditional enforcement mechanisms, such as market conduct examinations. (Market conduct examinations generally focus on the business practices of insurers, and they are designed to monitor marketing, advertising, policyholder services, underwriting, rating, and claims practices, among others, for compliance with applicable state law.)

As a general rule, the law of the state where an insurance policy is *issued* governs the terms of the policy. In the case of a group health insurance policy, this is usually the law of the state where the policyholder is domiciled, since this is where the policy is issued. The law or laws of states where insureds reside and, thus, where certificates of insurance are issued have no application to the policy. This result is premised on basic "choice of law" principles, under which contracts ought to be governed by the law of the state in which the insurance transaction

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occurs. The leading case in support of this proposition is *Boseman v. Conn. Gen. Life Ins. Co*.,[176] in which the U.S. Supreme Court held that the certificate of insurance issued to a plan participant was not essential to effect coverage under the contract so that its delivery in a state other than the state of the plan sponsor did not establish a sufficient basis for the application of that state's law.[177] This basic rule can, however, be altered by statute, in which the law is referred to as having "extraterritorial" effect.[178] Certain Massachusetts benefits mandates, for example, follow the general rule (i.e., they are not applied extraterritorially), while other follow the exception.[179]

The Act's insurance non-discrimination rule does not, by its terms, apply extraterritorially. Rather, it applies only to policies issued, delivered, or renewed in Massachusetts on or after July 1, 2007. So, for example, if an insurance company issues a group health policy in New York to an employer that has Massachusetts employees that policy need not comply with the Act's insurance non-discrimination rules.

Another approach taken by some insurers is to establish a trust in a (friendly) foreign jurisdiction to which it issues a policy of insurance, so that the trust is the policyholder. The policy then issues participation certificates to subscribing employers (e.g., located in Massachusetts). Thus, the law of the (friendly) foreign jurisdiction rather than Massachusetts will apply, at least as to any requirement of the Massachusetts insurance code without extraterritorial reach—such as the Act's nondiscrimination and dependent requirements. Examples include so-called "executive premium" health plans that provide excess or additional coverage (e.g., coverage for items not covered under a company's basic group health insurance plan such as co-pay, deductibles, and excluded medical expenses). Though these arrangements purport to be insured (so as to be able to escape the reach of the non-discrimination rules under Code § 105(h) described above), many are minimum premium or "cost-plus" arrangements that might not withstand scrutiny.

> **NOTE:** This issue of whether executive premium plans are "fully insured" for purposes of the Code's nondiscrimination rule has not surfaced principally because the Internal Revenue Service has focused little if any of its audit resources on this question.

It remains to be seen whether the Massachusetts Division of Insurance will endorse the "trust" approach in the context of executive premium plans or seek, by regulation, to impose

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[176] 301 U.S. 196 (1973).

[177] *See also*, Bynum v. Prudential Ins. Co., 77 F. Supp. 56 (D.C. S.C 1948) (holding that the certificate issued to an employee is not the contact of insurance, the law of the state where the certificate is delivered has no controlling effect, and the rights of the parties are governed by the law of the state in which the master policy is executed and delivered); Bernstein v. Mut. of N.Y., 454 N.Y. 2d 527 (1982) (holding that maternity care expenses under a group health policy delivered outside New York, but which insured New York residents, did not violate a New York insurance law requiring group or blanket accident or health policies to provide coverage for maternity care to the same extent that hospital, surgical or medical coverage was provided).

[178] *See, e.g*., Caspersen v. Acad. Life Inc. Co. of Denver, (Tenn. App. Ct.) 1989-1990 CCH Life & Health Cases 2292 (holding that an insurance certificate was an integral part of the insurance contract and that, as a result, Tennessee law applied to a Colorado policy delivered to a Rhode Island employer covering a Tennessee employee).

[179] *Compare* M.G.L. c. 175, § 110(H) (providing that mandates for the treatment of alcoholism apply extraterritorially) *with* M.G.L. c. 175, § 110(I) providing that mandates for podiatry coverage apply only to Massachusetts employers).

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limits. Because these plans do not (at least after December 31, 2008) provide minimum creditable coverage (*see* Section II.B above) for purposes of satisfying the Act's individual mandate, the regulators might not object. But, to the extent that the trust approach could be applied to plans that do provide minimum creditable coverage, the regulators (and the Legislature) might well object.

This discussion of the extraterritorial effect of the insurance non-discrimination provisions of the Act applies as well to the expanded dependent coverage requirement discussed below.

B. Expanded Dependent Coverage

Technical Corrections Act § 34 (relating to general and blanket policies of insurance),[180] Act § 53 (relating to non-profit hospital services, i.e., Blue Cross/Blue Shield hospital payments),[181] Act § 56 (relating to medical service corporations, i.e., Blue Cross/Blue Shield physician payments),[182] and Act § 58 (health maintenance organizations),[183] each require that carriers with insured health benefit plans that provide for dependent coverage make dependent coverage available through the earlier of their 26th birthday or the day 2 years following the loss of their dependent status according to Federal tax rules. (These requirements do not apply to self-funded plans.) The Act originally extended coverage to dependents under age 25, but this was changed to age 26 in technical corrections.[184] Chapter 205, §§ 5, 31 and 33 to 38 later clarified that the two year extension runs to the close of the second calendar year following the loss of Federal dependent status.

> **NOTE:** The Act did not amend the definition of "dependent" under M.G.L. c. 32B relating to municipal plans, under which only unmarried children may be "dependents."[185]

In Bulletin 2007-1,[186] the Massachusetts Division of Insurance clarified the Act's new dependent coverage requirements. Bulletin 2007-1 confirms that these requirements apply to all insured health plans offered by commercial insurance companies, Blue Cross and Blue Shield of Massachusetts, and Health Maintenance Organizations, but not stand-alone dental products and Medicare Supplement plans. In addition, health plans with limited networks can restrict coverage to employees and dependents living in the plan's service area. Beginning January 1, 2007, carriers are generally barred from imposing limitations on eligibility for dependent coverage.

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[180] Adding § 110(p) to M.G.L. c. 175; *see also* M.G.L. c. 205, § 31 (clarifying end point of extension).
[181] Act § 53, adding § 8Z to M.G.L. c. 176A; *see also* M.G.L. c. 205, § 33, 34 (clarifying end point of extension; striking § 8Z and adding § 8AA).
[182] Act § 56 adding § 4Z to M.G.L. c. 176B; *see also* M.G.L. c. 205, § 35, 36 (clarifying end point of extension; striking § 4Z and adding § 4AA).
[183] Act § 58 adding § 4R to M.G.L. c. 176G; *see also* M.G.L. c. 205, § 37, 38 (clarifying end point of extension; striking § 4R and adding § 4AA).
[184] Technical Corrections Act § 34.
[185] *See* M.G.L. c. 32B, § 2(b) (defining dependent to include "an employee's spouse, and employee's unmarried children under nineteen years of age . . .").
[186] January 18, 2007.

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Bulletin 2007-1 adopts a two-part test for dependent status under the Act: (i) is the individual a dependent under the criteria established by the Code for dependent status,[187] and (ii) is the individual claimed as a dependent on the employee's federal income tax form (or, in the case of divorced/separated spouses who have had joint custody over a child, or married couples who file separate federal income tax returns, either spouse's or ex-spouse's federal income tax return as permitted by federal tax rules). Dependent status is determined on the basis of a calendar year. The date on which a person loses dependent status is December 31 of the last year for which the person was claimed as a dependent on another person's federal income tax form.

Under COBRA and the Massachusetts mini-CORBA rules,[188] a dependent child is considered to have had a "qualifying event" eligible for continuation coverage under an employer's plan as of the date that the "dependent child ceases to be a dependent child under the generally applicable requirements of the health benefit plan." Bulletin 2007-1 provides that, for continuation coverage purposes, the date of the qualifying event is the earlier of the dependent's 26th birthday or the date two years after the loss of dependent status. This rule is consistent with the basic COBRA scheme, since the dependent does not lose coverage until he or she ceases to be a dependent under the more generous Massachusetts rule.

The Act's dependent coverage extension addresses a legitimate and compelling policy goal of expanding coverage among young people who "age out" under their parents' plan but may not be in a position to immediately obtain other coverage. Prior to the Act, a child generally "aged out" when he or she ceased to be a "dependent" for Federal income tax purposes. By expanding dependent coverage, the Act creates a class of dependents who are "dependents" for Massachusetts purposes, but not for Federal purposes, resulting in the need to impute to the employee as income the fair market value of the coverage provided to child who no longer qualifies as a dependent for Federal purposes.[189] (A similar issue arises in connection with group health coverage provided to non-dependent domestic partners and same-gender spouses.)

(1) *Imputed Income under Code § 61*

Code § 61(a)(1) provides, in relevant part:

> "Except as otherwise provided in this subtitle, gross income means all income from whatever source derived, including (but not limited to) . . . compensation for services, including fees, commissions, fringe benefits, and similar items . . . ."

Treasury regulations expand upon and clarify this basic rule. According to Treas. Reg. § 1.61-21(a)(3), a fringe benefit provided in connection with the performance of services is considered "to have been provided as compensation for such services," and Treas. Reg. § 1.61-21(a)(2) directs us to other provisions of the Code to determine whether a particular fringe benefit is deductible, providing (again in relevant part)—

[187] Code § 151(b).
[188] M.G.L. c. 176J, § 9.
[189] *See generally* Mass. Dept. of Rev., Tech. Info. Release 07-16 ("Personal Income Tax Treatment of Employer-Provided Health Insurance Coverage for and Employee's Child").

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> "To the extent that a particular fringe benefit is specifically excluded from gross income pursuant to another section of subtitle A of the Internal Revenue Code of 1986, that section shall govern the treatment of that fringe benefit. Thus, if the requirements of the governing section are satisfied, the fringe benefits may be excludable from gross income."

Also, Treas. Reg. § 1.61-21(a)(4)(i) provides:

> "A taxable fringe benefit is included in the income of the person performing the services in connection with which the fringe benefit is furnished. *Thus, a fringe benefit may be taxable to a person even though that person did not actually receive the fringe benefit*. If a fringe benefit is furnished to someone other than the service provider such benefit is considered in this section as furnished to the service provider, and use by the other person is considered use by the service provider. . . ." (Emphasis added).

Under Treas. Reg. § 1.61-21(b)(1), "an employee must include in gross income the amount by which the fair market value of the fringe benefit exceeds the sum of—(i) the amount, if any, paid for the benefit by or on behalf of the recipient, and (ii) the amount, if any, specifically excluded from gross income by some other section of subtitle A of the Internal Revenue Code of 1986." For the reasons described below, pre-tax employee contributions made under cafeteria plan elections are treated as "employer" contributions. No part of the benefit is treated as employee-paid for purposes of this regulatory provision, and the fair market value of the fringe benefit provided to the domestic partner is taxable to the employee under these circumstances.

Treas. Reg. § 1.61-21(b)(2) attempts to clarify the meaning of fair market value in this context. It reads—

> "In general, fair market value is determined on the basis of all the facts and circumstances. Specifically, the fair market value of a fringe benefit is the amount that an individual would have to pay for the particular fringe benefit in an arm's-length transaction. Thus, for example, the effect of any special relationship that may exist between the employer and the employee must be disregarded. Similarly, an employee's subjective perception of the value of a fringe benefit is not relevant to the determination of the fringe benefit's fair market value nor is the cost incurred by the employer determinative of its fair market value."

As a result of extended employer-provided health insurance coverage for children under the Act, there will be instances where the benefits provided to an employee, including health insurance for a non-dependent child, will be taxed (or imputed) to the employee. The amount of the imputed income will be the fair market value of the child's coverage to the extent that it exceeds any amount paid by the employee on an after-tax basis (employee pre-tax contributions are considered to be employer contributions for this purpose).

(2) *Federal Tax Exclusion for Medical Coverage*

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Code § 106 provides that amounts that an employer pays toward coverage of an employee are not taxable to the employee if the coverage is for the employee, his or her spouse, or dependents. Treas. Reg. § 1.106-1 describes the operation of § 106 as follows:

> "The gross income of an employee does not include contributions which his employer makes to an accident or health plan for compensation (through insurance or otherwise) to the employee for personal injuries or sickness incurred by him, his spouse, or his dependents, as *defined in section 152*." (Emphasis added).

Code § 106 ensures that premiums paid by the employer on an employee's behalf are not included in the employee's income, but this income exclusion does not apply where coverage is provided to a dependent that is not defined in Code § 106. Instead, the general rules of Code § 106 apply to tax the employee at the fair market value of the coverage provided to the non-dependent, as defined in Code § 152.

(3) *Fair Market Value*

The long-recognized standard for establishing "fair market value" for tax purposes is set out in Rev. Rul. 59-60. 400,[190] under which "fair market value" is defined as:

> "the price at which an asset would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, and both parties are able, as well as willing, to trade and are well informed about the asset and the market for such asset."

In this instance, the "asset" is health insurance. Perhaps the most logical starting point is the plan's individual rate (i.e., the COBRA rate less the 2% allocated to overhead and administration). The Service did not object to the use of COBRA rates as a proxy for fair market in the context of a ruling on related matters of law.[191] There is, however, another plausible measure: The amount of income to be imputed to the employee could be equal to what the dependent would have to pay for similar Connector coverage (i.e., Gold, Silver or Bronze) based on his or her age and geographic location. Because these dependents will be age 26 or less, this amount will usually be less than the plan's COBRA rate, which is a blended rate.

(4) *Definition of Dependent*

Under Code § 152, a "dependent" is either a "qualifying child" dependent or a "qualifying relative" dependent. A "qualifying child" is a child who lives with an employee for more than half a year, who is either under age 19 or is a full-time student under age 24, and who does not provide over half of his or her own support for the calendar year. A "qualifying relative" is an individual who bears a relationship to the taxpayer (including any child of the taxpayer who is not a "qualifying child," regardless of the child's age), whose gross income is less than the exemption amount ($3,400 in 2007), and who receives over one-half of his or her support from the taxpayer. But for purposes of the exclusion for employer-provided health

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[190] 1959-1 C.B. 237.
[191] PLR 200108010 (Nov. 17, 2000).

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coverage, the gross income limit does not apply a qualifying relative. It is therefore possible for an individual to be a dependent for group health plan purposes but not for the purposes of claiming a dependency exemption.[192]

An employee may exclude from gross income the value of employer-provided health insurance coverage for a child who, while not a "qualifying child," meets the definition of a "qualifying relative" determined without regard to the child's gross income. (In effect, many children who do not meet the age requirements of a "qualifying child" will meet the requirements of a "qualifying relative" where the income limitation is not applied). Thus, a child of an employee who exceeds the age to be a "qualifying child" can nevertheless still be a "qualifying relative" if the employee provides over half of the child's support for the calendar year. Special rules apply in the case of divorced parents, under which a child who meets the expanded definition of dependent in connection with one parent is treated as a dependent of both parents.

(5) *Massachusetts Income Tax*

According to M.G.L. c. 62, § 2(a), Massachusetts gross income is Federal gross income, with certain modifications. Generally, with respect to the personal income tax, Massachusetts adopts the Code as amended and in effect on January 1, 2005. G.L. c. 62, § 1. Thus, Massachusetts would ordinarily follow the Federal rules governing employer-provided health and accident premiums. Under the Act as most recently amended, however, for tax years beginning on or after January 1, 2007, amounts that would otherwise constitute imputed income by reason of dependent coverage provisions of the Act are not subject to tax for Massachusetts purposes.

(6) *Examples*

The appendix to Massachusetts Department of Revenue, TIR 07-16 contains the following, helpful examples:

> ***Example 1***. A child, age 25, who earns $10,000 receives over half of her support from her mother and is included in the mother's employer-provided health insurance coverage.
>
> The child is considered a dependent for purposes of the income exclusion for employer-provided health insurance coverage. Under IRS Notice 2004-79, the child is a "qualifying relative" because, (1) the child receives over half of her support from her mother, and (2) for purposes of the exclusion from gross income for employer-provided health insurance, the amount of the child's earnings is disregarded. As a result, there is no imputed income to the mother for federal or Massachusetts purposes.
>
> However, the mother is not allowed to claim either a federal or a Massachusetts dependency exemption for the child. The child is not a "qualifying child" because the child's age exceeds the maximum age. Also, the child is not a

[192] *See* IRS Notice 2004-79, 2004 C.B. 898 (clarifying that the annual income requirement does not apply).

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"qualifying relative" for purposes of the dependency exemption because the child's earnings exceed the exemption amount ($3,400 in 2007).

Example 2. A child of divorced parents, age 25, is a full-time student who lives with his mother. The father is a Massachusetts resident. The child is included in the father's employer-provided health insurance coverage. The child is supported by both his parents. Under the terms of the divorce agreement, the mother may claim the federal dependency exemption for him.

The child is considered a dependent for purposes of the income exclusion for employer-provided health insurance coverage. Under IRS Notice 2004-79, the child is a "qualifying relative" because the child is supported by his parents. For both federal and Massachusetts purposes, there is no imputed income to the father as a result of the employer-provided health insurance coverage of the child.

Because of the terms of the divorce agreement, the father does not take a dependency exemption for the child. However, the mother is entitled to take the federal dependency exemption for the child. The child is not a "qualifying child" because the child's age exceeds the maximum age. However, the child is a "qualifying relative" for purposes of the dependency exemption because the child has no earnings. If applicable, the mother is entitled to take the Massachusetts dependency exemption for the child.

Example 3. A child, age 25, who earns $30,000 does not live with the parent (and the parent does not otherwise provide over one-half of the child's support). As a result of the expanded coverage required by the Massachusetts health care reform law, the child is included in the parent's employer-provided health insurance coverage.

The employer's carrier is required to make coverage available for this child for two years after the end of the calendar year in which such person last qualified as a dependent under IRC § 106 or until the child reaches 26 years of age, whichever occurs first.

The child is not considered a dependent for purposes of the income exclusion for employer-provided health insurance coverage. The child does not come within the requirements of IRS Notice 2004-79 because the child does not receive over half of his or her support from the parent. Thus, for federal purposes, the value of health insurance coverage for the age-25 child will be imputed income to the employee. In contrast, under G.L. c. 62, § 2(a)(2)(Q), Massachusetts does not impose tax on this imputed income because the coverage is required by state law.

The parent is not allowed to claim a federal or Massachusetts dependency exemption for the child. The child is not a "qualifying child" because the child's age exceeds the maximum age; the child is not a "qualifying relative" because (1)

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the child does not receive over half of his or her support from the parent, and (2) the child's earnings exceed the exemption amount of $3,400 in 2007.

C. Small Group Insurance Requirements

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")[193] for the first time established nationwide health insurance "portability" requirements. In the parlance of HIPAA, "portability" refers generically to (i) "guaranteed issue" (with respect to small group health insurance products), (ii) "guaranteed renewability" (with respect to all insurance products), and (iii) reforms relating to pre-existing condition limitations, special enrollment rights, and health insurance non-discrimination requirements.

Guaranteed issue laws prohibit insurers from denying coverage to applicants based on health status. HIPAA requires that all small group policies be issued on a guaranteed-issue basis. "Guaranteed renewability" laws prohibit insurers from canceling coverage on the basis of medical claims or diagnosis of an illness. Under HIPAA, all group and individual health insurance policies must be guaranteed renewable. Insurers may cancel *all* their policies in a particular state and leave the market, but there is a penalty on market reentry of 5 years. While guaranteed issue and renewability requirements are imposed on insurance carriers (or "health insurance issuers" as they are referred to in HIPAA), HIPAA's other portability standards—i.e., pre-existing condition limitations, special enrollment rights, and health insurance non-discrimination requirements—are imposed both on insurers and group health plans. HIPAA's pre-existing condition requirements are subject to special rules under which state insurance laws may impose even stricter standards.

(1) *Guaranteed Issue/Renewability*

Under the Act all "small group policies" sold or offered for sale in the Commonwealth must be available to every "eligible small business," including non-group plans (i.e., those covering only self-employed individuals). An "eligible small business" means "any sole proprietorship, firm, corporation, partnership or association actively engaged in business with not more than fifty eligible employees, the majority of whom work in the Commonwealth." [194] Following the Act's merger of the small group and individual markets (see Section I.E above), policies must also be made available to "eligible individuals,"[195] i.e., individuals who are a residents of the Commonwealth).

Health benefit plans must generally be "renewable" with respect to all eligible persons and eligible dependents (i.e., dependents of eligible individuals) in accordance with the requirements of HIPAA. A carrier is not required to renew a health benefit plan if an eligible small business fails to pay premiums, or has committed fraud or misrepresentation in connection with the purchase of health insurance. In addition, a carrier is not required to renew an employee

[193] P.L. 104-191.
[194] *Id.*
[195] M.G.L. c. 176J, § 1.

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or dependent, or eligible individual if the individual has committed fraud, or misrepresented information necessary to determine eligibility or comply with material plan provisions.[196]

(2) *Pre-existing Conditions*

No policy may provide pre-existing condition provisions that exclude coverage for a period beyond 6 months following the individual's date of enrollment. The term "date of enrollment" in this context means the date on which the individual is enrolled for coverage, or, if earlier, the first day of any applicable waiting period. As a result, waiting periods reduce the periods during which pre-existing condition exclusions may be applied.[197]

No pre-existing condition exclusion may be imposed on Trade Act/HCTC-eligible persons. The federal Trade Act of 2002 provided trade adjustment assistance in the form of health coverage tax credits (HCTCs) that pay for private health insurance purchased by some workers who have been laid off and certain early retirees. "Trade Act/HCTC eligible persons" include persons who are eligible for assistance under the Trade Act.

Under the Act, a pre-existing condition limitation or exclusion is defined as:

> "a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to that information. Pregnancy shall not be a pre-existing condition."

Under HIPAA, a pre-existing condition limitation or exclusion is defined as:

> "a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period."

NOTE: The Massachusetts and Federal definitions of what constitutes a pre-existing condition are not consistent. Given the way the HIPAA interacts with Federal law, individuals covered under small group health insurance arrangements will, in effect, get the better of the two.

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[196] 211 C.M.R. 66.06.
[197] M.G.L. 176J, § 4(a)(3), as amended by Act § 83 and Technical Corrections Act § 48.

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Under HIPAA, when applying a pre-existing condition exclusion or limitation, health benefit plans must give individuals credit for their prior creditable coverage if the break in coverage is less than 63 days (exclusive of any applicable waiting periods). The term "creditable coverage" means coverage under most group health plans, Medicare Parts A or B, Indian tribal plans, state high risk pools, and any other coverage that would qualify as creditable coverage under HIPAA.[198]

(3) *Waiting Periods*

Waiting periods may not exceed 4 months measured from an eligible employee's or eligible dependent's "date of enrollment." The term "date of enrollment" is defined as the date the individual is enrolled by the carrier in the health benefit plan. Waiting periods are further limited as follows:[199]

(a) No waiting period may be imposed if an eligible individual, eligible employee or eligible dependent lacked creditable coverage for 18 months or more;

(b) When determining whether a waiting period applies, health benefit plans must give individuals credit for their prior creditable coverage if the break in coverage is less than 63 days, but only to the extent that the prior coverage was reasonably actuarially equivalent to the new coverage;

> **NOTE:** Whether the prior coverage is a reasonable actuarial equivalent of the new coverage is based on rate adjustment factors prescribed by the Massachusetts Division of Insurance.

(c) Emergency services must be covered during a waiting period;

> **NOTE:** Whether services are "emergency services" is measured using a subjective standard, i.e., whether "a prudent layperson who possesses an average knowledge of health and medicine" would reasonably seek "prompt medical attention."[200]

(d) No waiting period may be imposed on a Trade Act/HCTC-eligible individual.

(e) Under current regulations, waiting periods and pre-existing condition exclusions must run concurrently,[201] but, under a draft rule, this requirement has been changed to require that a carrier may impose either a waiting period or a pre-

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[198] M.G.L. c. 176J, § 1.
[199] M.G.L. c. 176J, § 5, as amended by Act § 84, and Technical Corrections Act § 43.
[200] M.G.L. c. 176N, § 1, as amended by Act § 96.
[201] 211 C.M.R. 66.07(7).

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existing condition exclusion, but not both. (The change appears to be a clarification. Both rules get to the same result, but the latter is easier to understand.)

(4) *Health Status Non-Discrimination*

Carriers may not exclude any employees or their dependent from a health benefit plan on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition.[202] Nor may a carrier modify the coverage through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. Pregnancy is not a pre-existing condition for this purpose, and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of a condition related to that information. These rules are in addition to the HIPAA rules barring discrimination on the basis of health factors, under which individuals may not be excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors.

See Appendix 1 for a side-by-side comparison of Federal and Massachusetts small group health insurance portability requirements.

D. Health Insurance Portability

The Act revises the Massachusetts health insurance portability rules by (i) expanding the definition of "emergency services" to include mental health emergencies, provide assistance to pregnant women, and adopt a "prudent layperson standard," (ii) excluding pregnancy as a pre-existing condition, (iii) extending the time an individual can be without coverage from 30 days to 63 days, and (iv) changing the maximum waiting period from 6 to 4 months.

(1) *Pre-existing conditions*

No preexisting conditions exclusion may be imposed for more than six months after the individual's date of enrollment. A preexisting conditions provision may only relate to conditions which had, during the 6 months immediately before the date of enrollment, "manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received." The period during which a pre-existing condition exclusion may be imposed is reduced by an individual's prior creditable coverage, provided that (i) there has not been a break in creditable coverage of 63 days or more before the effective date of the new coverage (exclusive of any applicable waiting periods), and (ii) the previous coverage was reasonably actuarially equivalent to the new coverage.[203]

(2) *Waiting periods*

No waiting period may be imposed for more than 4 months beyond the eligible insured's date of enrollment under the health plan, and no waiting period may be imposed on an eligible individual who has not had creditable coverage for the 18 months before his or her date of

[202] M.G.L. c. 176J, § 5(a), as amended by Act § 84 and Technical Corrections Act § 49.
[203] M.G.L. c. 176N, § 2, as amended by Act § 100 and Technical Corrections Act § 52.

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enrollment. If a health plan includes a waiting period, emergency services must be covered during the waiting period. For this purpose, the waiting period can only apply to services which the new plan covers, but which were not covered under the old plan. Also, a health plan must credit the time the person was covered under a previous qualifying health plan if the person experiences only a temporary interruption in coverage.[204]

V. CONCLUSION

The employer and insurance mandates under the Act are a part of a much larger whole, and much guidance remains to be issued. What is clear, however, is that the Act will require changes that are material if not substantial. Complicating matters is that many of the new requirements either are already in effect or become effective shortly.

The wild card, of course, is the possible impact of a challenge based on ERISA preemption. It makes no sense to ask whether the Act is "preempted," but it can legitimately be asked whether any particular provision of the Act is preempted. Given recent developments in Maryland involving that state's pay-or-play law, the Act's fair share requirements could be vulnerable.[205] As for other employer and insurance mandates, it is too soon to tell. No challenges have yet emerged, but that may change as employers get a better sense of what is required of them.

The political environment in Massachusetts presents another variable. The Act was a compromise between a Republican Governor and a Democratic legislature. With the executive branch now in Democratic hands, the Act may well be interpreted or amended in a manner that is less favorable to employers, which itself might invite challenge where one was not previously contemplated.

So the speakers at the Act's signing ceremony, though hardly prescient, were certainly correct: the Act is very much a work in progress.

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[204] *Id*.

[205] *See* notes 68 - 70, *supra*.

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APPENDIX 1 Side-by-Side Comparison of Federal and Massachusetts Small Group and Health Insurance Portability Requirements			
Item No.	**Health Insurance Portability and Accountability Act of 1996**	**Massachusetts Small Group Portability Requirements (M.G.L. c. 176J)**	**Massachusetts Health Insurance Portability Requirements (M.G.L. c. 176N)**
Preexisting Condition Exclusions			
1.	*Code §(b)(1); ERISA § 701(b)(1)* A "preexisting condition" is defined to mean a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date (which is the earlier of the first day of health coverage or the first day of any waiting period for coverage).	*M.G.L. c. 176J, § 1 (as amended by Act § 77 and Technical Corrections Act § 45)* Pre-existing condition means "a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date." Genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to that information. Pregnancy may not be treated as a preexisting condition. "Date of enrollment" means the date of enrollment of an individual in the plan or coverage or, if earlier, the first day of any waiting period. (see description of M.G.L. C. 176J, §§ 4(a)(3)and 5(b) below.	*M.G.L. c. 176N, § 2(b) (as amended by Act § 97)* "Pre-existing condition provisions may only relate to (1) conditions which had, during the six months immediately preceding the effective date of coverage, manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommend or received." **NOTE:** Under M.G.L. c. 176N, § 2(e), to the extent that Federal rule requires "more extensive coverage," the Federal rule applies. The "ordinary prudent person" standard under this provision does not appear in HIPAA. Therefore, it would appear that the Federal rule will apply.
2.	*Code § 9801(a)(2); ERISA § 701(b)(2)*	*M.G.L. c. 176J, §§ 4(a)(3)and 5(b) (as amended by Act § 83 and Technical Corrections Act §§ 43 and 48)* No pre-existing condition	*M.G.L. c. 176N, § 2(b) (as amended by Act § 97 and Technical Corrections Act § 52)*

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	Group health plans and issuers may not exclude an individual's preexisting medical condition from coverage for more than 12 months (18 months for late enrollees) after an individual's enrollment date	exclusion can be applied for more than 6 months (3 months in the case of a "trade act/health coverage tax credit eligible person) measured from the individual's "date of enrollment". "Date of enrollment" means the date of enrollment of an individual in the plan or coverage or, if earlier, the first day of any waiting period.	No pre-existing condition exclusion can be applied for more than 6 months (3 months in the case of a "trade act/health coverage tax credit eligible person) measured from the individual's "effective date of coverage".
3.	*Code § 9801(c); ERISA § 701(c)* A new employer's plan must give individuals credit for prior continuous health coverage, without a break in coverage of 63 days or more (thereby reducing or eliminating the 12-month pre-existing conditions exclusion period (18 months for late enrollees))	*M.G.L. c. 176J, §§ 4(a)(3)and 5(b) (as amended by Act § 83 and Technical Corrections Act § 48)* Carriers must offer coverage effective within 30 days to any eligible individuals if they request coverage within 63 days of the loss of their prior creditable coverage. If the 63 days have lapsed, carriers may impose a 6-month coverage exclusion for pre-existing conditions.	*M.G.L. c. 176N, § 2(b) (as Technical Corrections Act § 52)* No health plan may impose a preexisting condition provision for more then 6 months (12 months in the case of a "late enrollee") following the individual's date of enrollment. The pre-existing condition period must be reduced by the time a person was under a previous qualifying health plan if (i) the previous coverage was continuous to a date not more than 63 days before the effective date of the new coverage (exclusive of any applicable waiting period) and (ii) the previous qualifying health plan coverage was reasonably actuarially equivalent to the new coverage.
Creditable Coverage and Certificates of Creditable Coverage			
4.	*Code § 9801(c); ERISA § 701(c)* "Creditable coverage" includes prior coverage under another group health plan, an	M.G.L. c. 176J, §§ 1 (as amended by Act § 67) "Creditable coverage," includes coverage under private and public group	*M.G.L. c. 176N* The term "creditable coverage" is not separately defined for purposed of

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	individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan.	health plans (including Medicare) with no lapse of coverage of more than 63 days. It also includes any coverage that would be creditable for HIPAA purposes.	M.G.L. c. 176N.
5.	*Code § 9801(c); ERISA § 701(c)* Waiting periods are ignored for purposes of determining creditable coverage and breaks in creditable coverage.	*M.G.L. c. 176J, §§ 4(a)(3)and 5(c) (as amended by Act § 83 and Technical Corrections Act § 43)* No health plan may impose a waiting period of more than 4 months beyond the eligible insured's date of enrollment, provided that: (i) No waiting period may be imposed if an eligible employee lacks creditable coverage for 18 months or more; (ii) When determining whether a waiting period applies, health benefit plans must give individuals credit for their prior creditable coverage if the break in coverage is less than 63 days, but only to the extent that the prior coverage was reasonably actuarially equivalent to the new coverage; and (iii) Emergency services must be covered during a waiting period.	*M.G.L. c. 176N, §§ 2(c) and (d) (as Technical Corrections Act § 52)* No health plan may impose a waiting period of more than 4 months beyond the eligible insured's date of enrollment, provided that: (i) An eligible individual who has not had creditable coverage for the 18 months before the date of enrollment may not be subject to a waiting period: (ii) Emergency services shall be covered during the waiting period; (iii) The waiting period can only apply to services which the new plan covers, but which were not covered under the old plan; and (iv) A health plan must credit the time the person was covered under a previous qualifying health plan if the person experiences only in the event of a "temporary interruption in coverage" (which is not further defines).
6.	*Code § 9801(c)(2)(A); ERISA § 701(c)(2)(A)* Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer	M.G.L. c. 176J, §§ 4(c)(1) (as amended by Act § 83) Plans must comply with HIPAA.	*M.G.L. c. 176N* M.G.L. c. 176N contains no separate provision—HIPAA controls. Also, under M.G.L. c. 176N, § 2(e) plans must

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	when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA continuation coverage. A certificate must also be provided free of charge upon request while the individual has health coverage or anytime within 24 months after the individual's coverage ends.		comply with "any more extensive coverage" required by "any other provision of the General Laws or any law of the United States."
7.	*Code § 9801(e)(1); ERISA § 701(e)(1)* Certificates of creditable coverage should contain information about the length of time the individual or his or her dependents had coverage as well as the length of any waiting period for coverage that applied to the individual or his or her dependents.	M.G.L. c. 176J, §§ 4(c)(1) (as amended by Act § 83) Plans must comply with HIPAA.	*M.G.L. c. 176N* M.G.L. c. 176N contains no separate provision—HIPAA controls. Also, under M.G.L. c. 176N, § 2(e) plans must comply with "any more extensive coverage" required by "any other provision of the General Laws or any law of the United States."
8.	*Treas. Reg. § 549801-5(a)(3)(ii)(G); DOL Reg. § 2590.701(a)(3)(ii)(G)* For plan years beginning on or after July 1, 2005, certificates of creditable coverage should also include an educational statement that describes individuals' HIPAA portability rights.	*M.G.L. c. 176J, §§ 4(c)(1) (as amended by Act § 83)* Plans must comply with HIPAA.	M.G.L. c. 176N *M.G.L. c. 176N* contains no separate provision—HIPAA controls. Also, under M.G.L. c. 176N, § 2(e) plans must comply with "any more extensive coverage" required by "any other provision of the General Laws or any law of the United States."
Special Enrollment Rights			
9.	*Code § 9801(f)(1); ERISA§ 701(f)(1)* Special enrollment rights are provided: (i) For individuals who lose their coverage in certain situations, including on	*M.G.L. c. 176J, §§ 4(c)(1) (as amended by Act § 83)* Plans must comply with HIPAA.	*M.G.L. c. 176N* M.G.L. c. 176N contains no separate provision—HIPAA controls. Also, under M.G.L. c. 176N, § 2(e) plans must comply with "any more extensive coverage" required

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	separation, divorce, death, termination of employment and reduction in hours, and (ii) If employer contributions toward the other coverage terminates.		by "any other provision of the General Laws or any law of the United States."
10.	*Code § 9801(f)(2); ERISA§ 701(f)(2)* Special enrollment rights are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption.	*M.G.L. c. 176J, §§ 4(c)(1) (as amended by Act § 83)* Plans must comply with HIPAA.	*M.G.L. c. 176N* M.G.L. c. 176N contains no separate provision—HIPAA controls. Also, under M.G.L. c. 176N, § 2(e) plans must comply with "any more extensive coverage" required by "any other provision of the General Laws or any law of the United States."
		Guaranteed Issue	
11.	*Public Health Service Act §§ 2711 and 2712; 45 C.F.R. §§ 146.150(a) and 146.152(b)* Guaranteed issue and renewability of health insurance coverage for small groups and Guaranteed renewability of health insurance for large groups	*M.G.L. c. 176J, § 4(a)(1) (Act § 83 and Technical Corrections Act §§ 43 and 48)* (*See also 45 CFR §150.201* imposing on each state the requirement to enforce HIPAA requirements with respect to health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State.) Carrier must enroll any eligible small business or eligible individual (and their dependents) seeking to enroll in a health benefit plan, subject to regulations issued by the commissioner of insurance.	*M.G.L. c. 176N* M.G.L. c. 176N contains no separate provision—HIPAA controls.
		Health Status Non-Discrimination	
12.	*Treas. Reg. § 54.9802-1(a)(1);DOL Reg. § 2590-702(a)(1)*	*M.G.L. c. 176J, § 5(a) (as amended by Act § 84 and Technical Corrections Act § 49)*	*M.G.L. c. 176N, § 2(a)*

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	Individuals may not be excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors	Neither eligible individuals nor their dependents may be excluded from coverage on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition.	Neither eligible individuals nor their dependents may be excluded from coverage on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition of such person.

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Alden J. Bianchi is a Member in the Boston office of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., where he leads the employee benefits and executive compensation practice group.

Mr. Bianchi advises corporate, not-for-profit, governmental and individual clients on a broad range of executive compensation and employee benefits issues, including qualified and non-qualified retirement plans, stock and stock-based compensation arrangements, ERISA fiduciary and prohibited transaction issues, benefit-related aspects of mergers and acquisitions, and health and welfare plans. He represented the Romney administration in connection with the ground-breaking Massachusetts health care reform act, and he currently advises the Massachusetts Health Insurance Connector Authority, the state agency established to facilitate the purchase of affordable health insurance by individuals and small groups. He has testified before the Senate Finance Committee on the subject of health care reform, and is also currently advising a handful of other states with respect to health reform issues.

Mr. Bianchi has written and lectured extensively on employee benefits issues. He is the author of three books, *Employee Benefits for the Contingent Workforce* and *Plan Disqualification and ERISA Litigation* (both published by Tax Management, Inc.), and *Benefits Compliance* (published by World-at-Work), and dozens of benefits-related articles. His speaking engagements include presentations to the ALI-ABA, American Bar Association, American Insurance Group, Deloitte & Touche, PricewaterhouseCoopers, Smith Barney, UBS, ING Financial Services and the Risk Insurance Management Society, as well as a host of bar groups and professional, educational and civic organizations.

Mr. Bianchi is a graduate of Worcester Polytechnic Institute and the Suffolk and Georgetown Law Schools, and he holds an LL.M. in taxation from the Boston University Law School. He is listed in Woodward & White's *The Best Lawyers in America*, and Marquis' *Who's Who in American Law*, and he is a Fellow of the American College of Employee Benefits Counsel.

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