

# AN EMPLOYERS' GUIDE TO THE 2006 MASSACHUSETTS HEALTH CARE REFORM ACT

Alden J. Bianchi, Esq.



**MINTZ LEVIN**  
MINTZ LEVIN COHN FERRIS GLOVSKY AND POPEO PC

One Financial Center  
Boston, Massachusetts 02111

**UPDATED JULY 9, 2007**

Boston | Washington | New York | Stamford | Los Angeles | Palo Alto | San Diego | London

**WWW.MINTZ.COM**

## TABLE OF CONTENTS

	Page
<b>I. OVERVIEW OF THE ACT</b> .....	3
A. The Commonwealth Health Insurance Connector .....	4
(1) <i>Overview</i> .....	4
(2) <i>Access to the Connector</i> .....	7
B. The Commonwealth Care Health Insurance Program .....	9
(1) <i>Plan Type 1</i> .....	9
(2) <i>Plan Type 2</i> .....	9
(3) <i>Plan Types 3 and 4</i> .....	9
C. Medicaid/MassHealth .....	10
D. The Insurance Partnership .....	11
E. Commonwealth Choice .....	11
F. Insurance Reform .....	11
G. Free Care .....	13
H. Quality Programs and Transparency .....	13
<b>II. THE INDIVIDUAL MANDATE</b> .....	13
A. Premium Schedule and Rates .....	13
B. Creditable Coverage and Minimum Creditable Coverage .....	14
(1) <i>July 1, 2007 to December 31, 2008</i> .....	16
(2) <i>From and After January 1, 2009</i> .....	17
(3) <i>The Self-Funded Plan Conundrum</i> .....	18
C. Affordability .....	19
D. Enforcement .....	20
<b>III. EMPLOYER MANDATES</b> .....	20
A. The Fair Share Premium Contribution .....	20
(1) <i>The Primary Test</i> .....	21
(2) <i>The Secondary Test</i> .....	24
(3) <i>Special Rules for Leasing Companies</i> .....	25
(4) <i>Amount of the Fair Share Premium Contribution</i> .....	26
(5) <i>Enforcement</i> .....	26
B. The Free Rider Surcharge .....	27
C. The Health Insurance Responsibility Disclosure Form .....	32
D. The Cafeteria Plan Requirement .....	36
(1) <i>The Act's Cafeteria Plan Mandates</i> .....	36
(2) <i>Selected Cafeteria Plan Tax Issues</i> .....	37

(3)	<i>The June 5, 2007 Final Section 125 Cafeteria Plan Regulation</i>	38
<b>IV.</b>	<b>INSURANCE MANDATES AFFECTING EMPLOYERS</b>	43
A.	The Insured Plan Non-Discrimination Requirement	44
(1)	<i>Relationship to Federal Law</i>	44
(2)	<i>The Insurance Non-discrimination Requirement</i>	44
(3)	<i>Extraterritorial Effect</i>	46
B.	Expanded Dependent Coverage	48
(1)	<i>Definition of Dependent</i>	48
(2)	<i>Tax Treatment of Massachusetts “Dependents”</i>	49
(3)	COBRA	50
C.	Small Group Insurance Requirements	51
(1)	<i>Guaranteed Issue/Renewability</i>	51
(2)	<i>Pre-existing Conditions</i>	51
(3)	<i>Waiting Periods</i>	53
(4)	<i>Health Status Non-Discrimination</i>	53
D.	Health Insurance Portability	54
(1)	<i>Pre-existing conditions</i>	54
(2)	<i>Waiting periods</i>	54
<b>V.</b>	<b>CONCLUSION</b>	55

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

Alden J. Bianchi, Esq.\*

“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.”<sup>1</sup>

—Justice Louis D. Brandeis

This oft-quoted statement penned by Justice Brandeis in 1932 aptly describes the sweeping health care reform bill—Ch. 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 State’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.<sup>2</sup>

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. While the relief provided by these laws is welcome, it is not as generous as many employers had hoped.

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:

---

\* Alden J. Bianchi is a Member in the law firm of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., Boston, Massachusetts.

<sup>1</sup> *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932).

<sup>2</sup> *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 be amended).

	<b>Requirement</b>	<b>Statutory Provision</b>	<b>Massachusetts General Laws Chapter/Section</b>
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; Ch. 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; Ch. 450 § 7	c. 118G, §§ 6B, 6C
4.	The cafeteria plan requirement	Act § 48	c. 151F
5.	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
6.	Expanded coverage of dependents	Act §§ 53, 56 and 58  Technical Corrections Act §§ 33, 34	c. 175, § 108(2)(a) c. 175, § 110(P) c. 176A, § 8Z c.176B, § 4Z c. 176G, § 4R
7.	Small group insurance requirements re: waiting periods, creditable coverage, and pre-existing conditions	Act §§ 77, 82, 83, 84  Technical Corrections Act §§ 43 through 50	c.176J, §§ 1, 3, 4, 5
8.	Health Insurance Portability	Act § 96 through 100  Technical Corrections Act §52	c. 176N, §§ 1, 2

Of these requirements, only the first four 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<sup>3</sup> and the potential loss of some \$385 million in Federal Medicaid revenues unless the number of uninsured individuals was reduced,<sup>4</sup> 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” (a/k/a the “free care pool”), which was used to partially reimburse hospitals and health centers for these non-covered expenses. 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 incomes below 300% of the federal poverty level will receive sliding-scale premium assistance

---

<sup>3</sup> Commonwealth of Massachusetts Executive Department, *Press Release: Romney Signs Landmark Health Insurance Reform Bill* (Apr. 12, 2006).

<sup>4</sup> Commonwealth of Massachusetts Executive Department, *Press Release: Implementation of Health Care Law Proceeds* (May 1, 2006).

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.<sup>5</sup>

A. The Commonwealth Health Insurance Connector

Act § 101, which adds M.G.L. c. 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*

The Connector is “a body politic and corporate and a public instrumentality”<sup>6</sup> of the Commonwealth of Massachusetts. Its purpose is to furnish access by eligible individuals and eligible small groups to affordable health insurance products. An eligible small group is defined in M.G.L. c. 176Q, § 1 to mean 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. A board of ten members<sup>7</sup> 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.”<sup>8</sup>

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, individuals will become a member of the health plan they select. (See Section I.D below for a discussion of Commonwealth Choice.) The Connector has the power to appoint an agent or agents, which are referred to as “sub-connectors,” for this purpose.<sup>9</sup>

(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

---

<sup>5</sup> *Id.*

<sup>6</sup> Act § 101, adding M.G.L. c. 176Q. *See* M.G.L. c. 176Q, § 2(a).

<sup>7</sup> *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)).

<sup>8</sup> Act § 67 amending M.G.L. c. 176J.

<sup>9</sup> *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.

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, “Commonwealth Care),”<sup>10</sup> which subsidizes health insurance coverage for low-income individuals through the Connector. (see Section I.B below).

(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.<sup>11</sup> It is the Connector that establishes standards for 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 purchase insurance. This pooling approach should reduce 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. It this feature of the Connector that fosters health insurance portability by enabling the smooth transition of coverage from job to job, particularly in the small group market. 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.

---

<sup>10</sup> Act § 45, adding M.G.L. c. 118H.

<sup>11</sup> M.G.L. c. 176Q, § 3(a)(5).

Insurance products offered through the Connector are generally required to satisfy all applicable state licensing requirements and to include all health insurance coverage mandates.<sup>12</sup> 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”)<sup>13</sup> with alternative coverage. Young adult coverage must, at a minimum, provide:

“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.” (Emphasis added.)

On or about April 17, the Massachusetts Division of Insurance issued emergency regulation, 211 CMR 63.00 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 are not counted) of 5,000 in health benefit plans sold, issued, or delivered through the Connector.<sup>14</sup>

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).<sup>15</sup> 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.<sup>16</sup> 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).<sup>17</sup> In addition, common cost control techniques commonly used in the health insurance industry, including tiered provider networks and selective provider contracting, are also permitted as approved 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.

---

<sup>12</sup> See generally M.G.L. c. 175, 175A, 176B and 176G.

<sup>13</sup> Act § 90 adding M.G.L. c. 176J, § 10.

<sup>14</sup> 211 CMR 63.05(1) (proposed).

<sup>15</sup> *Id.*

<sup>16</sup> *Id.* at 63.05(1)(b).

<sup>17</sup> *Id.* at 63.05(2).

Carriers are not required to issue a young adult health benefit plan to an eligible young adult if 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 with a material health benefit plan provision, or (iv) voluntarily ceased coverage under the carrier's health benefit plan before the contract renewal date.<sup>18</sup>

The emergency regulations also provide standards governing renewability,<sup>19</sup> which generally track the renewability standards of state<sup>20</sup> and Federal law.<sup>21</sup> Similarly, the standards relating the treatment of pre-existing condition limitations and waiting periods largely mirror the Commonwealth's small group rules.<sup>22</sup> Rating standards are also prescribed.<sup>23</sup>

(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.”<sup>24</sup> M.G.L. c. 176Q, § 1 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 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 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

---

<sup>18</sup> *Id.*

<sup>19</sup> 211 CMR 63.06.

<sup>20</sup> *Infra*, Section IV.C (relating to the Act's small group insurance reform requirements).

<sup>21</sup> *Id.* (relating to the HIPAA Title I portability rules).

<sup>22</sup> *Id.* at 63.08.

<sup>23</sup> *Id.* at 63.07.

<sup>24</sup> Act § 101, adding M.G.L. c. 176Q. *See* M.G.L. c. 176Q, § 1 (defining the term “eligible individuals” and “eligible small groups”).

employees with income below 300% of the 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,<sup>25</sup> 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");

**NOTE:** SCHIP's are established under Title XXI of the Social Security Act, and they are jointly financed by the Federal and state governments but 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.

- (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.

**NOTE:** 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 their obligations under the individual mandate by reasons of their inability to access affordable coverage. So 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 under 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

---

<sup>25</sup> Act § 45, as amended by the Technical Corrections Act § 27.

the cash equivalent of its premium contribution.<sup>26</sup> Where the employer offers more than one plan, the cash equivalent of its premium is based on its most popular plan.<sup>27</sup>

## **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.<sup>28</sup> 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:

### *(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 including 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 Type 1, 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 the employer covers at least 20 per cent of the annual premium cost of a family health insurance plan or at least 33 per cent of an individual health insurance plan (this requirement may be waived in certain circumstances), and (iv) must not have accepted a

---

<sup>26</sup> M.G.L. c. 118H, § 4(b).

<sup>27</sup> *Id.*

<sup>28</sup> Act § 45, adding M.G.L. c. 118H.

financial incentive from an employer to decline the employer's subsidized health insurance plan.<sup>29</sup>

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.

On June 5, 2007, the Connector adopted a final rule governing eligibility for Commonwealth care and establishing an appeals process through which individuals denied access are entitled to an administrative hearing to contest the denial.<sup>30</sup>

### **C. Medicaid/MassHealth**

The Act makes substantial changes to the Massachusetts Medicaid program (a/k/a MassHealth). Among other things, the Act increase reimbursement rates to hospitals and physicians for providing care to MassHealth patients, expands enrollment, establishes community-based outreach programs, and restores certain previously eliminated MassHealth benefits, including dental and vision services, chiropractic and prosthetics. It also creates a 2-year pilot program for smoking cessation treatment for MassHealth enrollees.

Act § 122 preserves FY 2006 funding levels for 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.<sup>31</sup> Under the Act, MassHealth will now cover children in families earning up to 300% of the Federal Poverty Level,<sup>32</sup> 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.<sup>33</sup> Medicaid rate increases in the bill are made contingent upon providers meeting performance benchmarks, including in the area of reducing racial and ethnic disparities. The bill creates a study of a sustainable "community health outreach worker program"<sup>34</sup> 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

---

<sup>29</sup> M.G.L. c. 118H, § 3.

<sup>30</sup> 956 CMR 3.00 (Eligibility and Hearing Process for Commonwealth Care).

<sup>31</sup> Act §§ 122 and 123.

<sup>32</sup> Act § 132.

<sup>33</sup> Act § 3.

<sup>34</sup> Act § 110.

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, (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 provide 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 gross (pre-tax) annual family income that is less than a specified percentage of the Federal Poverty Limit (“FPL”).<sup>35</sup>

The Act 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 May 1, 2007, and coverage will commence July 1, 2007.

#### **F. Insurance Reform**

One of the Act’s more ambitious reforms is the merger of the non- and small-group health insurance markets, effective July 1, 2007. Of the two markets, the non-group market is by

---

<sup>35</sup> 72 Fed. Reg. No.15 (January 24, 2007) pp. 3147, 8.

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,<sup>36</sup> 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 Ch. 163 of the Acts of 2005 (“An Act Relative to Tax Laws”), Massachusetts personal income tax law was updated to include, among other things, favorable tax treatment of HSAs.<sup>37</sup> The recently enacted Tax Relief and Health Care Act of 2006<sup>38</sup> includes provisions designed to enhance HSAs. It removes the annual plan limitation on deductible HSA contributions, and permits, among other things, flexible spending account and health reimbursement account terminations to fund HSAs. In TIR 07-4, the Massachusetts Department of Revenue ruled that HSAA-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<sup>39</sup> 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.”<sup>40</sup> Any carrier offering young adult health plans must offer at least one product with outpatient prescription drug coverage. It may also impose reasonable co-payments, coinsurance and deductibles and other common cost control techniques (e.g., tiered provider networks and selective provider contracting).<sup>41</sup> Act § 127 imposes a moratorium on the creation of new health insurance mandated benefits through 2008.

---

<sup>36</sup> “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,” December 26, 2006.

<sup>37</sup> 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).

<sup>38</sup> H.R. 6111 (December 20, 2006).

<sup>39</sup> Adding M.G.L. ch 176J, § 10.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

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.<sup>42</sup> 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 are also 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 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”<sup>43</sup> 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**

---

<sup>42</sup> M.G.L. ch 118E, § 57.

<sup>43</sup> Act § 12 adding M.G.L. c. 111M; Technical Corrections Act § 16.

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.*” (Emphasis added).<sup>44</sup>

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.

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.<sup>45</sup> 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:

---

<sup>44</sup> *But see* Treas. Reg. § 54.9802-1(f) (limiting the extent to which premiums may vary based on tobacco usage).

<sup>45</sup> Treas. Reg. § 54.9802-1(c)(1)(i).

- (1) Obtained a property tax exemption in real property located in Massachusetts;<sup>46</sup>
- (2) Filed a Massachusetts resident income tax return;
- (3) Obtained a Massachusetts rental deduction;<sup>47</sup> 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;
- (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 Part B;

---

<sup>46</sup> M.G.L. c. 59, §§ 5, 5C.

<sup>47</sup> M.G.L. c. 62, § 3(a)(9).

- (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 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 issue a final<sup>48</sup> 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.<sup>49</sup> 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

---

<sup>48</sup> 956 CMR 5.00, Minimum Creditable Coverage

<sup>49</sup> *Id.* at 5.03(1).

welfare benefit plan” providing medical, surgical or hospital benefits, as that term is defined in 29 U.S.C. section 1002.”<sup>50</sup>

Thus, fully-insured plans 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).

(2) *From and After January 1, 2009*

Beginning January 1, 2009, only those “Health Benefit Plans” that meet certain requirements will constitute “minimum creditable coverage.” These requirements include:<sup>51</sup>

- 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 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.

---

<sup>50</sup> *Id.* at 5.02 (definition of “Health Benefit Plan”).

<sup>51</sup> *Id.* at 5.03(2).

- 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) 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 proposed regulation also sets out a list of items that do not rise to the level of minimum creditable coverage. This list includes 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; automobile medical payment insurance; among others.

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 Part's A and B (but not, apparently, a Medicare HMO), Medicaid, are deemed to provide creditable coverage, as are plans covering young persons under the Act's provisions for "Young Adult Plans."<sup>52</sup>

**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 Employee Retirement Income Security Act of 1974<sup>53</sup> ("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. In issue is whether the individual mandate constitutes an indirect requirement that "relates to" an ERISA plan.

---

<sup>52</sup> MGL c. 176J, § 10.

<sup>53</sup> Pub. L. 93-406.

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, it says that coverage that is “creditable coverage” can be applied to reduce pre-existing condition exclusions.

### **C. Affordability**

On April 11, 2007, the Connector issued a release entitled “Affordability Standards Recommended to the Connector Board,” which recommends baseline “affordability” requirements. These requirements are important because individuals without access to affordable coverage are not subject to the individual mandate. According to the release, the income threshold for an individual who receives a full subsidy and does not have to pay monthly premiums for the Commonwealth Care health insurance program would increase from 100 percent of the federal poverty level (\$10,210) to 150 percent (\$15,315), and, for those earning between 151 and 200 percent of the federal poverty level (\$20,420), the monthly premiums for Commonwealth Care would be reduced from \$40 to \$35. For those earning more than the Commonwealth Care income threshold (individuals earning more than \$30,630 and a family of four earning more than \$61,950), a progressive sliding scale of affordability would be established.

The release contains the following example of what monthly premiums are deemed affordable: A single individual earning under \$15,315 who is not eligible for Commonwealth Care because he or she is eligible for employer-sponsored insurance would not be penalized for passing up the employer-sponsored insurance offer unless it were free. At the other end of the income scale, a single individual earning between \$40,001 and \$50,000 would not be penalized for passing up the offer if the monthly premium were more than \$300.

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,<sup>54</sup> which, among other things, establishes a formal process for determining affordability. Under the final rule, the Connector board must vote annually, not later than June 1st 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 is also included. Individuals who demonstrate that no Connector health plans are affordable for them may seek a certificate that the penalty should not be assessed.

---

<sup>54</sup> 956 CMR 6.00 (Determining Affordability for the Individual Mandate).

## **D. Enforcement**

The Commonwealth of Massachusetts Department of Revenue will enforce 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. Toward this end, the Act establishes a sliding "affordability scale." In addition, individuals will have appeal rights to dispute a determination that the mandate applies or that he or she can access affordable coverage.

## **III. EMPLOYER MANDATES**

The Act imposes the following employer mandates:

### **A. The Fair Share Premium Contribution**

Because of constraints imposed by Federal law,<sup>55</sup> 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.<sup>56</sup> 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<sup>57</sup>—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 establish a "fair share" premium contribution requirement under which employers with 11 or more full-time equivalent employees in the Commonwealth must either:

---

<sup>55</sup> 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).

<sup>56</sup> *New York Conference of Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

<sup>57</sup> *Cf.*, *Retail Industry Leaders Association v. James D. Fielder, Jr.*, Maryland Secretary of Labor, Licensing, and Regulation, No. 06-316 (D. Md. July 19, 2006), *aff'd*, 2007 U.S. App. LEXIS 920 (4<sup>th</sup> cir. 2007) (holding that the pay-or-play mandate adopted by the State of Maryland was preempted by ERISA).

- (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<sup>58</sup> an “Annual Fair Share Employer Contribution” not to exceed \$295 per Full-Time Equivalent (“FTE”) employee.<sup>59</sup>

A final regulation issued September 8, 2006<sup>60</sup> provides guidance on what constitutes a Fair and Reasonable Premium Contribution on the part of an employer, and on 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 full-time equivalent status based on a 2,000 hour year.<sup>61</sup>

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, . . .”<sup>62</sup> 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 foreign corporations, among others, which have or had “one or more individuals performing services for him or it within the Commonwealth of Massachusetts.”<sup>63</sup> 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*

Under the primary test,<sup>64</sup> an employer is deemed to make a Fair and Reasonable Premium Contribution if 25% or more of its Full-Time Massachusetts employees 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

---

<sup>58</sup> 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.

<sup>59</sup> Act § 47.

<sup>60</sup> 114.5 CMR 16.00 Determination of Employer Fair Share Contribution (September 8, 2006).

<sup>61</sup> Act § 47 (adding new M.G.L. c. 188).

<sup>62</sup> 114.5 CMR § 16.02 (definition of “Employer”).

<sup>63</sup> *Id.* (definition of “Employing Unit”).

<sup>64</sup> 114.5 CMR § 16.03(1)(a).

plan” is defined with reference to Code § 5000(b)(1)<sup>65</sup> that provides medical care,<sup>66</sup> 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.<sup>67</sup> 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.<sup>68</sup> 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:

- (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,<sup>69</sup> and it differs slightly

---

<sup>65</sup> 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”).

<sup>66</sup> Code §§ 213(d)(1)(A) and (B).

<sup>67</sup> 114.5 CMR § 16.03(1)(a), 1.b.

<sup>68</sup> Act § 12 adding M.G.L. c. 111M, § 3.

<sup>69</sup> 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”).

from the test set out in M.G.L. c. 149, § 148 relating to determinations of independent contractor status for workers compensation purposes.<sup>70</sup>

*Seasonal Employees.* The term “seasonal employee” is defined with reference to M.G.L. c. 151A, § 1(bb) to mean 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 a 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.<sup>71</sup>

To demonstrate compliance with the primary test, the percentage of Enrolled Employees is calculated by dividing (i) the total payroll hours of Full-Time Enrolled 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 both part time and full time 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% times 124,800).

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

---

<sup>70</sup> Massachusetts Attorney General Advisory 2004-2 (relating to amendments to Massachusetts independent contractor law).

<sup>71</sup> 114.5 CMR § 16.02 (definition of Seasonal Employee).

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.<sup>72</sup> 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.

The fair share premium contribution requirement is tested at the level of the employer, or at the level of the client company in the case of employees retained through “Employee Leasing Companies” (discussed below). This rule does not fit well in the context of Taft-Hartley and other multiple-employer plans, which do not operate at the employer level. And, in contrast to the free rider surcharge (*see* Section III.B) and the insured plan nondiscrimination rules (*see* Section IV.A), the fair share premium requirement does not have an exception for employees covered by a collective bargaining agreement.

**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 all 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.

## (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.”<sup>73</sup> Unlike the primary test, the secondary test is not based on “take-up” but is rather based on the amount the employer contributes 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.

---

<sup>72</sup> Adding new M.G.L. c. 111M, § 12.

<sup>73</sup> 114.5 CMR § 16.03(1)(b).

Because the definition of Full-Time employee is set out under the primary test, it is 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, have 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.) The 90-day requirement appears to refer to non-contiguous business days. For now, any reasonable, good faith interpretation should satisfy this standard.

Although employers must generally wait until the end of the year, i.e., September 30, in order to perform these tests, they need to begin immediately to collect the necessary data if they plan on passing the primary test.

### (3) *Special Rules for Leasing Companies*

The final regulations also contain special rules for Employee Leasing Companies.<sup>74</sup> The final regulation defines the term "Employee Leasing Company" 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."<sup>75</sup>

The term "Client Company" is defined to mean 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.)

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 clarified that Employee Leasing Companies will be required to perform the fair share contribution tests separately for each client company, but the client company is responsible for any fair share contribution liability. What is not entirely clear is whether these rules apply irrespective of whether the leasing company is a staffing company (whose employees are more likely to be employees of the leasing company) or a Professional Employer Organization (or "PEO") (who, despite claims of "co-employment" for many purposes, are almost certainly the employees of the client company for tax and benefits purposes). The reference to "co-employment" tends to indicate that the rule is intended to apply only to PEOs, and we understand this to be the informal position of the DHCFP.

---

<sup>74</sup> 114.5 CMR § 16.03(2)(a).

<sup>75</sup> 114.5 CMR § 16.02.

(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.<sup>76</sup> Specifically, under 114.5 CMR 16.04, the annual contribution is the lower 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,<sup>77</sup> 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. In Act § 47,<sup>78</sup> the Legislature assigned 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 Department of Labor, but that delegation was revoked in Technical Corrections Act § 29 and placed instead in the hands the Director of Workforce Development, in consultation with the Director of Unemployment Assistance (“DUA”).

On or about April 20, 2007, the Division of Unemployment Assistance issued a proposed regulation, 430 CMR 15.00, governing the collection and payment of fair share employer contributions. 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 proposed regulation generally (though not in all cases, as discussed below) tracts the definitions under the DHCFP’s final fair share premium regulations. Following a May 27, 2007 public hearing, DUA reissued 430 CMR 15.00 again in draft form.

The scope of the draft rule is expansive, perhaps to the point of exceeding the DUA’s statutory mandate. Under 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) 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,

---

<sup>76</sup> Act § 47, and amended by Technical Corrections Act § 30.

<sup>77</sup> Act § 47 adding M.G.L. c. 149, § 188(c).

<sup>78</sup> Adding M.G.L. c. 149, § 188.

in turn, determined by the DHC FP, and not DUA.<sup>79</sup> Presumably, this is intended to permit DUA to issue reporting rules under which employer must establish their status as a contributing employer. So long as its net effect is to impose liability in a manner consistent with the DHC FP rules governing which employers are and which are not contributing and non-contributing employers, the apparent expansiveness of this provision should not be a problem.

Under 430 CMR 15.04, an employers with eleven or more full-time equivalent employees in the Commonwealth is liable for the fair share employer contribution if it is: (i) a non-contributing employer or (ii) a contributing employer who meets the requirements of 114.5 CMR 16.03(1)(b) (i.e., the secondary test) “but does not meet the provisions of 430 CMR 15.05 (5).” 430 CMR 15.05 (5), in turn, requires that the employer 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.” But the rule goes to require that the “health care plan must be in effect and available to those full time employees for all 12 months of [an initial or subsequent measuring period].” This latter requirement appears to be aimed at clarifying an ambiguity in the DHC FP rule.

430 CMR is 15.05 also furnishes rules for determining whether and employer has eleven or more full-time equivalent employees in the Commonwealth. Full-time, for this purpose means 2,000 payroll hours during an initial “base period” (October 1, 2006 to September 30, 2007) or any subsequent base period (October 1 of each year to September 30th of the following year).

The balance of the proposed DUA regulation establishes rules governing the timing of payments. Employers are generally permitted to make contributions annually (on November 15), semi-annually (on November 15 and May 15), or quarterly (on November 15, February 15, May 15, and August 15).<sup>80</sup> Delinquent payments bear interest at 12% per annum, and DUA can refer employers who attempt to evade the rules to the Massachusetts attorney general.<sup>81</sup> There are also appellate rights.

The DUA draft regulation includes special rules for “employee leasing companies,” which do not appear to match the DHC FP final rule. Specifically, the regulation’s definition of “client company” does not contain a reference to “co-employment,” as a result of which the special leasing company rule under the DUA proposed regulation would likely to 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.

## **B. The Free Rider Surcharge**

Act § 44, as amended by Technical Corrections Act §§ 22 and 57, imposes on “Non-Providing Employers”<sup>82</sup> 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)

---

<sup>79</sup> M.G.L. c. 149, § 188(a).

<sup>80</sup> 430 CMR 15.07(4) (proposed).

<sup>81</sup> 430 CMR 15.08 (proposed)

<sup>82</sup> M.G.L. c. 118G, § 1, *see also* 114.5 CMR 17.03(2) and 17.04.

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 is July 1, 2007.

On December 22, 2006, the DHC FP issued a final regulation implementing the free rider surcharge.<sup>83</sup> The final regulation was later withdrawn, however, following the adoption of a technical correction.<sup>84</sup> On June 20, 2007, DHC FP 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.<sup>85</sup> (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, takes effect 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.”<sup>86</sup>

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<sup>87</sup> incurred in a designated measuring period by its employees (whether or not Massachusetts residents employed at Massachusetts locations for at least one month) or their dependents that 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.<sup>88</sup>

**NOTE:** Curiously, under the emergency regulation, an employer is a Non-Providing Employer if, among other things, it is not “in compliance with the

---

<sup>83</sup> 114.5 C.M.R. 17.00 et seq. (December 22, 2006).

<sup>84</sup> DHC FP Bulletin, January 19, 2007.

<sup>85</sup> M.G.L. c. 151F § 2.

<sup>86</sup> 114.5 CMR 17.03(2).

<sup>87</sup> 114.5 CMR 17.03(1)(c).

<sup>88</sup> 114.5 CMR 17.03(4).

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., that 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,<sup>89</sup> which is the successor to the state’s Uncompensated Care Pool Trust Fund.<sup>90</sup> 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.<sup>91</sup>

(b) State-Funded Employees

A “State-Funded Employee” is defined in 114.5 CMR 17.03(3) to mean 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.<sup>92</sup> The period for measuring full time equivalent status is the fiscal period beginning October 1 and ending September 30 (the “determination period”),<sup>93</sup> 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.<sup>94</sup> 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,

---

<sup>89</sup> M.G.L. c. 118E, 57.

<sup>90</sup> M.G.L. c. 118G, § 18.

<sup>91</sup> 114.5 CMR 17.03(4).

<sup>92</sup> 114.5 CMR 17.03(2).

<sup>93</sup> See 114.5 CMR 17.02.

<sup>94</sup> 114.5 CMR 17.03(2)(a)(1).

regular, vacation, sick, FMLA, short term disability, long term disability, overtime and holiday hours. Payroll hours of independent contractors are not counted.

To these general rules are 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”<sup>95</sup> or (ii) participates in the Massachusetts Insurance Partnership<sup>96</sup> (see Section I.D above). There is also a special rule that applies to “Employee Leasing Company” arrangements, under which it is the “Client Company” that is the employer for purposes the surcharge with respect to itself and its employees covered by the arrangement.<sup>97</sup> For this purpose, an “Employee Leasing Company” is defined 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.”<sup>98</sup>

114.5 CMR 17.02 defined 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.”<sup>99</sup> 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:<sup>100</sup>

- 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.

---

<sup>95</sup> 114.5 CMR 17.03(2)(c).

<sup>96</sup> M.G.L. c. 118E, § 9C.

<sup>97</sup> 114.5 CMR 17.03(2)(d).

<sup>98</sup> 114.5 CMR 17.02.

<sup>99</sup> *Id.*

<sup>100</sup> 114.5 CMR 17.04.

Under the emergency regulation, the percentage of state-funded costs assessed based on the following categories<sup>101</sup> 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:<sup>102</sup>

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.”<sup>103</sup>

**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 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

<sup>101</sup> 114.5 17.02.

<sup>102</sup> 114.5 CMR 17.04(4).

<sup>103</sup> 114.5 CMR 16.02.

The DHCFP will notify employers subject to surcharge at the end of each Fiscal Year.<sup>104</sup> 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.”<sup>105</sup> 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 per cent and late fees or penalties at a rate not to exceed 5 per cent 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.<sup>106</sup>

### **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. The HIRD requirements become effective July 1, 2007.<sup>107</sup> On December 29, 2006, DHCFP issued an emergency regulation providing guidance on the implementation of the HIRD form requirements, but, in a bulletin issued on or about January 19, 2007, DHCFP withdrew the emergency regulation following the enactment of Ch. 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.<sup>108</sup> 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.<sup>109</sup> 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 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 contractor” is defined (narrowly) with reference to M.G.L. c. 151A, § 2 (see the discussion above in Section III.A).

---

<sup>104</sup> 114.5 CMR 17.05.

<sup>105</sup> 114.5 CMR 17.05(2).

<sup>106</sup> 114.5 CMR 17.05.

<sup>107</sup> Ch. 450, § 7 (the HIRD requirement effective date prior to amendment was January 1 2007).

<sup>108</sup> 114.5 CMR 18.03(1).

<sup>109</sup> *Id.*

(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 administrative bulletin. Newly established employers must register with the DHC FP at the same time that they register with the Division of Unemployment Assistance.<sup>110</sup>

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;
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.

**NOTE:** The Division of Unemployment Assistance has indicated that it will incorporate the employer HIRD form reporting requirement into its filing rules under the fair share premium requirements (see Section III.A above), and that it will share the employers’ responses with DHC FP. According to an announcement

---

<sup>110</sup> 114.5 CMR 18.03(1)(b).

on the DUA website, this will relieve “the employer of the requirement to submit a separate report to [DHC FP].”<sup>111</sup>

(3) *Special Leasing Company Rule*

The emergency HIRD form rule contains special provisions that apply to “Employee Leasing Company” arrangements.<sup>112</sup> 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.<sup>113</sup>

(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.<sup>114</sup> These employees must sign an Employee HIRD Form and return it to the employer. If an employee fails to comply with the employer’s request to return the signed form, the employer

---

<sup>111</sup> Labor and Workforce Development Employer HIRD Reporting, [http://www.mass.gov/?pageID=dldwterminal&L=3&L0=Home&L1=Employers&L2=Understanding+Fair+Share+Contribution+\(FSC\)&sid=Edwd&b=terminalcontent&f=employers\\_revenueService\\_fscEmployerHirdRpt&csid=Edwd](http://www.mass.gov/?pageID=dldwterminal&L=3&L0=Home&L1=Employers&L2=Understanding+Fair+Share+Contribution+(FSC)&sid=Edwd&b=terminalcontent&f=employers_revenueService_fscEmployerHirdRpt&csid=Edwd), (cite last visited July 3, 2007).

<sup>112</sup> 114.5 CMR 18.03(1)(d).

<sup>113</sup> *Id.*

<sup>114</sup> 114.5 CMR 18.04.

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:<sup>115</sup>

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 acknowledgement that:<sup>116</sup>

- 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 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.

---

<sup>115</sup> 114.5 CMR 18.04(1)(a).

<sup>116</sup> 114.5 CMR 18.04(1)(b).

Employers must retain, and make available to the DHCFP on request, signed HIRD Forms for a period of three years.<sup>117</sup> 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 employers 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.<sup>118</sup> The Connector has issued a model HIRD form which is available on its web site.<sup>119</sup>

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.<sup>120</sup>

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. In the case of newly hired employees, then 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 enrollment period.

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.<sup>121</sup>

#### **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*

---

<sup>117</sup> 114.5 CMR 18.04(3).

<sup>118</sup> 114.5 CMR 18.04(3).

<sup>119</sup>

Commonwealth Connector, <http://www.mahealthconnector.org/portal/site/connector/menuitem.26c01aac2120f4ce505da95c0ce08041>, (cite last visited July 3, 2007).

<sup>120</sup> 114.5 CMR 18.04(5).

<sup>121</sup> 114.5 CMR 18.05(2).

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 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.” 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.<sup>122</sup> 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.

## (2) *Selected Cafeteria Plan Tax Issues*

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<sup>123</sup> 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

---

<sup>122</sup> Technical Corrections Act § 57.

<sup>123</sup> See discussion of interaction of the Federal and Massachusetts income rules in Section I.D above.

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.

Based on prior IRS guidance, it appears that the cafeteria plan requirement will achieve the desired Federal tax result even where coverage is provided through the Connector. In this regard, the Act makes clear that an employer may “designate” the Connector as its group health plan. But given the structure of applicable Code provisions, this is not required.

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

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.<sup>124</sup> 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.<sup>125</sup> 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.<sup>126</sup> Multi-state employers need only count Massachusetts payroll hours.<sup>127</sup> 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.

---

<sup>124</sup> 956 CMR 4.00, § 4.06(2).

<sup>125</sup> Administrative Information Bulletin 02-07: Guidance Regarding M.G.L. c. 151F, as implemented by 956 CMR 4.00 June 29, 2007 at 1.

<sup>126</sup> Id. at § 4.06(2)(a).

<sup>127</sup> Id. at 4.06(2)(c).

The cafeteria plan requirement does not apply to multiemployer health benefit plans.<sup>128</sup> 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.”<sup>129</sup>

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,<sup>130</sup> 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.<sup>131</sup> The requirement that the employer may 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.<sup>132</sup>

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 April 1, 2006 and ending March 31, 2007. Employer 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 October 1 and ending 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.

(a) Cafeteria Plan Adoption and Maintenance

---

<sup>128</sup> 956 CMR 4.07(3)(b)(4)(f)

<sup>129</sup> *Id.* at 4.02.

<sup>130</sup> 114.5 CMR 17.03(2)(c).

<sup>131</sup> *Id.* at 4.06(2)(e).

<sup>132</sup> *Id.*

The regulation requires each 151F Employer to adopt and maintain a 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:<sup>133</sup>

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.

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

---

<sup>133</sup> *Id.* at § 4.07(2).

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 both the to tax rules relating to mid-year election changes<sup>134</sup> and to 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.<sup>135</sup> In an effort to reduce administrative burdens, an employer could require 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:<sup>136</sup>

- 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 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.

---

<sup>134</sup> Treas. Reg. § 1.125-4.

<sup>135</sup> Treas. Reg. § 1.125-4(c)(4) (Example 8).

<sup>136</sup> Id. at § 4.07(3)(b)(4).

- Employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, section 152A) and who earn, on average, less than \$400 in monthly payroll wages (in 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; and
- 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.

(b) The Filing Requirement

151F Employers are generally 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 is 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.”<sup>137</sup> 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. Employers are, however, required to furnish a copy of their section 125 plan upon the Connector’s request.

**NOTE:** It is anticipated that the Legislature will adopt a technical correction to the Act dispensing with the filing requirement altogether. The delay in the filing requirement gives the Legislature the time it needs to act.

(c) Waiting Periods

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 the 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

---

<sup>137</sup> Id. at § 4.08.

as payroll, direction and control of workers, and the right to hire and fire workers.”<sup>138</sup> 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 to mean an entity “that is a co-Employer of workers provided by an Employee Leasing Company pursuant to a contract.”<sup>139</sup> 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 retains subject to the free rider surcharge.<sup>140</sup>

#### (d) 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 must take the cost of coverage into income and claim a deduction under Code § 162(I).<sup>141</sup> 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.

### 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

---

<sup>138</sup> Id. at § 4.05 (definition of “Employee Leasing Company”).

<sup>139</sup> Id. at § 4.05 (definition of “Client Company”).

<sup>140</sup> Id. at § 4.06(2)(d).

<sup>141</sup> Rev. Rul 91-26, 1991-1 C.B. 184.

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 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<sup>142</sup> 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”),<sup>143</sup> 52 (relating to non-profit hospital service corporations, *i.e.*, Blue Cross),<sup>144</sup> 55 (relating to medical service corporations, *i.e.*, Blue Shield),<sup>145</sup> and 59 (health maintenance organizations)<sup>146</sup> 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

---

<sup>142</sup> P.L. 101-140, §202(a).

<sup>143</sup> Act § 50, adding M.G.L. c. 175, s. 110(O).

<sup>144</sup> Act § 52, adding s. 8 ½ to M.G.L. c. 176A.

<sup>145</sup> Act § 55, adding s. 3B to M.G.L. c. 176B.

<sup>146</sup> Act § 59, adding s. 6A to M.G.L. c. 176G.

- 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 35 or more hour 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 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 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.

- (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 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 contain 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 occurs. The leading case in support of this proposition is *Boseman v. Connecticut General Life*

*Ins. Co.*,<sup>147</sup> 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.<sup>148</sup> This basic rule can, however, be altered by statute, in which the law is referred to as having "extraterritorial" effect.<sup>149</sup> Certain Massachusetts benefits mandates, for example, follow the general rule (i.e., they are not applied extraterritorially), while other follow the exception.<sup>150</sup>

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 foreign jurisdiction to which is the nominal policyholder. Thus, the law of the 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 requirement. Example 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 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

---

<sup>147</sup> 301 U.S. 196 (1973).

<sup>148</sup> *See also*, *Bynum v. Prudential Insurance Company*, 77 F. Supp. 56 (D.C. S.C 1948) (holding that the certificate issued to an employee is not the contract 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. Mutual of New York*, 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).

<sup>149</sup> *See, e.g.*, *Caspersen v. Academy Life Inc. Co. of Denver*, (Tenn. Ct. Appeals) 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).

<sup>150</sup> *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).

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.

## **B. Expanded Dependent Coverage**

Technical Corrections Act § 34 (relating to general and blanket policies of insurance),<sup>151</sup> Act § 53 (relating to non-profit hospital services, i.e., Blue Cross/Blue Shield hospital payments),<sup>152</sup> Act § 56 (relating to medical service corporations, i.e., Blue Cross/Blue Shield physician payments),<sup>153</sup> and Act § 58 (health maintenance organizations),<sup>154</sup> each require that carriers with insured health benefit plans that provide for dependent coverage to make dependent coverage available through the earlier of their 26<sup>th</sup> 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.<sup>155</sup>

**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.”<sup>156</sup>

In Bulletin 2007-1,<sup>157</sup> the Massachusetts Division of Insurance clarified the new Act’s 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.

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,<sup>158</sup> 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 spouses’ or ex-spouses’ federal income tax return as permitted by federal tax rules). Dependent status is determined on the basis of a calendar year, and 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.

### (1) *Definition of Dependent*

---

<sup>151</sup> Adding § 110(p) to M.G.L. c. 175.

<sup>152</sup> Act § 53, adding s. 8Z to M.G.L. c. 176A.

<sup>153</sup> Act § 56 adding s. 4Z to M.G.L. c. 176B.

<sup>154</sup> Act § 58 adding s. 4R to M.G.L. c. 176G.

<sup>155</sup> Technical Corrections Act § 34.

<sup>156</sup> 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 . . .”).

<sup>157</sup> January 18, 2007.

<sup>158</sup> Code § 151(b).

Code § 152 defines a “dependent” as either a “qualifying child” or a “qualifying relative.”

*Qualifying Child.* A “qualifying child” for any taxable year is someone (i) who is the taxpayer’s child, sibling or step-sibling, or a descendant of any such relative; (ii) who has the same principal place of abode as the taxpayer for more than one-half of the taxable year; (iii) who is younger than 19 as of the close of the year, or is a student younger than 24 as of the close of the year (no age limit for someone who is disabled); and (iv) who has provided one-half or less of his or her own support for the year.

*Qualifying Relative.* A “qualifying relative” for a taxable year is someone (i) who is the taxpayer’s child (or descendant of a child), sibling or step-sibling, parent (or ancestor of either parent), step-mother or step-father, niece, nephew, uncle, aunt, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law or any other individual who has the same principal place of abode as the taxpayer for the year and was a member of the taxpayer’s household; (ii) who receives from the taxpayer more than one-half of his or her individual support for the year; (iii) who is not a qualifying child of the taxpayer (or any other taxpayer) for the year; and (iv) who has gross income for the year that is less than the dependent exemption amount listed in Tax Code § 151(d) (\$3,400 in 2007)<sup>159</sup> (this latter requirement is not applied to the deductions and exclusions under the provisions of the Code that regulate group health plan coverage.)

Of course, there is no requirement that health insurance carriers extend coverage to all Federal income tax dependents, and most do not. Bulletin 2007-1 makes clear that carriers may impose limitations based on familial relationships (e.g., spouse and children, or spouse, children and parents).

(2) *Tax Treatment of Massachusetts “Dependents”  
who are not Federal Dependents*

Once an individual “ages out,” though he or she may retain dependent status for Massachusetts insurance purposes, he or she is no longer a dependent for Federal income tax purposes. Under 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.”<sup>160</sup> Under Treas. Reg. § 1.61-21(b)(1), the employee must include in gross income the fair market value of the benefit in income. Therefore, the fair market value of health insurance coverage provided to a Massachusetts dependent that is not a dependent for Federal income tax purposes is taxable income to the employee.

---

<sup>159</sup> Rev. Proc. 2006-53, § 3.18(1), 2006-48 I.R.B. 996 (November 9, 2006).

<sup>160</sup> See also Treas. Reg. § 1.61-21(a)(4)(i) (providing that 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”).

But what exactly is the fair market value of the group coverage provided to Massachusetts dependent that is not a dependent for Federal income tax purposes? The long-recognized standard for establishing “fair market value” for tax purposes is set out in Rev. Rul. 59-60, 400,<sup>161</sup> 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.<sup>162</sup> Service personnel have also endorsed this position in informal remarks at industry conferences and other forums, but only after making clear that their remarks reflected their own views and did not bind the IRS or any other agency of government.

There is, however, another plausible measure: Under an earlier ruling, the IRS determined that the fair market value of the benefit health insurance provided to a non-dependent domestic partner was the value “of such coverage determined, under principles set forth in section 1.61-21(b)(2) of the regulations, on the basis of the amount that an individual would have to pay for the particular coverage in an arm’s-length transaction (i.e., at *individual* market rates).”<sup>163</sup> While the IRS later backed off this position,<sup>164</sup> saying instead that the appropriate measure of fair market value is the value of *group* coverage in the hands of the domestic partner, the underlying principle remains valid. The amount to be included must be determined not by what the employer charges the employee, but by the value of the coverage in the hand of the person obtaining the benefit. Thus, the amount of income to be imputed to the employee with reference could be equal to what the dependent would have to pay for Connector coverage based on his or 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.

### (3) COBRA

Under COBRA and the Massachusetts mini-CORBA rules,<sup>165</sup> 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.

---

<sup>161</sup> 1959-1 C.B. 237.

<sup>162</sup> PLR 200108010 (November 17, 2000).

<sup>163</sup> PLR 9034048 (May 29, 1990).

<sup>164</sup> PLR 9111018 (December 14, 1990).

<sup>165</sup> M.G.L. c. 176J, § 9.

### C. Small Group Insurance Requirements

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)<sup>166</sup> 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.”<sup>167</sup> 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,”<sup>168</sup> i.e., individuals who is a resident 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, nor is a carrier required to renew an employee or dependent, or eligible individual if the individual has committed fraud, or misrepresented information necessary to determine eligibility or comply with material plan provisions.<sup>169</sup>

#### (2) *Pre-existing Conditions*

---

<sup>166</sup> P.L. 104-191.

<sup>167</sup> *Id.*

<sup>168</sup> M.G.L. c. 176J, § 1.

<sup>169</sup> 211 C.M.R. 66.06.

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.<sup>170</sup>

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 to mean:

"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 to mean:

"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.

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

---

<sup>170</sup> M.G.L. 176J, § 4(a)(3), as amended by Act § 83 and Technical Corrections Act § 48.

plans, state high risk pools, and any other coverage that would qualify as creditable coverage under HIPAA.<sup>171</sup>

### (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:<sup>172</sup>

(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."<sup>173</sup>

(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,<sup>174</sup> but, under a draft rule, this requirement has been changed to require that a carrier may impose either a waiting period or a pre-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*

---

<sup>171</sup> M.G.L. c. 176J, § 1.

<sup>172</sup> M.G.L. c. 176J, § 5, as amended by Act § 84, and Technical Corrections Act § 43.

<sup>173</sup> M.G.L. c. 176N, § 1, as amended by Act § 96.

<sup>174</sup> 211 C.M.R. 66.07(7).

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.<sup>175</sup> 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 the 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 been a break in creditable coverage of not more than 63 days 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.<sup>176</sup>

##### *(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 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

---

<sup>175</sup> M.G.L. c. 176J, § 5(a), as amended by Act § 84 and Technical Corrections Act § 49.

<sup>176</sup> M.G.L. c. 176N, § 2, as amended by Act § 100 and Technical Corrections Act § 52.

credit the time the person was covered under a previous qualifying health plan if the person experiences only a temporary interruption in coverage.<sup>177</sup>

## 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 effective 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.<sup>178</sup> 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.

---

<sup>177</sup> *Id.*

<sup>178</sup> *Supra* notes 52, 53 and 54.

**APPENDIX 1**

**Side-by-Side Comparison of Federal and Massachusetts Small Group and Health Insurance Portability Requirements**

<b>Item No.</b>	<b>Health Insurance Portability and Accountability Act of 1996</b>	<b>Massachusetts Small Group Portability Requirements (M.G.L. Ch. 176J)</b>	<b>Massachusetts Health Insurance Portability Requirements (M.G.L. Ch. 176N)</b>
<u>Preexisting Condition Exclusions</u>			
1.	<p><i>Code §(b)(1); ERISA § 701(b)(1)</i></p> <p>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).</p>	<p><i>M.G.L. Ch. 176J, § 1 (as amended by Act § 77 and Technical Corrections Act § 45)</i></p> <p>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.”</p> <p>Genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to that information.</p> <p>Pregnancy may not be treated as a preexisting condition.</p>	<p><i>M.G.L. Ch. 176N, § 2(b) (as amended by Act § 97)</i></p> <p>“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.”</p> <p><b>NOTE:</b> Under M.G.L. c. 176N, § 2(e), to the extent that Federal 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.</p>
2.	<p><i>Code § 9801(a)(2); ERISA § 701(b)(2)</i></p> <p>Group health plans and issuers</p>	<p><i>M.G.L. Ch. 176J, §§ 4(a)(3) and 5(b) (as amended by Act § 83 and Technical Corrections Act §§ 43 and 48)</i></p> <p>No pre-existing condition</p>	<p><i>M.G.L. Ch. 176N, § 2(b) (as amended by Act § 97 and Technical Corrections Act § 52)</i></p> <p>No pre-existing condition</p>

	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.	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.	<i>Code § 9801(c); ERISA § 701(c)</i>  A new employer's plan must give individuals credit 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))	<i>M.G.L. Ch. 176J, §§ 4(a)(3) and 5(b) (as amended by Act § 83 and Technical Corrections Act § 48)</i>  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.	<i>M.G.L. Ch. 176N, § 2(b) (as Technical Corrections Act § 52)</i>  No health plan may impose a preexisting condition provision for more than 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.
<u>Creditable Coverage and Certificates of Creditable Coverage</u>			
4.	<i>Code § 9801(c); ERISA § 701(c)</i>  "Creditable coverage" includes prior coverage under another group health plan, an	<i>M.G.L. Ch. 176J, §§ 1 (as amended by Act § 67)</i>  "Creditable coverage," includes coverage under any most private and public group	<i>M.G.L. Ch. 176N</i>  The term "creditable coverage" is not separately defined for purposes of

	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. Ch. 176N.
5.	<i>Code § 9801(c); ERISA § 701(c)</i>  Waiting periods are ignored for purposes of determining creditable coverage and breaks in creditable coverage.	<i>M.G.L. Ch. 176J, §§ 4(a)(3) and 5(c) (as amended by Act § 83 and Technical Corrections Act § 43)</i>  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 actuarial equivalent to the new coverage; and  (iii) Emergency services must be covered during a waiting period.	<i>M.G.L. Ch. 176N, §§ 2(c) and (d) (as Technical Corrections Act § 52)</i>  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 must 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 a "temporary interruption in coverage."
6.	<i>Code § 9801(c)(2)(A); ERISA § 701(c)(2)(A)</i>  Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses	M.G.L. Ch. 176J, §§ 4(c)(1) (as amended by Act § 83)  Plans must comply with HIPAA.	<i>M.G.L. Ch. 176N</i>  M.G.L. Ch. 176N contains no separate provision—HIPAA controls. Also, under M.G.L. Ch. 176N, § 2(e) plans must comply with "any more

	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 you have health coverage or anytime within 24 months after your coverage ends.		extensive coverage” required by “any other provision of the General Laws or any law of the United States.”
7.	<i>Code § 9801(e)(1); ERISA § 701(e)(1)</i>  Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents.	M.G.L. Ch. 176J, §§ 4(c)(1) (as amended by Act § 83)  Plans must comply with HIPAA.	<i>M.G.L. Ch. 176N</i>  M.G.L. Ch. 176N contains no separate provision—HIPAA controls. Also, under M.G.L. Ch. 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.	<i>Treas. Reg. § 549801-5(a)(3)(ii)(G); DOL Reg. § 2590.701(a)(3)(ii)(G)</i>  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.	<i>M.G.L. Ch. 176J, §§ 4(c)(1) (as amended by Act § 83)</i>  Plans must comply with HIPAA.	M.G.L. Ch. 176N  <i>M.G.L. Ch. 176N</i> contains no separate provision—HIPAA controls. Also, under M.G.L. Ch. 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.”
<b><u>Special Enrollment Rights</u></b>			
9.	<i>Code § 9801(f)(1); ERISA § 701(f)(1)</i>  Special enrollment rights are provided:  (i) For individuals who lose their coverage in certain situations, including on separation, divorce, death, termination of employment	<i>M.G.L. Ch. 176J, §§ 4(c)(1) (as amended by Act § 83)</i>  Plans must comply with HIPAA.	<i>M.G.L. Ch. 176N</i>  M.G.L. Ch. 176N contains no separate provision—HIPAA controls. Also, under M.G.L. Ch. 176N, § 2(e) plans must comply with “any more extensive coverage” required by “any other provision of the General Laws or any law of

	and reduction in hours, and  (ii) If employer contributions toward the other coverage terminates.		the United States.”
10.	<i>Code § 9801(f)(2); ERISA § 701(f)(2)</i>  Special enrollment rights are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption.	<i>M.G.L. Ch. 176J, §§ 4(c)(1) (as amended by Act § 83)</i>  Plans must comply with HIPAA.	<i>M.G.L. Ch. 176N</i>  M.G.L. Ch. 176N contains no separate provision—HIPAA controls. Also, under M.G.L. Ch. 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.”
<u>Guaranteed Issue</u>			
11.	<i>Public Health Service Act §§ 2711 and 2712; 45 C.F.R. §§ 146.150(a) and 146.152(b)</i>  Guaranteed issue and renewability of health insurance coverage for small groups and Guaranteed renewability of health insurance for large groups	<i>M.G.L. Ch. 176J, § 4(a)(1) (Act § 83 and Technical Corrections Act §§ 43 and 48)</i>  (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.	<i>M.G.L. Ch. 176N</i>  M.G.L. Ch. 176N contains no separate provision—HIPAA controls.
<u>Health Status Non-Discrimination</u>			
12.	<i>Treas. Reg. § 54.9802-1(a)(1); DOL Reg. § 2590-702(a)(1)</i>  Individuals may not be excluded from coverage,	<i>M.G.L. Ch. 176J, § 5(a) (as amended by Act § 84 and Technical Corrections Act § 49)</i>  Neither eligible individuals nor their dependents may be	<i>M.G.L. Ch. 176N, § 2(a)</i>  Neither eligible individuals nor their dependents may be

	denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors	excluded from coverage on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition.	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.
--	---	--	--

### **About the Author**

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 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.