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An Employer's Guide to the 2006 Massachusetts Health Care Reform Act

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“It is one of the happy accidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory, and try novel social and economic experiments without risk to the rest of the country.”¹

—Justice Louis D. Brandeis

This oft-quoted statement penned by Justice Brandeis in 1932 aptly describes the sweeping health care reform bill—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. In a display of candor not usually associated with such occasions, however, the speakers acknowledged that the Act’s prescriptions (and proscriptions) were novel and untested, and that they will in all likelihood need to be revisited.²

Chapter 324 of the Acts of 2006, *An Act Relative to Health Care Access* (the “Technical Corrections Act”), made certain technical corrections to the Act, including changes to a handful of effective dates. Chapter 450 of the Acts of 2006, *An Act Further Regulating Health Care Access* (“Chapter 450”), further tinkered with certain of the Act’s provisions and also pushed back certain effective dates of particular interest to employers. 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:

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

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

	Requirement	Statutory Provision	Massachusetts General Laws Chapter/Section
1.	Fair share contribution requirement	Act §§ 47 and 134	c. 149, §§ 187, 188
2.	The free rider Surcharge	Act §§ 32, 33, 35 through 40, 44 and 46 Technical Corrections Act § 22; 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

Faced with an uninsured population of over 500,000 residents³ and the potential loss of some \$385 million in Federal Medicaid revenues from the Centers for Medicare & Medicaid Services (“CMS”) unless the number of uninsured individuals was reduced,⁴ the Commonwealth of Massachusetts needed to do something to reign in health care spending. 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 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.⁵

The Act’s essential goals are set out in the preamble—to expand access to health care for Massachusetts residents and to increase the affordability of health care insurance products. Toward these ends, and in addition to the requirement imposed on employers and employees, the Act makes important changes to the Massachusetts Medicaid program, and it reforms the free care pool. Funding for these initiatives is provided through the newly created Commonwealth Care Trust Fund, which obtains funds through (i) employer-paid contributions and surcharges, (ii) matching Medicaid revenues, (iii) other federal appropriations, and (iv) payments from and penalties collected from individuals and employers.

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”). The Connector is “a body politic and corporate and a public instrumentality”⁶ 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 members⁷ from

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

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

⁵ *Id.*

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

⁷ *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

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.”⁸

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. Insurance purchased through the Connector is portable. It can, in effect, be carried from job to job.

The Connector will also administer the “Commonwealth Care Health Insurance Program” (or “Commonwealth Care”), which makes available subsidies for the purchase of health insurance through the Connector for low-income individuals. With one exception described below (relating to individuals between ages 19 and 26), insurance products offered through the Connector must meet all applicable state licensing requirements and coverage mandates.⁹ The Connector will begin offering plans to small groups on April 1, 2007, and open enrollment is from March 1, 2007 to May 31, 2007.

Importantly, though, eligible individuals who have access to employer-sponsored medical care are prohibited from accessing care through the Connector irrespective of the quality of the coverage (other than it must be “subsidized”) or the relative amounts of the employer’s and employee’s contribution.¹⁰ This rule has important implications for employees who have access to employer-sponsored coverage that does not rise to the level of “creditable coverage” for purposes of the individual mandate. The employee in this case would need to obtain coverage under the individual mandate (unless they could otherwise qualify for a waiver), but be unable to purchase coverage through the Connector.

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.¹¹ 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

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)).

⁸ Act § 67 amending M.G.L. c. 176J.

⁹ See generally M.G.L. c. 175, 175A, 176B and 176G.

¹⁰ Act § 101, adding M.G.L. c. 176Q. See M.G.L. c. 176Q, § 1 (defining the term “eligible individuals”).

¹¹ Act § 45, adding M.G.L. c. 118H.

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 financial incentive from an employer to decline the employer’s subsidized health insurance plan.¹²

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.

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

¹² M.G.L. c. 118H, § 3.

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.¹³ Under the Act, MassHealth will now cover children in families earning up to 300% of the Federal Poverty Level,¹⁴ 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.¹⁵ 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”¹⁶ to target vulnerable populations in an effort to eliminate health disparities and remove linguistic barriers to health access.

D. 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 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 2006,¹⁷ 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

¹³ Act §§ 122 and 123.

¹⁴ Act § 132.

¹⁵ Act § 3.

¹⁶ Act § 110.

¹⁷ “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.

to Tax Laws”), Massachusetts personal income tax law was updated to include, among other things, favorable tax treatment of HSAs.¹⁸ The recently enacted Tax Relief and Health Care Act of 2006¹⁹ contains 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. These changes will not apply for Massachusetts personal income tax purposes unless and until the Massachusetts legislature adopts a conforming change.

Although the Act does not tamper with the insurance mandates under current law, health insurance issuers are permitted under Act § 90²⁰ 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.”²¹ 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).²² Act § 127 imposes a moratorium on the creation of new health insurance mandated benefits through 2008.

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

E. 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.²³ 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

¹⁸ 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).

¹⁹ H.R. 6111 (December 20, 2006).

²⁰ Adding M.G.L. ch 176J, § 10.

²¹ *Id.*

²² *Id.*

²³ M.G.L. ch 118E, § 57.

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.

F. 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"²⁴ 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 rate.

"Creditable coverage" includes coverage under an individual or group health plan that meets the definition of "minimum creditable coverage" as established by the board of the Connector. It also includes "qualifying student health insurance programs," Medicare and Medicaid, TRICARE, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, and public health plans (as defined in federal regulations authorized by the Public Health Service Act), but excludes, accident only, credit only, limited scope vision or dental benefits if offered separately, and most hospital indemnity insurance policies, among others. The Technical Correction Act added Medicare Advantage plans to the list of plans that do not constitute creditable coverage.

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

²⁴ Act § 12 adding M.G.L. c. 111M; Technical Corrections Act § 16.

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,²⁵ 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.²⁶ 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’ behalf²⁷—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:

- (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 Fund²⁸ an “Annual Fair Share Employer Contribution” not to exceed \$295 per FTE employee.²⁹

²⁵ 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).

²⁶ *New York Conference of Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

²⁷ *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 (4th cir. 2007) (holding that the pay-or-play mandate adopted by the State of Maryland was preempted by ERISA).

²⁸ 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.

²⁹ Act § 47.

A final regulation (the “final regulation”) issued September 8, 2006³⁰ 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.³¹

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, ...”³² 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.”³³ 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,³⁴ 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 plan” is defined with reference to Code § 5000(b)(1)³⁵ that provides medical care,³⁶ 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.

³⁰ 114.5 CMR 16.00 Determination of Employer Fair Share Contribution (September 8, 2006).

³¹ Act § 47 (adding new M.G.L. c. 188).

³² 114.5 CMR § 16.02 (definition of “Employer”).

³³ *Id.* (definition of “Employing Unit”).

³⁴ 114.5 CMR § 16.03(1)(a).

³⁵ 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”).

³⁶ Code §§ 213(d)(1)(A) and (B).

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.³⁷ 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.³⁸ 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 he or she (i) is free from control and direction in the execution of his or her job, (ii) performs a service outside the usual course of business of the employer, and (iii) routinely works in an independently established trade, occupation, profession or business.

Seasonal Employees. The term “seasonal employee” is defined with reference to M.G.L. c. 151A, § 1(b) 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 30.³⁹

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

³⁷ 114.5 CMR § 16.03(1)(a), 1.b.

³⁸ Act § 12 adding M.G.L. c. 111M, § 3.

³⁹ 114.5 CMR § 16.02 (definition of Seasonal Employee).

employees who work 40 hours per week for 26 weeks during the period and 30 hours per week remaining 26 weeks. For Year X, Employer A's total payroll hours of full time employees is the sum of (i) 50 x 40 104,000, plus (ii) 20,800 or 124,800. 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 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 § 12.⁴⁰ 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

⁴⁰ Adding new M.G.L. c. 111M, § 12.

Employer to its Full Time Employees that were employed at least 90 days during the period from October 1 [through] September 30, 2007.”⁴¹ 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.

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.

(3) *Special Rules for Leasing Companies*

The final regulations also contain special rules for Employee Leasing Companies.⁴² 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.”⁴³

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,

⁴¹ 114.5 CMR § 16.03(1)(b).

⁴² 114.5 CMR § 16.03(2)(a).

⁴³ 114.5 CMR § 16.02.

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 DHC FP.

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.

The Technical Corrections Act assigned responsibility for the collection of the fair share contribution to the Division of Unemployment Assistance.⁴⁴

B. The Free Rider Surcharge

NOTE: In an undated Bulletin issued on or about January 19, 2007, the DHC FP withdrew the final regulation implementing the free rider surcharge described below. The final regulation was issued after the Technical Corrections Act (which made certain substantive changes) but before Ch. 450 (which merely postponed the provision’s effective date). DHC FP also announced that it expects to issue a new proposed regulation and schedule a public hearing in time to issue a final rule in advance of the new, July 1, 2007 effective date. The discussion below retains the explanation of the final free rider regulation in the belief the forthcoming final regulation will be substantially similar in all material respects, since the substance of the underlying law has not changed.

Act § 44, as amended by Technical Corrections Act §§ 22 and 57, imposes on “non-providing” employers a charge equal to a portion of the Commonwealth’s cost of providing health benefits to employers’ uninsured employees if (i) any employee (or dependent of an employee) receives free care services more than three times in a single year or (ii) the employer has five or more instances in a single year of employees (or their dependents) receiving free care. This requirement is referred to colloquially as the “free rider surcharge, and it was originally based on the premise that employers that neither offer nor arrange for health insurance coverage for their employees ought to shoulder some responsibility for free care provided to their employees. The DHC FP a final regulation (the “final free rider regulation”) on December 22, 2006 implementing the “Employer Surcharge for State-Funded Health Costs”⁴⁵

The free rider surcharge rules took effect January 1, 2007, but the determination of what state-funded costs will be subject to the surcharge will not begin to be taken into account until July 1, 2007. As a practical matter, therefore, employers have a six month grace period within

⁴⁴ Technical Corrections Act § 32.

⁴⁵ 114.5 C.M.R. 17.00 et seq. (December 22, 2006).

which to come into compliance. The Technical Corrections Act § 22 made clear that an employer that failed to comply with the cafeteria plan requirements (*see* Section III.D below) is a non-providing employer. But the cafeteria plan requirements do not take effect until July 1, 2007. The six-month delay in determination of state funded costs reconciles these to provisions of the Act without the need of any further technical corrections.⁴⁶

The surcharge is imposed only on employers with ten or more employees, and it is imposed only with respect to “state-funded employees.” According to the final free rider regulation, an employer has more than ten employees —

“[I]f the sum of total payroll hours for all employees for the period from October 1 through September 30 divided by 1,820 is greater than 10. Payroll hours include regular, vacation, sick, Federal Medical Leave of Absence, short term disability, long term disability, overtime and holiday payroll hours.”⁴⁷

The Employer is defined with reference to M.G.L. c. 151A. This definition is sufficiently broad to cover seasonal and temporary employees, but it should not include independent contractors (see Section III.A(1) for a description of the definition of independent contractor under M.G.L. c. 151A.) If there is a co-employment arrangement between a client company and an “Employee Leasing Company,” the client company is subject to the free rider surcharge.⁴⁸ For this purpose, the leasing arrangement must be “long term” and not an arrangement “to provide the Client Company temporary help services during seasonal or unusual conditions.” (See Section III.A above for a discussion of Employee Leasing Companies.)

An employer is subject to the surcharge if:⁴⁹

- (i) The employer is a “non-providing employer;
- (ii) Any of its employees are “state-funded employees;”
- (iii) The employer’s state-funded employees receive state-funded health services that total at least \$50,000 in a fiscal year.

A “non-providing employer” is an employer of a state-funded employee that employs more than ten employees and fails to adopt and maintain a Section 125 cafeteria plan in accordance with the rules of the Connector. This definition reflects changes made by the Technical Corrections Act. The free rider surcharge under the Act was directed to employers that neither provided nor “arranged for” health insurance, and an employer was deemed to have “arranged for” coverage if it adopted a cafeteria plan and directed employees to the Connector. The Technical Corrections Act recognized that the net result of the Act’s approach was to make imposition of the free rider surcharge the penalty for failing to comply with the cafeteria plan requirement. Separately, an employer is not a non-providing employer to the extent its state-

⁴⁶ 114.5 C.M.R. 17.03(4)(b).

⁴⁷ 114.5 C.M.R. 17.03(2)(a).

⁴⁸ 114.5 C.M.R. 17.02.

⁴⁹ 114.5 C.M.R. 17.04.

funded employees are covered under a bona fide collective bargaining agreement or if the employer participates in the Insurance Partnership Program.⁵⁰

A “state-funded employee” is 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 each October 1 through September 30 a fiscal year.

Under the final free rider regulation, the percentage of state-funded costs assessed based on the following categories that vary by the number of the employer’s FTEs:

Category 1	11 to 20 employees
Category 2	21 to 40 employees
Category 3	41 to 50 employ
Category 4	more than 50 employees

The final free rider regulation establishes a table of “assessment percentages” based on the number of annual admissions and visits by state-funded employees, the percentage of employees for whom the employer provides insurance, the employers’ compliance with the HIRD requirements, and the number of successive years that the employer is subject to the surcharge.⁵¹ For 2007, the assessment percentages are as follows:

	Category 1	Category 2	Category 3	Category 4
4 to 6 visits by one employee or 5 to 10 visits for all state-funded employees	10%	15%	20%	25%
7 to 14 visits by one employee or 11 to 20 visits for all state-funded employees	20%	25%	30%	35%
More than 15 visits by one employee or more than 21 visits for all state-funded employees	30%	35%	40%	45%
Non-compliance with HIRD requirements, or employer subject to surcharge for second successive year	40%	45%	50%	55%

⁵⁰ 114.5 C.M.R. 17.03(2)(b).

⁵¹ 114.5 CMR 17.04(c).

The amount derived from the table above is then reduced (but by no greater than 75%) by the employer's "enrollment percentage," i.e., the percentage of the employer's full time employees enrolled in the employers group health plan.

Example: A Category 3 employer with between five to ten visits for all of the employer's state-funded employees would be assessed 20% of the state-funded costs, provided that the employer was otherwise in compliance with the HIRD requirements, was not a repeat offender, and did not cover its full-time employees.

The DHCFP enforces the free rider surcharge. DHCFP will notify employers subject to surcharge at the end of each fiscal year. Where a state-funded employee is employed by more than one non-providing employer at the time services are provided, the surcharge is apportioned based on the employee's hours with each employer. An employer can challenge the DHCFP's determination only if it can document either that an individual identified as a state-funded Employee was not its employee or dependent of one of its employees; or that the employer is not a non-providing employer⁵² (i.e., that its has a cafeteria plan and timely filed a copy with the Connector).

C. The Health Insurance Responsibility Disclosure Form

NOTE: In an undated Bulletin issued on or about January 19, 2007, the DHCFP withdrew the emergency regulation implementing the HIRD form described below. The emergency regulation was issued after the Technical Corrections Act (which made certain substantive changes) but before Ch. 450 (which merely postponed the provision's effective date). DHCFP also announced that it expects to issue a new proposed HIRD regulation and schedule a public hearing in time to issue a final rule in advance of the new, July 1, 2007 effective date. The discussion below retains the explanation of the final HIRD regulation in the belief the forthcoming final regulation will be substantially similar in all material respects, since the substance of the underlying law has not changed.

Act § 42 directs DHCFP to promulgate a "Health Insurance Responsibility Disclosure Form" (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 take effect July 1, 2007,⁵³ and employers must report information as of September 30 of each year. On December 29, 2006, DHCPF issued an emergency regulation providing guidance on the implementation of the HIRD form requirements.

⁵² 114.5 C.M.R. 17.05.

⁵³ Ch. 450, § 7 (the HIRD requirement effective date prior to amendment was January 1 2007).

(1) The Employer HIRD Form⁵⁴

Massachusetts Employers with more than ten employees are required to report the following information:

- Employer Legal Name
- Employer DBA Name
- Employer FEIN
- Division of Unemployment Assistance Account Number
- Number of full time Employees
- Number of part time Employees
- Whether the Employer offers subsidized insurance to full time employees
- Whether Employer offers subsidized insurance to part time employees
- Whether the Employer offers a section 125 cafeteria plan
- Whether the Employer has complied with the requirements of M.G.L. c. 151F

An employer has more than ten employees if the “sum of total payroll hours for all employees for the period from October 1 through September 30 divided by 1,820 is greater than 10.”⁵⁵ Payroll hours include regular, vacation, sick, FMLA leave, short term disability, long term disability, overtime and holiday payroll hours.” In reporting the number of full time and part time employees, employers must include seasonal and temporary employees employed as of September 30 of each year, but independent contactors are excluded. The definitions of seasonal and temporary employees and independent contactors for purposes of the HIRD requirement are similar to the definitions of seasonal and temporary employees and independent contactors under the fair share contribution rule discussed above in Section III.A.1.

The Employer HIRD form is due on November 15 of each year, based on information as of the immediately preceding September 30 of each year. New employers are required to file with the DHCFFP when they register with the Division of Unemployment Assistance.

For enforcement purposes, the DHCFFP plans to establish a data matching program in concert with the Division of Unemployment Assistance and the Department of Revenue. An Employer that knowingly falsifies or fails to file any information required by the DHCFFP is subject to a fine of not less than \$1,000 or more than \$5,000.

(2) The Employee HIRD Form⁵⁶

Employees who are employed by a Massachusetts Employer with ten or more employees and who either decline employer sponsored insurance or the employer’s offer to arrange for insurance (through the Connector with pre-tax dollars) must sign an Employee HIRD form. Employers are required to provide the employee HIRD form for the employee’s signature. The Employer must retain the signed HIRD form for a period of three years. If the employee does

⁵⁴ 114.5 C.M.R. 18.03.

⁵⁵ 114.5 C.M.R. 17.03(2)(a).

⁵⁶ 114.5 C.M.R. 18.04.

not comply with the employer's request to return the signed form, the employer is required to document its efforts to obtain the form and maintain the documentation for a period of three years.

The Employee HIRD Form must contain the following information:

- The employee's name
- The name of the Employer
- Whether the Employee has alternative insurance coverage
- An acknowledgement that the employee is aware of the individual mandate and the penalties for failure to comply with the individual mandate.

Employers must require each employee who has either declined to enroll in employer sponsored health insurance or declined the employer's offer to arrange for the purchase of health insurance to sign an Employee HIRD Form by the earlier of 15 days after the close of the open enrollment period for the employer's health insurance, or July 1 of each year. New hires who decline coverage must sign their HIRD form within 15 days of hire. A model employee HIRD form can be downloaded at http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/employee_hird.pdf.

(3) Special Leasing Company Rules

The regulation singles out "Employee Leasing Companies" for special treatment. An "Employee Leasing Company" is defined to mean an entity that—

"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."

The regulation goes on to provide that the leasing arrangement must be "long term" and not an arrangement "to provide the Client Company temporary help services during seasonal or unusual conditions." If an Employee Leasing Company files the HIRD Form on behalf of its clients, it must file a separate form for each company.

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 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.” The 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.”

Because the scope of the cafeteria plan requirement is determined “under regulations promulgated by the connector,” the scope of the requirement is not yet known. For example, will a cafeteria plan be necessary for employee contributions to an employer-sponsored plan that does not provide creditable coverage for purposes of the individual mandate (e.g., a mini-med program). Though it has not yet issued formal guidance, the Connector has telegraphed the answer in a Q&A posted to its website in which it interprets the cafeteria plan requirement broadly.

NOTE: The recent Federal appeals court decision holding the Maryland fair share act preempted by ERISA⁵⁷ will require the regulators to consider ERISA preemption issued when settling on the scope of the cafeteria plan regulation.

The Technical Corrections Act made clear that that cafeteria plan requirement is limited to so-called “premium-only” arrangements.⁵⁸ 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.

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 treatment⁵⁹ to highly paid employees:

(1) *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.

(2) *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 nontaxable benefits and total benefits (or employer contributions allocable to

⁵⁷ *Supra* note 27

⁵⁸ Technical Corrections Act § 57.

⁵⁹ See discussion of interaction of the Federal and Massachusetts income rules in Section I.D above.

nontaxable benefits and employer contributions for total benefits) do not discriminate in favor of highly compensated participants.”

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

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

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.

The cafeteria plan requirement takes effect July 1, 2007. It is anticipated that the Connector will issue a model cafeteria plan form. Employers that currently maintain cafeteria plans will likely have to amend their plans to provide access to employees not covered by the employer’s group health plan, who will now have access coverage through the Connector.

IV. INSURANCE MANDATES AFFECTING EMPLOYERS

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

Comment: 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 Act⁶⁰ retroactive to 1989, and the prior law rules were resurrected.

Federal law (*i.e.*, the preemption provisions of the Employee Retirement Income Security Act of 1974 (ERISA)) bars states from imposing group health plan nondiscrimination requirements, among others, directly on employers. Under ERISA’s “insurance savings 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.

Act §§ 50 (relating to any “general or blanket policy of insurance”),⁶¹ 52 (relating to non-profit hospital service corporations, *i.e.*, Blue Cross),⁶² 55 (relating to medical service corporations, *i.e.*, Blue Shield),⁶³ and 59 (health maintenance organizations)⁶⁴ 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
- 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.

⁶⁰ P.L. 101-140, §202(a).

⁶¹ Act § 50, adding M.G.L. c. 175, s. 110(O).

⁶² Act § 52, adding s. 8 ½ to M.G.L. c. 176A.

⁶³ Act § 55, adding s. 3B to M.G.L. c. 176B.

⁶⁴ Act § 59, adding s. 6A to M.G.L. c. 176G.

The insured plan non-discrimination requirement takes effect on July 1, 2007.⁶⁵ Once this rule is in force, it will no longer be possible to offer coverage to certain full-time employees and not other full-time employees, nor will it be possible to offer to pay a greater amount of the premium cost of the plan for full-time employees with higher incomes. The Act does not define the term “full-time” employee for this purpose. These rules govern all fully insured group health plans licensed under the provisions of Massachusetts law cited above (not just those in the small-group market), but they do not apply to self-funded arrangements. There is also an exception for coverage provided under collective bargaining agreements.

Based on a draft notice on the subject circulated by the Massachusetts Division of Insurance, health insurance contracts will be required to cover all Massachusetts full-time employees and cannot discriminate against lower paid employees. But employers will not be required to offer the insured group health benefit contract to retirees, or part-time, temporary or seasonal employees. The terms “full-time employee” and “part-time, temporary or seasonal employee” will likely be consistent with definitions within regulations promulgated by the Division of Health Care Finance and Policy (see Section III(a) above). In satisfying these requirements, the following practices will likely be permitted:

- An employer may establish different percentage contributions for different plan choices, so long as the contributions made with respect to each plan on behalf of employees do not differ based on the salary level of the employees.
- An employer may establish a fixed dollar amount as a contribution to premium for all employees regardless of salary satisfies the statutory requirements.
- Greater contribution levels for increasing lengths of service will satisfy the statutory requirements so long as it is designed as a reward for longevity rather than as a pretext for providing better health insurance contributions to more highly paid employees.
- An employer may establish greater contributions levels for persons who participate in company-sponsored health and wellness programs.

This new rule will all but eliminate disparate treatment of different classes of employees, such as hourly versus salaried employees, both as to waiting periods and 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. Also prohibited are executive-premium or excess plans, at least those licensed in Massachusetts (but see discussion below regarding out-of-state carriers) that are marketed as “insured,” even though they are usually minimum-deposit or cost-plus arrangements. These latter plans were treated 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.)

These insurance non-discrimination provisions of the Act require only that insurance policies and HMO contracts issued or delivered within the Commonwealth contain certain

⁶⁵ Ch. 450, § 7 (the insured plan non-discrimination requirement effective date prior to amendment was January 1 2007).

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.)

Out-of-state insurance companies that issue policies to out-of-state employers are generally exempt from regulation under Massachusetts law, even if the policy covers some Massachusetts employees. But, because the employer is the policy-holder in a group insurance arrangement, out-of-state insurance companies that issue policies to Massachusetts employers must be licensed in Massachusetts. Some out-of state carriers claim to be exempt from the insurance non-discrimination rule either because they are not licensed in Massachusetts or (in the case of certain executive premium plans) because they are not selling a "general or blanket policy of insurance." These claims are difficult to square with the express provisions of M.G.L. c. 175, §108, which governs all policies of accident and sickness insurance "delivered or issued for delivery to any person" in Massachusetts.⁶⁶ These policies must be filed with the Division of Insurance; they are subject to the advance approval of the Commonwealth's Division of Insurance; and they are subject to the insurance non-discrimination rule, among others.

B. Expanded Dependent Coverage

Technical Corrections Act § 34 (relating to general and blanket policies of insurance),⁶⁷ Act § 53 (relating to non-profit hospital services, i.e., Blue Cross/Blue Shield hospital payments),⁶⁸ Act § 56 (relating to medical service corporations, i.e., Blue Cross/Blue Shield physician payments),⁶⁹ and Act § 58 (health maintenance organizations),⁷⁰ each require that carriers with insured health benefit plans that provide for dependent coverage to make dependent coverage available through the earlier of their 26th birthday or the day 2 years following the loss of their dependent status according to Federal tax rules. (These requirements do not apply to self-funded plans.) The Act originally extended coverage to dependents under age 25, but this was changed to age 26 in technical corrections.⁷¹

In Bulletin 2007-1,⁷² 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

⁶⁶ See M.G.L. c. 175, § 108, para. 1 (defining policy of accident and sickness insurance with reference to M.G.L. c. 175, § 47, para. 6 (a) through (d), which is sufficiently broad to include executive premium health plans).

⁶⁷ Adding § 110(p) to M.G.L. c. 175.

⁶⁸ Act § 53, adding s. 8Z to M.G.L. c. 176A.

⁶⁹ Act § 56 adding s. 4Z to M.G.L. c. 176B.

⁷⁰ Act § 58 adding s. 4R to M.G.L. c. 176G.

⁷¹ Technical Corrections Act § 34.

⁷² January 18, 2007.

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,⁷³ 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*

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)⁷⁴ (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).

⁷³ Code § 151(b).

⁷⁴ Rev. Proc. 2006-53, § 3.18(1), 2006-48 I.R.B. 996 (November 9, 2006).

(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.”⁷⁵ 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.

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? Perhaps the most logical starting point is the plan’s individual 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.⁷⁶ 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.

(3) COBRA

Under COBRA and the Massachusetts mini-CORBA rules,⁷⁷ 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.

C. Small Group Insurance Requirements

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)⁷⁸ 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

⁷⁵ 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”).

⁷⁶ PLR 200108010 (November 17, 2000).

⁷⁷ M.G.L. c. 176J, § 9.

⁷⁸ P.L. 104-191.

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.”⁷⁹ Following the Act’s merger of the small group and individual markets (see Section I.D above), policies must also be made available to “eligible individuals,”⁸⁰ 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.⁸¹

(2) *Pre-existing Conditions*

No policy may provide pre-existing condition provisions that exclude coverage for a period beyond 6 months following the individual’s date of enrollment. The term “date of enrollment” in this context means the date on which the individual is enrolled for coverage, or, if

⁷⁹ *Id.*

⁸⁰ M.G.L. c. 176J, § 1.

⁸¹ 211 C.M.R. 66.06.

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.⁸²

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

⁸² 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.⁸³

(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:⁸⁴

(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."⁸⁵

(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,⁸⁶ 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.)

⁸³ M.G.L. c. 176J, § 1.

⁸⁴ M.G.L. c. 176J, § 5, as amended by Act § 84, and Technical Corrections Act § 43.

⁸⁵ M.G.L. c. 176N, § 1, as amended by Act § 96.

⁸⁶ 211 C.M.R. 66.07(7).

(4) *Health Status Non-Discrimination*

Carriers may not exclude any employees or their dependent from a health benefit plan on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition.⁸⁷ 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.⁸⁸

(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

⁸⁷ M.G.L. c. 176J, § 5(a), as amended by Act § 84 and Technical Corrections Act § 49.

⁸⁸ M.G.L. c. 176N, § 2, as amended by Act § 100 and Technical Corrections Act § 52.

the new plan covers, but which were not covered under the old plan. Also, a health plan must credit the time the person was covered under a previous qualifying health plan if the person experiences only a temporary interruption in coverage.⁸⁹

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.⁹⁰ 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.

⁸⁹ *Id.*

⁹⁰ *Supra* note 27.

APPENDIX 1

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

Item No.	Health Insurance Portability and Accountability Act of 1996	Massachusetts Small Group Portability Requirements (M.G.L. Ch. 176J)	Massachusetts Health Insurance Portability Requirements (M.G.L. Ch. 176N)
<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>NOTE: 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 (3) (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.”
<u>Special Enrollment Rights</u>			
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.
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