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**Employee Benefits Committee
Welfare Plans Update**

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

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Health Plan Update

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.”

—Justice Louis D. Brandeis

This oft-quoted statement penned by Justice Brandeis in 1932¹ deftly anticipates and gives context to 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 at an elaborate ceremony at Boston’s historic Faneuil Hall. In addition to Governor Romney, presenters included the President of the Massachusetts Senate, Robert Travaglini, the Speaker of the Massachusetts House of Representatives, Salvatore DiMasi, and the State’s Senior United States Senator, Edward Kennedy, each of whom in turn spoke glowingly of the role of the new law in expanding access to affordable health care. But, in a display of candor not usually associated with such occasions, each speaker also acknowledged that the bill’s prescriptions (and proscriptions) were novel and untested, and that they may need to be revisited based on experience.²

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:

- (i) The Fair Share Contribution requirement (Act §§ 47 and 134);
- (ii) The Free Rider Surcharge (Act §§ 32, 33, 35, 44 and 46);
- (iii) The “Health Insurance Responsibility Disclosure” form (Act § 42);

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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 report to issue an periodically update an implementation plan tracking progress on the Act’s implementation, the purpose of which is to alert the legislature to instances where certain of the Act’s provisions may need to amended).

- (iv) The cafeteria plan requirement (Act § 45);
- (v) The insured plan non-discrimination requirement (Act §§ 50, 52, 55 and 59); and
- (iv) Expanded coverage of dependents (Act §§ 49, 53, 36 and 58).

Of these requirements, only the first four are properly referred to as “employer mandates,” i.e., as imposing obligations directly on employers. The last two, the group health plan non-discrimination requirement and the expanded definition of “dependent” under group health plans, are imposed on insurance companies, but they will result in plan design changes and impose additional administrative burdens on employers that 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 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 (derived

³ Commonwealth of Massachusetts Executive Department, *Press Release: Romney Signs Landmark Health Insurance Reform Bill* (Apr. 12, 2006) http://www.mass.gov/?pageID=pressreleases&agId=Agov2&prModName=gov2pressrelease&prFile=gov_pr_060412_Healthcare_signing.xml (last visited September 26, 2006).

⁴ Commonwealth of Massachusetts Executive Department, *Press Release: Implementation of Health Care Law Proceeds* (May 1, 2006), http://www.mass.gov/?pageID=pressreleases&agId=Agov2&prModName=gov2pressrelease&prFile=gov_pr_060501_healthcare_waiver.xml (last visited September 26, 2006).

⁵ *Id.*

from a newly established “Health Safety Net Trust Fund,” the new name for the prior law free care pool trust fund), (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. ch. 176Q, establishes as a quasi-legislative body known as the “Commonwealth Health Insurance Connector” (or simply, the “Connector”), the purpose of which is to furnish access by individuals and “eligible” small groups to affordable health insurance products. An eligible small group is defined in M.G.L. ch. 176Q, s. 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 eleven members⁶ from government and the private sector governs the Connector. Insurance products offered through the Connector will carry with them the Connector’s “seal of approval,” which is given by “the board of the connector to indicate that a health benefit plan meets certain standards regarding quality and value.”⁷

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.⁸ 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.

(b) The Commonwealth Care Health Insurance Program

Beginning October 1, 2006, eligible individuals at or below 100% of the Federal Poverty Level (the “FPL”) will be able to obtain coverage under Connector-approved insurance products. Commencing January 1, 2007, this coverage will be extended to

⁶ Act § 101, adding M.G.L. ch. 176Q. See M.G.L. ch. 176Q, s. 2(b) (providing that the Connector board will consist of the Secretary for Administration and Finance, chair, the director of Medicaid, the Commissioner of Insurance, the Executive Director of the Group Insurance Commission; 3 members appointed by the Governor (an actuary, a health economist and a representative of small business), 3 members appointed by the Attorney General (a health benefits plan specialist, a representative of a health consumer organization, and a representative of organized labor), which totals 10, not 11).

⁷ Act § 67 amending M.G.L. ch. 176J.

⁸ See generally M.G.L. Ch. 175, 175A, 176B and 176G.

eligible individuals with incomes above 100% but at or below 300% of the FPL. In addition, 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) or family member's employer must not have 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. No premium will be charged to individuals who earn below 100% FPL.

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 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 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.⁹ Under the Act, MassHealth will now cover children in families earning up to 300% of the Federal Poverty Level,¹⁰ 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.¹¹ Medicaid rate increases in the bill are made contingent upon providers meeting performance benchmarks, including in the area of reducing racial and ethnic disparities.

⁹ Act §§ 122 and 123.

¹⁰ Act § 132.

¹¹ Act § 3.

The bill creates a study of a sustainable “community health outreach worker program”¹² 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 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. It is expected that the merger will produce an estimated drop of 24% in non-group premium costs, but it will increase group premiums anywhere from 2% to 8%. The Act mandates an actuarial study of the consequences of merging of the two insurance markets before the merger is completed. 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. Waiting periods are barred for plans offered to individuals who have been without coverage for 18 months prior to application.

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.) The definition of “dependents” is also expanded to allow young adults to stay on their parents’ insurance plans for two years past the loss of their dependent status, or until they turn 25 (whichever occurs first). And, although the Act does not tamper with the insurance mandates under current law, health insurance issuers are permitted under Act § 90 to provide lower-cost, specially designed products through the Connector to 19-26 year-olds. Finally, Act § 127 imposes a moratorium on the creation of new health insurance mandated benefits through 2008.

(e) Free Care

Act § 8 eliminates the current uncompensated care trust fund under M.G.L. 118G, s. 18 as of October 1, 2007, and establishes in its place the “Health Safety Net 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.¹³ Like the uncompensated care trust fund, the purpose of the Health Safety Net 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 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 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 Fund. The Health Safety Net Office will develop a new standard fee schedule for hospital reimbursements, including a fee-for-service reimbursement

¹² Act § 110.

¹³ M.G.L. ch 118E, s. 57.

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"¹⁴ 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. (The requirement has been likened to the requirement imposed on motorists to obtain automobile insurance.) Residents will be required to confirm that they have health insurance coverage on their state income tax forms filed in 2008, and coverage will be verified through a database of insurance coverage for all individuals.

"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 Commonwealth of Massachusetts Department of Revenue will enforce the Act's individual mandate. Residents will 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 an exception) 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

¹⁴ Act § 12 adding M.G.L. ch. 111M.

“minimum insurance premium for creditable coverage” for each month without coverage. The penalty is first satisfied by forfeiture of any available tax refunds (subject to higher statutory priority claims on use of refunds), and, if that is insufficient, a direct assessment on the affected individual for the balance.

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

III. EMPLOYER MANDATES

The Act imposes the following employer mandates:

(a) The Fair Share Premium Contribution

Because of constraints imposed by Federal law,¹⁵ 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.¹⁶ What was not clear was whether a state could 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’ behalf¹⁷—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 Massachusetts 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 Fund¹⁸ an “Annual Fair Share Employer Contribution” not to exceed \$295.¹⁹ A final regulation (the “final

¹⁵ 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).

¹⁶ *New York Conference of Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

¹⁷ *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) (holding that the a pay-or-play mandate adopted the State of Maryland was preempted by ERISA).

¹⁸ 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.

¹⁹ Act § 47.

regulation”) issued September 8, 2006²⁰ provides guidance on what constitutes a Fair and Reasonable Premium Contribution on the part of an employer and how the Annual Fair Share Employer Contribution is determined.

In assessing whether an employer makes a Fair and Reasonable Premium Contribution, the final regulation establishes two tests—a primary test and a secondary test. If an employer passes either test for a year, then it has no obligations to make any payments to the Commonwealth Care Trust Fund. But if an employer employs 11 or more full time employees in the Commonwealth and is unable to pass either test, it must make a per employee fair share contribution not to exceed \$295.00, pro-rated for full-time equivalent status based on a 2,000 year.²¹

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, . . .”²² 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.”²³ 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,²⁴ 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)²⁵ that provides medical care,²⁶ whether insured or self-funded, that is

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

²¹ Act § 47 (adding new M.G.L. ch. 188).

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

²³ *Id.* (definition of “Employing Unit”).

²⁴ 114.5 CMR § 16.03(1)(a).

²⁵ 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”).

²⁶ Code §§ 213(d)(A) and (B).

“sponsored and paid for, *in whole or in part*, by an employer . . .” (Emphasis added.) Thus, the primary test does not require the employer to make any particular level of contribution (but it must contribute something), nor does it require any particular level or type of coverage.

For purposes of applying the primary test, the term Full-Time employee is defined to mean those employees who work at least 35 hours per week.²⁷ 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.²⁸ 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 the definition set out in M.G.L. ch. 151A, s. 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 in M.G.L. c. 151A, s. 1(bb) to mean employment that is seasonal in nature and lasts up to four months.

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 30.²⁹

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

²⁷ 114.5 CMR § 16.03(-)(-).

²⁸ M.G.L. c. 111M, § 3.

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

period, (ii) 20 employees who work 30 hours per week for the entire period, and (iii) 20 employees who work 40 hours per week for 26 weeks during the period and 30 hours per week remaining 26 weeks. Employer A's total payroll hours of full time employees is the sum of (i) 50 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 § 11.³⁰ 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.

(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 offers to pay "at least 33% of the premium cost of any Group Health Plan offered by the Employer to its Full Time Employees that were employed at least 90 days during the period from October 1 [through] September 30, 2007."³¹ 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. Also not clear is whether the exceptions for part-time seasonal and temporary employees apply. So, for example, can the employer exclude from this test employees who have not worked 90 days in the year and employees who do not perform services for 12-consecutive weeks? Lastly, the 90-day requirement appears to refer to non-contiguous business days.

³⁰ Adding new M.G.L. ch. 111M, § 12.

³¹ 114.5 CMR § 16.03(1)(b).

(3) *Special Rules for Leasing Companies*

The final regulation also contains a series of special rules dealing with Employee Leasing Companies³² under which, where an employer retains leasing company employees, it is the leasing company that must calculate and remit the Fair Share Contribution on behalf of the client company. Presumably, this obligation can be shifted by agreement, but responsibility will remain with the leasing company. 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.³³

This special leasing company rule imposes the principle compliance obligation on the leasing company, but it says nothing about how workers are counted for purposes of the primary and secondary tests. Though not entirely clear, it appears that leasing company employees are treated as employees of the leasing company under this rule and not as employees of the end-user client. Also unclear is whether this result would change depending on 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)?

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.

(b) The Free Rider Surcharge

Act § 44 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. The Division of Health Care Finance and Policy (DHCFP) of the Commonwealth’s Executive Office of Health and Human Services issued proposed regulations (the “proposed regulations”) implementing

³² 114.5 CMR § 16.03(1)(c).

³³ 114.5 CMR § 16.02.

the free rider surcharge on June 30, 2006.³⁴ The surcharge is imposed only on employers with ten or more employees, and it is imposed only with respect to “state-funded employees.”

An employer will not be considered non-providing if it offers to contribute toward, or arranges for the purchase of, health coverage. Under the proposed regulation, if the employer merely maintains a cafeteria plan (under Code § 125) and makes coverage available through the Connector, the employer is deemed to satisfy the “arranges for” requirement and will therefore be exempt from the surcharge. An employer is also exempt if it is a signatory to a collective bargaining agreement, or if it participates in the Commonwealth’s Insurance Partnership (which is a program of state subsidies for employer-provided health insurance for low income individuals). The surcharge is triggered when an employee receives free care more than three times, or a company has five or more instances of employees receiving free care in a year. The surcharge ranges from 10% to 100% of the state’s costs of services provided to the employees, with the first \$50,000 per employer exempted.

Under the proposed regulations, the percentage of state-funded costs assessed will vary by the number of the employer’s FTEs. State-funded costs are the costs incurred by the Commonwealth for services to the employees of non-providing employers and their dependents that are paid from the Health Safety Net Trust Fund. The amount of the assessment increases with the number of occurrences, the employer’s failure to comply with the HIRD requirement (discussed below), and the employer’s status as a repeat offender. The assessment can decrease if the employer has a high percentage of full-time employees enrolled in employer-sponsored health insurance.

For purposes of assessing the surcharge, employers are assigned to one of the following four categories:

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 proposed regulations establish a table or “assessment percentages” based on the number of 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.³⁵ For 2007, the assessment percentages are as follows:

³⁴ 114.5 C.M.R. 17.00 et seq. (June 30, 2006) (“The Employer Surcharge for State-Funded Health Care Costs”).

³⁵ Prop. 114.5 CMR 17.04(c).

	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%	39%	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%

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.

(c) The Health Insurance Responsibility Disclosure Form

Act § 42 directs DHCFF to promulgate a "Health Insurance Responsibility Disclosure Form" (or "HIRD" form) that provides information necessary to enforce the fair share contribution and free-rider surcharge mandates. On June 30, 2006, DHCFF proposed regulations (the "withdrawn regulation") implementing the HIRD form requirements, but the proposed HIRD regulation was withdrawn on September 8, 2006. A press release announcing the withdrawal of the HIRD form regulation explained "the agency [i.e., DHCFF] is in discussions with other agencies regarding filing in a manner that would eliminate the risk of identity theft and avoid the duplication of data collection among the various agencies." The press release went on to explain that the further action is expected before the end of the year.

Under the withdrawn regulation, every Massachusetts employer must file an initial HIRD form that includes:

- The employer’s Division of Unemployment Assistance account number;
- The employer’s federal employer identification number;
- The number of employees employed by the employer;
- Whether the employer offers access to employer-sponsored group health insurance;
- Whether the employer offers or arranges for access to group health insurance (including under a cafeteria plan); and
- Whether the employer maintains a self-funded plan.

The initial form would have been required to be submitted May 15, 2007, based on employees employed as of April 15, 2007. Following the initial HIRD filing, smaller employers will file annual updates, while large employers will file quarterly. If an employee declines the employer’s offer or arrangement of insurance, the employee must also sign the HIRD form. Each such employees would also need to disclose (i) his or her name and social security number, (ii) the name of the employer, (iii) whether the employer offered health insurance or offered to arrange for health insurance; and (iv) whether the employee declined and, if so, whether he or she has other coverage. The obligation for filing this form rests with the employer.

(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. Effective January 1, 2007, Act § 48 adds new M.G.L. ch. 151F s. 48, which provides as follows:

“Each employer with more than 10 employees in the commonwealth shall adopt and maintain a cafeteria plan that satisfies 26 U.S.C. 125 and the rules and regulations promulgated by the connector. A copy of such cafeteria plan shall be filed with the connector.”

Nothing in the Act requires an employer to make its own coverage available through a cafeteria plan. The cafeteria plan requirement is included under the Act’s provisions establishing the Connector. Under Act § 101, an eligible small group³⁶ that

³⁶ M.G.L. ch. 176Q, s. 1 (defining “eligible small group” to mean a sole proprietorship, labor union, educational, professional, civic, trade, church, not-for-profit or social organization or firm, corporation, partnership or association that “on at least 50 per cent of its working days during the preceding year employed at least one but not more than 50 employees”).

chooses to access health insurance coverage through the Connector (a “participating institution”) must make coverage available on a pre-tax basis under a cafeteria plan. The cafeteria plan requirement appears to be limited to so-called “premium-only” arrangements. 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.

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.

IV. INSURANCE MANDATES AFFECTING EMPLOYERS

The Act significantly changes the way that group health insurance is regulated in the Commonwealth of Massachusetts. While most of these changes affect health insurance issuers and providers, there are at least two provisions that will require employers with Massachusetts employees to modify the design of their insured group health plans. These are the insured plan non-discrimination requirement, and an expanded definition of who is a dependent.

(a) The Insured Plan Non-Discrimination Requirement

In crafting the various provisions of the bill relating to employers, the legislature did not want to create an incentive for employers to drop coverage in favor of coverage that became available under the Connector—a phenomenon that is referred to as “crowd out.” Act §§ 50 (relating to any “general or blanket policy of insurance”),³⁷ 52 (relating to non-profit hospital service corporations, i.e., Blue Cross),³⁸ 55 (relating to medical service corporations, i.e., Blue Shield),³⁹ and 59 (health maintenance organizations)⁴⁰ each direct the insurer or HMO to offer policies or contracts only with respect to which (using HMOs as a representative example):

“the employer shall not make 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 each specific or general blanket policy of insurance for all employees.”⁴¹

Under this rule, which takes effect January 1, 2007, whatever health insurance arrangement an employer offers to one employee must be offered to all other who have a

³⁷ Act § 50, adding M.G.L. ch.175, s. 110(O).

³⁸ Act § 53, adding s. 8 to M.G.L. ch.176A.

³⁹ Act § 55, adding s. 3A to M.G.L. ch.176B.

⁴⁰ Act § 59, adding s. 6A to M.G.L. ch.176G.

⁴¹ *Id.*

similar or lesser salary. And while there is in each case a carve-out for collective bargained arrangements, there is no carve-out for part-time, seasonal or temporary employees. These rules are directed to insured plans; they do not apply to self-funded arrangements.

This requirement is revolutionary in many respects. It will all but eliminate disparate treatment of different classes of employees, such as hourly and salaried. Also prohibited are executive-premium or excess plans that are marketed as “insured,” even though they are usually minimum deposit or cost-plus arrangements. These latter plans were marketed as insured in order to avoid the application of the non-discrimination rules that apply to self-funded (but not insured) medical reimbursement plans under Code § 105(h).

The Legislature apparently intended to mimic the non-discrimination rules of the Internal Revenue Code, but ended up adopting a far less flexible rule. Given the express terms of the statutory provision, it does not appear that the Division of Insurance has much leeway to grant relief even if it was inclined to do so. There are no interpretive regulations under these provisions of the Act. A technical correction may be necessary to mitigate the rule’s apparent harshness.

(b) Expanded Dependent Coverage

Act §§ 49 (relating to any “general or blanket policy of insurance”),⁴² 53 (relating to non-profit hospital services, i.e., Blue Cross/Blue Shield hospital payments),⁴³ 56 (relating to medical service corporations, i.e., Blue Cross/Blue Shield physician payments),⁴⁴ and 58 (health maintenance organizations),⁴⁵ each expand coverage for dependents under insured plans until the later of age 25 or “2 years following loss of dependent status under the Internal Revenue Code.”

Code §152 defines the term “dependent” to mean either (i) a “qualifying child” or (ii) a “qualifying relative.”

- A “qualifying child” is a daughter, son, stepchild, sibling, or stepsibling (or descendent of any of any of these) who has the same principal place of abode as the taxpayer for more than one half of the taxable year and who (other than in the case of total disability) has not has not yet attained a specified age.
- A “qualifying relative” is a person who is not a qualifying child and who (i) has the same principal place of abode as the taxpayer for more than one half of the taxable year, (ii) receives more than half of his or her support from the taxpayer, and (iii) has gross income for the year in excess of the Code §151(d) exemption

⁴² Act § 49, amending s. 108 of M.G.L. ch.175.

⁴³ Act § 53, adding s. 8Y to M.G.L. ch.176A.

⁴⁴ Act § 56 adding s. 4Y to M.G.L. ch.176B.

⁴⁵ Act § 58 adding s. 4R to M.G.L. ch.176G.

amount (\$3,300 in 2006). For health plan purposes, however, the income limit does not apply.

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.”⁴⁶ 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.⁴⁷ 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.

This provision does not apply to self-funded plans.

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.⁴⁸ 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.

⁴⁶ 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”).

⁴⁷ PLR 200108010 (November 17, 2000).

⁴⁸ *Supra* note 16.

The political environment in Massachusetts presents another variable. The Act was a compromise between a Republican Governor and a Democratic legislature. Should the executive branch fall into Democratic hands in the upcoming elections, 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.