

MASSACHUSETTS HEALTH CARE REFORM – UPDATED GUIDANCE AS OF OCTOBER 24, 2008

The following is updated guidance summarizing the Massachusetts Health Care Reform Act which applies to all employers with 11 or more full-time equivalent employees working in Massachusetts. There are recent changes under the Act that are included in this bulletin.

The Massachusetts Health Care Reform Act (the “Act”) went into effect July 1, 2007.

The Act is complicated, occasionally contradictory, subject to an ERISA preemption attack, and continually changing.

The centerpiece of the law is the requirement that Massachusetts residents purchase creditable health coverage or face a penalty. The law imposes various requirements on employers.

This memo summarizes the key components of the Act relevant to employers as of October 24, 2008.

Please note that information on the governmental websites listed below is not up-to-date at this time (and that the websites are very difficult to navigate).

Employers Subject to the Law

Employers with 11 or more full-time equivalent (“FTE”) employees working at Massachusetts locations must comply with the Act. The residency of the employees is not relevant.

Employers will need to count the payroll hours of all employees working in Massachusetts except for:

- employees working in Massachusetts for less than one month;
- independent contractors;
- temporary employees; and
- seasonal employees.

Before October 1, 2008

In determining whether an employer has 11 FTE employees prior to October 1, 2008, the employer had to look at the payroll hours for the “applicable base period” - October 1

through September 30. The maximum number of hours counted for any one employee in a year was 2,000. Therefore, the minimum employer threshold for compliance with the Act was 22,000 payroll hours in the applicable base period – 11 x 2,000 payroll hours.

On and after October 1, 2008

In determining whether an employer has 11 FTE employees on and after October 1, 2008, the employer will look at the payroll hours for the “applicable base period” - October 1 through December 31, January 1 through March 30, April 1 through June 30, or July 1 through September 30. The maximum number of hours counted for any one employee in a quarter is 500. Therefore, the minimum employer threshold for compliance with the Act is 5,500 payroll hours in the applicable base period – 11 x 500 payroll hours.

The responsibility for determining whether an employer is subject to the Act rests with each employer. Currently, the Commonwealth does not collect information about the number of FTE employees at each business. Some agencies may have this information on record (like the Division of Unemployment Assistance (“DUA”)) and may provide notice reminders to certain registered employers. However, not all employers will receive such notices, particularly if they are companies new to Massachusetts or if they increase their employee group size mid-year.

It is important for employers who may be on the threshold of 11 FTE employees to monitor their hours to determine if they become subject to the Act.

Fair Share Contribution Requirement

The Act includes a Fair Share Contribution (“FSC”) requirement imposing an annual fee (\$295 per Full-Time Employee per year) on employers who do not make a certain contribution (described below) to the health care coverage of some or all of its Full-Time Employees.

“Full-Time Employees” are employees who work at least the lesser of (a) 35 hours per week or (b) the required number of hours per week required by the employer to participate in the health plan.

Before January 1, 2009

An employer has satisfied the FSC requirement prior to January 1, 2009 if:

- the percentage of Full-Time Employees enrolled in its group health plan is 25%;
or
- it meets the “premium contribution standard” (defined below)

On and After January 1, 2009

1. Employers with 50 or Fewer FTE Employees

An employer with 50 or fewer FTE employees will satisfy the FSC requirement based on the pre-2009 criteria set out above.

2. Employers with More Than 50 FTE Employees

An employer with more than 50 FTE employees will satisfy the FSC requirement if:

- the percentage of Full-Time Employees enrolled in its group health plan is 25% and it meets the “premium contribution standard” (defined below); or
- the percentage of its Full-Time Employees enrolled in the employer’s group health plan for the quarter is at least 75%.

The “premium contribution standard” requires the employer contribute at least 33% toward the premium cost for individual coverage to all Full-Time Employees employed more than 90 days during the applicable base period.

For the revised rules, visit:

http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_5_16.pdf

FSC Filing Requirement

Generally, the information reported by employers for purposes of the FSC report will encompass payroll, employment, cafeteria plan (employer HIRD disclosure), and health insurance coverage data for the “applicable base period.”

Before October 1, 2008, the applicable base period was October 1 – September 30 and the due date for filing was November 15. So, the final annual filing will be due November 15, 2008.

For periods beginning on and after October 1, 2008, the applicable base period and due date for filing is as follows:

<u>Applicable Base Period</u>	<u>Due Date</u>
October 1 – December 31	February 15th
January 1 – March 30	May 15
April 1 – June 30	August 15
July 1 – September 30	November 15

How?

The system is accessed online via the website at: <https://fsc.detma.org/>

An employer must be registered as an employer subject to unemployment insurance with DUA and must have already received its 8-digit DUA number. The employer must use its unique DUA number each time it accesses this FSC filing system to initiate or continue its FSC filing process.

The filing process will also be the vehicle for initiating the payment process if the employer is determined to be liable for payment.

All data filed by the employer is subject to audit and/or validation by DUA and/or other agencies of the Commonwealth.

For more information, visit:

[http://www.mass.gov/?pageID=elwdtopic&L=3&L0=Home&L1=Businesses&L2=Fair+Share+Contribution+\(FSC\)&sid=Elwd](http://www.mass.gov/?pageID=elwdtopic&L=3&L0=Home&L1=Businesses&L2=Fair+Share+Contribution+(FSC)&sid=Elwd)

Free Rider Surcharge

Employers are subject to a “free rider surcharge” of between 10 percent and 55 percent of claim costs if more than 5 uninsured employees or dependents use free public health care or if one uninsured employee or dependent uses free state-provided care more than 3 times a year. The first \$50,000 of care is not considered. However, employers that adopt a cafeteria plan that meets the requirements described below or are subject to a collective bargaining agreement are exempt from the surcharge.

Cafeteria Plan Requirement

An employer must adopt and maintain a cafeteria plan that satisfies both a) Section 125 of the Internal Revenue Code and b) regulations established by the Commonwealth Connector (the “Health Connector”).

The Plan must be, at minimum, a “premium-only plan” that allows employees to pay for or contribute to the cost of health care coverage on a pre-tax basis. The cafeteria plan must allow access to one or more health care coverage options. Health care coverage options made available under the employer’s cafeteria plan may (but are not required to) include those offered through the Health Connector.

There is a limited exception to the cafeteria plan requirement for noncontributory plans where the employer pays the full monthly cost of medical coverage for all employees (and any covered dependents).

One or more of the following classes of employees may be specifically excluded from cafeteria plan eligibility:

- employees who are less than 18 years of age;
- temporary employees;
- part-time employees working, on average, fewer than 64 hours per month for an employer¹;

¹ When determining whether employees qualify as excludable, part-time employees on the basis of their having worked, on average, fewer than 64 hours per month, an employer shall make a reasonable, good faith effort to identify, determine, and document those employees excluded by this classification using the following procedures:

a. Determining Hours On Average for Existing Employees. Other than for new employees described in subparagraph b. below, an employer will have made a reasonable, good faith effort with regard to the exclusion of an existing employee under this classification if the employer determines that the employee has worked an average of 63 or fewer hours per calendar month for the 180 days immediately preceding the first day of any open or special enrollment period under the section 125 cafeteria plan for which the employee is eligible (including eligibility subject to a waiting period). Average hours will be determined by dividing the employee’s gross payroll hours during the 180 day period by 6.

b. Determining Hours On Average for New Employees. A new employee is an employee whose first day of employment commences on or after (A) July 1, 2007 and (B) the effective date of the employer’s section 125 cafeteria plan for which the employee is eligible (including eligibility subject to a waiting period). The employer will have made a reasonable, good faith effort with regard to the exclusion of a new employee under this classification if the employer reasonably determines that, as of the employee’s date of hire, the employee will be

- employees for whom the employer is required to contribute to a multiemployer health benefit plan based on their employment;
- employees who are considered wait staff, service employees, or service bartenders and who earn, on average, less than \$400 in monthly payroll wages; tips are not included in monthly payroll wages for this purpose;
- seasonal employees who are international workers with either a U.S. J-1 student visa or a U.S. H2B visa and who are also enrolled in travel health insurance;
- student employees who are employed as interns or as cooperative education student workers; and
- students who are employed part-time as employees of the educational institution they attend and who, as a condition of attending that educational institution, participate in a qualifying student health insurance program or in a health plan with comparable coverage, as required by state law.

Employers are required to submit a copy of their cafeteria plans within 7 business days of a request by the Health Connector.

An employer's failing to implement a cafeteria plan may subject the employer to the Free Rider Surcharge (discussed above).

A handbook on the cafeteria plan requirement can be found at:

<http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Section%2520125%2520Handbook%2520documents/Section%2520125%2520Handbook.pdf>

Guidance can be found at:

<http://www.mahealthconnector.org/portal/site/connector/menuitem.5de15e4af5dc94de505da95c0ce08041/?fiShown=default>

Employee HIRD Requirement

Employees working in Massachusetts who decline to enroll in the employer-sponsored health plan and/or the Section 125 cafeteria plan must sign and submit to the employer the employee Health Insurance Responsibility Disclosure (“HIRD”) form.

Employers are supposed to collect the HIRD form from individuals who decline coverage within 30 days after the end of an open enrollment period or otherwise decline coverage outside of open enrollment (for example, at the time of hire). Employers are expected to retain the form for three years.

This form can be found at:

http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Healthcare+Reform&L4=Health+Care+Reform+Employer+Requirements&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_hird&csid=Eeohhs2#employee_hird

scheduled or will be expected to work an average of 63 or fewer hours per calendar month during the first 180 days following commencement of employment. An employee will be considered a new employee, so long as he/she remains employed, until (X) the 180th day following commencement of employment or (Y) if later, until the date immediately preceding the first day of the next open or special enrollment period under the section 125 cafeteria plan.

MA Form 1099-HC

Employers have the following reporting requirements to be fulfilled by **January 31** with respect to their health plans:

- Form MA 1099-HC distribution to all participants who reside in Massachusetts; and
- A report filed with the Commissioner of the Massachusetts Department of Revenue (“DOR”) verifying that Forms MA 1099-HC were, in fact, sent.

If the plan is insured, the insurance carrier is generally responsible for these reports; if the plan is self-funded, the employer is generally responsible for these reports. Sponsors of insured plans should confirm with their carrier that it is handling these requirements; sponsors of self-funded plans that use the services of a third party administrator (“TPA”) should first check with the TPA to see whether it already intends to handle these requirements.

There is no standardized format for the Form MA 1099-HC. The look of the form may vary depending upon each carrier; however, the information fields are consistent. A sample form is available at: www.mass.gov/Ador/docs/dor/health%20care/1099_hc.pdf

Massachusetts residents use the information on MA 1099-HC to complete Schedule HC of their state income tax return to establish compliance with the individual mandate to maintain health coverage. See <http://www.mass.gov/Ador/docs/dor/health%20care/HC.pdf>

Schedule HC must be completed by Massachusetts residents even they did not receive the Form MA 1099-HC from the employer. In this case, they will complete the bubble on line 2 of the schedule indicating that they did not receive a Form MA 1099-HC and provide the name of their administrator and the subscriber/policy number (as shown on the insurance card).

DOR Commissioner’s Report

Sponsors of self-funded plans also have to file a report with the DOR Commissioner that essentially electronically files the information on multiple Forms MA 1099-HC regarding their health plans. Sponsors should check with their TPA to determine whether the TPA is submitting this report on behalf of the plan.

The report must be submitted online. The DOR’s Web site includes technical instructions on how to file the DOR Commissioner’s Report. See http://www.mass.gov/Ador/docs/dor/softwaredevelopers/health%20care/pdfs/MADOR_1099HC_Instructions.pdf

Plan sponsors required to submit the reports may wish to provide the instructions to their IT staff, as additional programming may be necessary to comply.

Penalties for Noncompliance - MA 1099-HC and DOR Commissioner's Report

Plan sponsors and insurance carriers that fail to provide a Form MA 1099-HC to Massachusetts residents or to file a DOR Commissioner's Report are subject to a penalty of \$50 per individual to which the failure relates, to a maximum of \$50,000, although it can be inferred from the language used by the State in describing the process on its website that penalties will not be assessed for the first year. Penalties can be abated for reasonable cause, but inadvertent oversight does not meet the reasonable cause standard.

Minimum Creditable Coverage

Financial penalties are imposed on residents not enrolled in health care plans providing so-called "minimum creditable coverage." Currently, any health coverage will suffice.

Beginning January 1, 2009, only those health plans that meet certain requirements will constitute minimum creditable coverage. These requirements include:

- A "broad range of medical benefits, including but not limited to, preventive and primary care, emergency services, hospitalization, ambulatory patient services, prescription drugs, and mental health services" (but the plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers).
- Varied levels of co-payments, deductibles, and co-insurance are permitted within limits (i.e., the plan must disclose to covered persons the deductible, co-payment and co-insurance amounts applicable to in-network and out-of-network covered services; any deductible for in-network covered services must not exceed \$2,000 for an individual and \$4,000 for a family; and any separate deductible imposed for prescription drug coverage may not exceed \$250 for an individual and \$500 for a family).
- If the plan includes deductibles or co-insurance, the plan must set out-of-pocket maximums for in-network covered services that do not exceed \$5,000 for an individual and \$10,000 for a family (this requirement does not apply to a plan that includes co-insurance only for a limited number of select covered services).
- A plan's calculation of any out-of-pocket maximum must include all the following payments for covered services made by the individual or family: co-payments over \$100, coinsurance and deductibles (provided, however, that amounts paid for prescription drugs, whether through deductibles, co-insurance or co-payments, need not be considered in calculating the out-of-pocket maximum).
- A plan may not impose an annual maximum benefit or a per-illness annual maximum benefit for covered services, nor may it impose a fee schedule of indemnity benefits for covered services.
- A plan that imposes a deductible must cover the following on an annual basis before imposing a deductible: for an individual, at least three preventive care visits to a physician or other health care provider; and for a family, at least a total of six preventive-care visits to a physician or other health care provider.
 - *Note that plans may not necessarily offer this many preventive care visits under current designs.*

- Any preventive-care visits covered before the imposition of a deductible may be subject to co-payments or co-insurance, but co-payments or co-insurance may not exceed the co-payment or co-insurance applied by the plan to primary care or routine physician office visits.
- A plan must either include prescription drugs as a covered medical benefit, after a deductible ranging from \$0 to \$250 for individual coverage and ranging from \$0 to \$500 for family coverage; or (as approved by the Health Connector) provide alternative plan designs that would allow for coverage of preventive prescription drugs without any deductible, in addition to coverage of other prescription drugs with a deductible, co-payment or co-insurance, for a projected average increase of no more than 5% in the price of premiums.
- The proposed regulation also sets out a list of items that do not rise to the level of minimum creditable coverage. This list includes accident-only, credit-only or limited-scope vision or dental benefits; hospital indemnity insurance policies if offered as independent, non-coordinated benefits (e.g., policies which provide an in-patient hospitalization benefit not to exceed \$500 per day); disability income insurance; supplemental liability insurance; specified disease insurance; insurance arising out of a workers' compensation law or similar law; and automobile medical payment insurance, among others.
 - *Tip: Employers providing mini-med plans likely are not offering creditable coverage as they typically have a per benefit limit.*

High deductible health plans linked with Health Savings Accounts are exempt from these requirements.

While employers are not required to provide a plan that satisfies the definition of "minimum creditable coverage," their employees need creditable coverage in order to avoid significant penalties. Employers may wish to review their plan designs when working with employees residing in Massachusetts.

ERISA Preemption

It appears that the cafeteria plan requirement, the FSC filing obligations, and the 2009 creditable coverage rules are increasingly susceptible to an ERISA preemption argument. Time will tell whether employers raise this issue and whether a federal court agrees that parts of the Massachusetts Health Care Reform Act are preempted by ERISA which is designed to promote uniform benefits plan design and administration.

Employer Action

Employers should:

- determine if the Act applies to them;
- consider discussing with counsel whether these state requirements are enforceable, including whether the requirements are preempted by ERISA;
- make a fair and reasonable contribution;
- file a final annual FSC report by November 15, 2008;
- file quarterly FSC reports, beginning February 15, 2009;
- evaluate their cafeteria plans for compliance to avoid the free rider surcharge;
- ensure that the carrier or TPA (in a self-insured arrangement) will provide MA 1099-HC to covered employees annually by January 31;

- ensure that the carrier or TPA (in a self-insured arrangement) will file MA 1099-HC with the Department of Revenue annually by January 31;
- if self-funded, file (or ensure that the TPA will file) the DOR Commissioner's Report;
- review current plan designs to determine whether they comply with minimum creditable coverage requirements and, if not, determine whether to make any design changes to better assist employees in complying with their coverage requirement.

Future Developments

Employers can monitor developments at:

<http://www.mahealthconnector.org/portal/site/connector/menuitem.d7b34e88a23468a2dbef6f47d7468a0c?fiShown=default>

Additional detail about employer obligations under the Act can be found at:

<http://www.mahealthconnector.org/portal/site/connector/menuitem.26c01aac2120f4ce505da95c0ce08041>

The law can be found at:

<http://www.mahealthconnector.org/portal/site/connector/menuitem.969392a5ed3d84c2dbef6f47d7468a0c/?fiShown=default>

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